LEGISLATIVE PACKET

MEDICAL BOARD MEETING

April 25, 2013
Los Angeles, CA

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
April 16, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 27	Medina	UC Riverside Medical School: Funding	Asm. Approps.	Reco: Support	3/21/13
AB 154	Atkins	Healing Arts: Reproductive Health Care	Asm. Health	**Exec. Reco: Neutral**	3/19/13
AB 186	Mainschein	Professions & Vocations: Military Spouses: Temporary Licenses	Asm. B&P	Reco: Oppose Unless Amended	4/1/13
AB 496	Gordon	Task Force: LGBT Cultural Competency	Asm. B&P	Reco: Neutral	4/10/13
AB 512	Rendon	Sponsored Health Care Events: Sunset Extension	Asm. Approps.	Reco: Support	Intro.
AB 565	Salas	California Physician Corps Program	Asm. Health	Reco: Support	4/10/13
AB 589	Fox	Underrepresented Medical Specialties	Asm. Health	2-year Bill	Intro.
AB 635	Ammiano	Drug Overdose Treatment: Liability	Senate	**Exec. Reco: Support in Concept**	4/11/13
AB 809	Logue	Healing Arts: Telehealth	Asm. Health	Reco: Neutral	4/3/13
AB 831	Bloom	Drug Overdoses	Asm. Approps.	**Exec. Reco: Support**	4/3/13
AB 860	Perea	Medical School Scholarships	Asm. Approps.	Reco: Support	4/8/13
AB 916	Eggman	Healing Arts: False or Misleading Advertising	Asm. B&P	**Exec. Reco: Support**	Intro.
AB 1000	Wieckowski	Physical Therapists: Direct Access to Services	Asm. B&P	Reco: Oppose **Exec - Defer**	3/21/13
AB 1003	Mainschein	Professional Corporations: Healing Arts Practitioners	Asm. B&P	Reco: Support	4/1/13
AB 1176	Bocanegra & Bonta	Medical Residency Training Program Grants	Asm. Health	Reco: Support	3/21/13
AB 1182	Brown	Medically Underserved Areas	Assembly	SPOT	Intro.
AB 1269	Gray	Medicine: Special Faculty Permit	Asm. B&P	SPOT	Intro.
AB 1278	Hueso	Integrative Cancer Treatment	Now SB 117	**Exec. Reco: Neutral**	SB 117
AB 1288	Perez, M.	Medical Board of California: Licensing Application	Asm. Health	Reco: Neutral	4/11/13

Green – For Discussion, Yellow – Consent Items, Orange – Position Taken, Blue – Spot or 2-year Bill

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
April 16, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 1308	Bonilla	Midwifery	Asm. B&P	**Exec. Reco: Support if Amended**	3/21/13
ACR 40	Perez	Donate Life California Day	Enrollment	Reco: Support	4/8/13
SB 20	Hernandez	Health Care: Workforce Training	Sen. Approps.	Reco: Support	2/14/13
SB 21	Roth	UC Riverside Medical School: Funding	Sen. Education	Reco: Support	3/18/13
SB 62	Price	Coroners: Reporting Requirements: Prescription Drug Use	Sen. B&P, 4/15	Support if Amended	4/9/13
SB 117	Hueso	Integrative Cancer Treatment	Sen. Health	**Exec. Reco: Neutral**	4/8/13
SB 304	Price	Healing Arts: Sunset Bill	Sen. B&P	Reco: Support	Intro.
SB 305	Price	Healing Arts: Boards	Sen. B&P	Reco: Support	4/15/13
SB 352	Pavley	Medical Assistants: Supervision	Sen. 3rd Reading	**Exec. Reco: Neutral if Amended**	4/10/13
SB 410	Yee	Controlled Substances & Dangerous Drugs	Senate	SPOT	Intro.
SB 491	Hernandez	Nurse Practitioners	Sen. B&P	Reco: Oppose	4/1/13
SB 492	Hernandez	Optometric Corporations	Sen. B&P	Reco: Oppose	4/1/13
SB 493	Hernandez	Pharmacy Practice	Sen. B&P	Reco: Oppose	4/1/13
SB 670	Steinberg	Limitation on Licensee Authority: Controlled Substances	Sen. B&P	Reco: Support in Concept	4/8/13
SB 701	Emmerson	Hospital-Affiliated Outpatient Settings	Sen. B&P	Reco: Neutral	Intro.
SB 796	Nielsen	Medicine: Physicians and Surgeons	Senate	SPOT	Intro.
SB 809	DeSaulnier	Controlled Substances: Reporting: CURES	Sen. B&P, 4/15	**Exec. Reco: Support in Concept**	Intro.
SCR 8	DeSaulnier	Prescription Drug Abuse Awareness Month	Asm. 3rd Reading	Support	Intro.

Green – For Discussion, Yellow – Consent Items, Orange – Position Taken, Blue – Spot or 2-year Bill

AB 27

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 27 and SB 21
Author:	Medina and Roth
Bill Date:	March 21 and 18, 2013, amended
Subject:	UC Riverside Medical School: Funding
Sponsor:	Authors

STATUS OF BILL:

AB 27 is in the Assembly Appropriations Committee and SB 21 is in the Senate Education Committee.

DESCRIPTION OF CURRENT LEGISLATION:

These bills mirror each other and would both annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California, Riverside. Both bills contain urgency clauses, which mean that the bills would take effect immediately once signed into law.

ANALYSIS:

The foundation of the School of Medicine at UC Riverside goes back to 1974, when the UC Riverside / University of California, Los Angeles (UCLA) Thomas Haider Program in Biomedical Sciences was established. This program has allowed approximately 700 students to complete their first two years of medical school at UC Riverside, and their last two years at the David Geffen School of Medicine at UCLA, which confers their medical degrees.

In July 2008, the UC Board of Regents officially approved the proposed establishment of an independent four-year School of Medicine at UC Riverside, intended to serve the medically underserved in the Inland Empire. However, in the summer of 2011, UC Riverside failed to gain accreditation for an independent four-year medical school from the Liaison Committee on Medical Education (LCME), the national accrediting body for educational programs leading to the Medical Doctor degree in United States. LCME withheld preliminary accreditation due to a lack of stable state funding support for the school. In April 2012, UC Riverside secured substantial new funding from a variety of non-state funding sources, and submitted a second accreditation application to LCME. In June 2012, a second accreditation site visit took place and in October 2012, UC Riverside received notification from LCME that its planned medical school received "preliminary accreditation." Preliminary accreditation from LCME enables prospective students to begin applying to the UC Riverside School of Medicine in order to potentially enroll in August 2013.

These bills would appropriate $15,000,000 from the General Fund in order to establish a more viable funding source for the UC Riverside School of Medicine. According to the author, the highest indicator of where a physician practices is where he or she attends medical school and the Inland

Empire trails behind much of the state in several key health indicators, including coronary heart disease and diabetes. The author believes that the establishment of a medical school in the Inland Empire will help to ensure more physicians are trained and remain in the Inland Empire. The author contends that one of the areas that will aid in the UCR School of Medicine receiving final accreditation from LCME and meeting the medical needs of the Inland Empire is for the Medical School to receive a stable funding source, which is why this bill seeks to appropriate General Fund monies.

According the Public Policy Institute of California, the Inland Empire is the fastest-growing region of the state and it is estimated that more than 300,000 residents of the Inland Empire will have health insurance coverage extended to them as a result of the Affordable Care Act. The U.S. Department of Health and Human Services' Council on Graduate Medical Education recommends that a given region have 60 to 80 primary care physicians per 100,000 residents and 85 to 105 specialists. The Inland Empire has about 40 primary care doctors and 70 specialists per 100,000 residents, which is a severe shortage.

These bills will help to increase access to care and help the Inland Empire area of California to prepare and be ready for implementation of the Affordable Care Act. Board staff suggests that the Board support this bill.

FISCAL: None to the Board

SUPPORT: California Department of Insurance; California Medical Association; City of Riverside; Enterprise Media; Riverside County Superintendent of Schools, Kenneth M. Young; Southwest California Legislative Council; University of California at Riverside; UC Riverside Alumni Association; UC Riverside Board of Trustees; and two individuals.

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY MARCH 21, 2013

AMENDED IN ASSEMBLY MARCH 13, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 27

Introduced by Assembly Member Medina
(Coauthor: Assembly Member Linder)

December 3, 2012

An act relating to the University of California, ~~and~~ making an appropriation therefor, *and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

AB 27, as amended, Medina. University of California: UC Riverside Medical School: funding.

Existing provisions of the California Constitution establish the University of California as a public trust under the administration of the Regents of the University of California. The University of California system includes 10 campuses, which are located in Berkeley, Davis, Irvine, Los Angeles, Merced, Riverside, San Diego, San Francisco, Santa Barbara, and Santa Cruz.

This bill would annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California, Riverside.

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

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

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

SECTION 1. The sum of fifteen million dollars ($15,000,000) is hereby appropriated annually from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California, Riverside.

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 serve students without disrupting their education at the School of Medicine at the University of California, Riverside, and to ensure the continuation of funding to this school, it is necessary for this act to take effect immediately.

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AB 154

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 154
Author:	Atkins
Bill Date:	March 19, 2013, amended
Subject:	Abortion
Sponsor:	ACCESS Women's Health Justice American Civil Liberties Union of California Black Women for Wellness California Latinas for Reproductive Justice NARAL Pro-Choice California Planned Parenthood Affiliates of California

STATUS OF BILL:

This bill is in the Assembly Health Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would eliminate the distinction in existing law between "surgical" and "nonsurgical" abortions and would allow physician assistants (PAs), nurse practitioners (NPs), and certified nurse-midwives (CNMs) to performs an abortion by medication or aspiration techniques in the first trimester of pregnancy, if specified training is completed and clinical competency is validated.

ANALYSIS:

This bill will codify the Health Workforce Pilot Project (HWPP) #171, coordinated through the Office of Statewide Health Planning and Development (OSHPD) and sponsored by the Advancing New Standards in Reproductive Health (ANSIRH) program at the University of California, San Francisco (UCSF). The purpose of the pilot project was to evaluate the safety, effectiveness and acceptability of NPs, NMs, and PAs in providing aspiration abortions, and to evaluate the implementation of a standardized, competency based curriculum in provision of aspiration abortion care.

As part of the pilot, 40 NPs, CNMs and PAs were trained to be competent in aspiration abortion care. Clinicians participated in a comprehensive didactic and supervised clinical training program, which included a written exam and competency-based evaluation process. Trainee competency was evaluated daily and at the end of training on confidence, procedural performance, patient care, communication /interpersonal skills, professionalism, practice-based learning, and clinical knowledge.

This bill would require PAs, NPs, and CNMs to complete specified training and achieve clinical competency, which was also required as a part of the pilot project, before they are allowed to perform abortions by aspiration techniques.

STATISTICS of the HWPP Pilot Project (#171) (Taken from the Peer Reviewed Study published in the American Journal of Public Health):

Patient sample selection, enrollment and consent:

- 5,675 first-trimester aspiration abortion procedures were completed by NPs/CNMs/PAs and 5,812 procedures were completed by physicians, for a total of 11,487 abortion procedures.

Abortion-related complications summary:

- A complication is identified at the time of the procedure (immediate) or after the procedure (delayed) and classified as either major (defined by the DCSMC as "complications requiring abortion-related surgeries, transfusion or hospitalization") or minor.
- Overall abortion-related complication rate: 1.3% of all procedures (152 of 11,487) had abortion-related complication diagnoses.
- Group-specific abortion-related complication rate: 1.8% for NPs, CNMs, and PAs and 0.9% for physicians.
- 96% (146 out of 152) of abortion-related complications were minor; 6 cases have been classified as major complications.
- The most common type of minor abortion-related complication diagnoses reported were incomplete abortion, hematometra, and failed abortion. Major abortion-related complications include hemorrhage, infection, and uterine perforation.
- The peer reviewed study found that abortion complications were clinically equivalent between newly trained NPs, CNMs, and PAs and physicians.

According to the author's office, this bill is needed to ensure that women in California have access to early abortion. According to the author's office early abortion access is a critical public health issue as many women in California do not have sufficient access to aspiration abortion because many counties in California lack an abortion provider, which requires women to travel a significant distance for care. The sponsors believe that increasing the number of providers for aspiration abortions will increase the ability of women to receive safe reproductive health care from providers in their community.

FISCAL: None

SUPPORT: ACCESS Women's Health Justice (sponsor); American Civil Liberties Union of California (Sponsor); Black Women for Wellness California (sponsor); Latinas for Reproductive Justice (sponsor); NARAL Pro-Choice California (sponsor); and Planned Parenthood Affiliates of California (sponsor); ACT for Women and Girls; American Association of University Women; American College of Nurse-Midwives; American Nurses Association; Bay Area Communities for Health Education; California Academy of Family Physicians; California Academy of Physician Assistants; California Association for Nurse Practitioners; California Church IMPACT; California Family Health Council; California Nurse-Midwives Association; California Women's Law Center; Cardea Institute; Center on Reproductive Rights and Justice at UC Berkeley School of Law; Choice USA; Choice USA at California State University Long Beach; Choice USA at

California State University Sacramento; Choice USA at Mills College; Choice USA at San Jose State University; Choice USA at Scripps College Beach; Forward Together; Fresno Barrios Unidos; Khmer Girls in Action; Law Students for Reproductive Justice; League of Women Voters of California; National Asian Pacific American Women's Forum; National Center for Lesbian Rights; National Health Law Program; National Latina Institute for Reproductive Health; National Network of Abortion Funds; Nevada County Citizens for Choice; Physicians for Reproductive Health; Planned Parenthood Mar Monte; Planned Parenthood of Orange and San Bernadino Counties; Planned Parenthood Pasadena & San Gabriel Valley; Planned Parenthood of Santa Barbara, Ventura, and San Luis Obispo Counties; Planned Parenthood of the Pacific Southwest; Reproductive Justice Coalition of Los Angeles; Six Rivers Planned Parenthood; Students for Reproductive Justice at Stanford University; Women's Community Clinic; Women's Health Specialists of California; and numerous private individuals

OPPOSITION: California Catholic Conference; California Right to Life Committee; Capitol Resource Institute; and numerous private individuals and churches

POSITION: Executive Committee Recommendation: Neutral

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 154

Introduced by Assembly Member Atkins

January 22, 2013

~~An act relating to reproductive health care.~~ *An act to amend Section 2253 of, and to add Sections 734, 2725.4, and 3502.4 to, the Business and Professions Code, and to amend Section 123468 of the Health and Safety Code, relating to healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

AB 154, as amended, Atkins. ~~Healing arts: reproductive health care.~~ *Abortion.*

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

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

~~Existing law authorizes the Office of Statewide Health Planning and Development to designate experimental health workforce projects as approved projects that, among other things, teach new skills to existing categories of health care personnel. The office has designated a pilot project, known as the Access through Primary Care Project, relating to the provision of health care services involving pregnancy.~~

~~This bill would state that it is the intent of the Legislature to enact legislation that would expand access to reproductive health care in California by allowing qualified health care professionals to perform early abortions.~~

This bill would instead make it a public offense, punishable by a fine not exceeding $10,000 or imprisonment, or both, for a person to perform an abortion if the person does not have a valid license to practice as a physician and surgeon, except that it would not be a public offense for a person to perform an abortion by medication or aspiration techniques in the first trimester of pregnancy if he or she holds a license or certificate authorizing him or her to perform the functions necessary for an abortion by medication or aspiration techniques. The bill would also require a nurse practitioner, certified nurse-midwife, or physician assistant to complete training, as specified, in order to perform an abortion by aspiration techniques, and would indefinitely authorize a nurse practitioner, certified nurse-midwife, or physician assistant who completed a specified training program and achieved clinical competency to continue to perform abortions by aspiration techniques. The bill would delete the references to a nonsurgical abortion and would delete the restrictions on assisting with abortion procedures. The bill would also make technical, nonsubstantive changes.

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

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

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

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

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

SECTION 1. Section 734 is added to the Business and Professions Code, to read:

734. It is unprofessional conduct for any nurse practitioner, certified nurse midwife, or physician assistant to perform an abortion pursuant to Section 2253, without prior completion of training and validation of clinical competency.

SEC. 2. Section 2253 of the Business and Professions Code is amended to read:

2253. (a) Failure to comply with the Reproductive Privacy Act (Article 2.5 (commencing with Section 123460) of Chapter 2 of Part 2 of Division 106 of the Health and Safety Code) ~~in performing, assisting, procuring or aiding, abetting, attempting, agreeing, or offering to procure an illegal abortion~~ constitutes unprofessional conduct.

(b) (1) ~~A~~ *Except as provided in paragraph (2), a* person is subject to ~~Sections~~ *Section* 2052 ~~and 2053~~ if he or she performs ~~or assists in performing a surgical~~ *an* abortion, and at the time of so doing, does not have a valid, unrevoked, and unsuspended license to practice as a physician and surgeon ~~as provided in this chapter, or if he or she assists in performing a surgical abortion and does not have a valid, unrevoked, and unsuspended license or certificate obtained in accordance with some other provision of law that authorizes him or her to perform the functions necessary to assist in performing a surgical abortion~~.

(2) A person ~~is~~ *shall not be* subject to ~~Sections~~ *Section* 2052 ~~and 2053~~ if he or she performs ~~or assists in performing a nonsurgical abortion,~~ *an abortion by medication or aspiration techniques in the first trimester of pregnancy,* and at the time of so doing, ~~does not have a valid, unrevoked, and unsuspended license to practice as a physician and surgeon as provided in this chapter, or does not have~~ *has* a valid, unrevoked, and unsuspended license or certificate obtained in accordance with some other provision of law, *including, but not limited to, the Nursing Practice*

Act (Chapter 6 (commencing with Section 2700)) or the Physician Assistant Practice Act (Chapter 7.7 (commencing with Section 3500)), that authorizes him or her to perform ~~or assist in performing~~ the functions necessary for ~~a nonsurgical abortion.~~ *an abortion by medication or aspiration techniques.*

~~(c) For purposes of this section, "nonsurgical abortion" includes termination of the use of pharmacological agents.~~

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

SEC. 3. Section 2725.4 is added to the Business and Professions Code, to read:

2725.4. (a) In order to perform an abortion by aspiration techniques, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall complete training recognized by the Board of Registered Nursing. Beginning January 1, 2014, and until January 1, 2016, the competency-based training protocols established by Health Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development shall be used.

(b) A nurse practitioner or certified nurse-midwife who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques.

SEC. 4. Section 3502.4 is added to the Business and Professions Code, to read:

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

(b) The training protocols established by HWPP No. 171 shall be deemed to meet the standards of the Physician Assistant Board. A physician assistant who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques.

SEC. 5. Section 123468 of the Health and Safety Code is amended to read:

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

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

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

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

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

SEC. 6. 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.

~~SECTION 1. It is the intent of the Legislature to enact legislation that would expand access to reproductive health care in California by allowing qualified health care professionals to perform early abortions, provided that the functions are within the scope of their licenses.~~

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http://blog.ansirh.org/2013/01/roe-v-wade-california-abortion-law-hwpp-171-and-the-future-of-access/

Roe v Wade, California abortion law, HWPP #171, and the future of access

Posted January 17, 2013 By Tracy Weitz

A newly published landmark study by ANSIRH demonstrates that trained nurse practitioners, certified nurse midwives, and physician assistants match physicians in the safety of aspiration abortions they provide. We hope that these results will give policymakers the evidence they need to move beyond physician-only restrictions in order to enable more women to have their reproductive health care needs met in their local communities by health care providers they know and trust.

January 22, 2013 marks the 40th anniversary of the *Roe v. Wade* Supreme Court decision that legalized abortion nationwide. While abortion in California had been legal under more limited circumstances since 1967, *Roe* did have an effect on our law. It eliminated the need for a psychiatrist to approve a woman's abortion, negated the requirement that abortions be performed in hospitals, and extended when a woman could have an abortion. But the law on the books didn't change.

It wasn't until 2000, when the FDA was poised to approve mifepristone (the "abortion pill"), that advocates considered asking the legislature to modernize the abortion law. Legal research in California confirmed that the state's physician-only law would prohibit nurse practitioners (NPs), certified nurse midwives (CNMs), and physician assistants (PAs) from being able to offer women the abortion pill, thereby limiting the benefit of this new abortion option. Although they knew it wouldn't be easy, advocates took on the challenge of reforming California's abortion law. A lot of hard work paid off, and on January 1, 2003, California enacted a contemporary abortion law. Known as the Reproductive Privacy Act, SB1301 codified the *Roe v. Wade* standards and affirmed the legal right of NPs, CNMs, and PAs to perform abortions using medications.

One of the unsettled parts of the discussion over SB1301 was whether non-physician clinicians should be allowed to offer other types of low-risk abortion procedures. At the time, there were two published studies on the provision of aspiration abortion by PAs in Vermont and New Hampshire. While the authors found no difference in safety, the studies included both a small number of patients and only a few clinicians. For many stakeholders, the evidence was insufficient to give them comfort opening up California's law in this way. What was needed was a more comprehensive study of the safety of aspiration abortion provision by NPs, CNMs, and PAs.

This is where UCSF entered the picture

After a few years of research design and fundraising, ANSIRH researchers were prepared to study the safety and competency of NPs, CNMs, and PAs performing aspiration abortions. In order to conduct the study, we utilized the Health Workforce Pilot Project (HWPP) mechanism within the Office of Statewide Health Planning and Development (OSHPD), which provides legal waivers for demonstration projects to test and evaluate new or expanded roles for health care professionals to improve access to health care and encourage workforce development. In 2007, UCSF obtained a legal waiver from the State and the HWPP #171 study began.

HWPP #171 was designed to answer two questions:

1. Can NPs, CNMs, and PAs be trained to competence in aspiration abortion?
2. Can they perform those procedures with outcomes comparable to those of their physician colleagues?

There were three principal investigators on the application to the state: Tracy A. Weitz, PhD, MPA; Diana Taylor, PhD, FNP, and Philip Darney, MD, MSc. There is also a principal investigator for each of the five partner organizations where clinicians were trained and offered services (four Planned Parenthood affiliates and Kaiser Permanente of Northern California).

Today, the results of our study were released in the *American Journal of Public Health*, one of the nation's most prestigious peer-reviewed journals.

The study results are relatively simple. A total of 5,675 women had their abortions performed by an NP, CNM, or PA and 5,812 by a licensed physician. The first major conclusion is that abortion is incredibly safe no matter who performed it. Fewer than 2% of all patients required any additional care after the initial abortion; only 6 patients (less than .05%) needed any hospital-based care (3 of those patients were seen by physicians and 3 by an NP, CNM, or PA); and all of those women recovered without any long-term physical harm.

The study was designed to assess the equivalence between the two groups of providers. The goal of the study was not to show that one group was better than the other, rather to see if they are the same. To do this, we set a margin of difference of 2%. In the physician group, 0.9% of women had a complication, compared to 1.8% of women in the NP/CNM/PA group. This slightly higher number among newly trained providers was expected and is not clinically significant. The risk difference for complications between the two groups fell within the predetermined margin of non-inferiority. As a result, we conclude that NPs, CNMs, and PAs can perform aspiration abortions as safely as their physician colleagues.

So why does all this matter?

Nationally, 92% of abortions take place in the first trimester—but black, uninsured, rural, and low-income women continue to have less access to this care. In California, 13% of women using state Medicaid insurance obtain abortions after the first trimester. Because the average cost of a second-trimester abortion is substantially higher than a first-trimester procedure and abortion complications increase as the pregnancy advances, shifting the population distribution of abortions to earlier gestations would result in safer, less costly care.

In addition, NPs, CNMs, and PAs provide the majority of well-woman care in primary care settings and are key health access points for low-income and rural women. Allowing a larger group of health care professionals to offer early aspiration abortion care is one way to reduce this health care disparity and increase continuity of care. The evidence to support this policy option is now in hand.

In 2013, policy advocates in Sacramento will once again work with the California legislature to modernize California's abortion law and allow NPs, CNMs, and PAs to perform early aspiration abortions. By utilizing these skilled health care professionals, perhaps many more California women will have their reproductive health care needs met in their local communities by health care providers they know and trust.

Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver

Tracy A. Weitz, PhD, Diana Taylor, PhD, Sheila Desai, MPH, Ushma D. Upadhyay, PhD, Jeff Waldman, MD, Molly F. Battistelli, BA, and Eleanor A. Drey, MD

Objectives. We examined the impact on patient safety if nurse practitioners (NPs), certified nurse midwives (CNMs), and physician assistants (PAs) were permitted to provide aspiration abortions in California.

Methods. In a prospective, observational study, we evaluated the outcomes of 11 487 early aspiration abortions completed by physicians (n = 5812) and newly trained NPs, CNMs, and PAs (n = 5675) from 4 Planned Parenthood affiliates and Kaiser Permanente of Northern California, by using a noninferiority design with a predetermined acceptable risk difference of 2%. All complications up to 4 weeks after the abortion were included.

Results. Of the 11 487 aspiration abortions analyzed, 1.3% (n = 152) resulted in a complication: 1.8% for NP-, CNM-, and PA-performed aspirations and 0.9% for physician-performed aspirations. The unadjusted risk difference for total complications between NP–CNM–PA and physician groups was 0.87 (95% confidence interval [CI] = 0.45, 1.29) and 0.83 (95% CI = 0.33, 1.33) in a propensity score–matched sample.

Conclusions. Abortion complications were clinically equivalent between newly trained NPs, CNMs, and PAs and physicians, supporting the adoption of policies to allow these providers to perform early aspirations to expand access to abortion care. (*Am J Public Health.* Published online ahead of print January 17, 2013: e1–e8. doi:10.2105/AJPH.2012.301159)

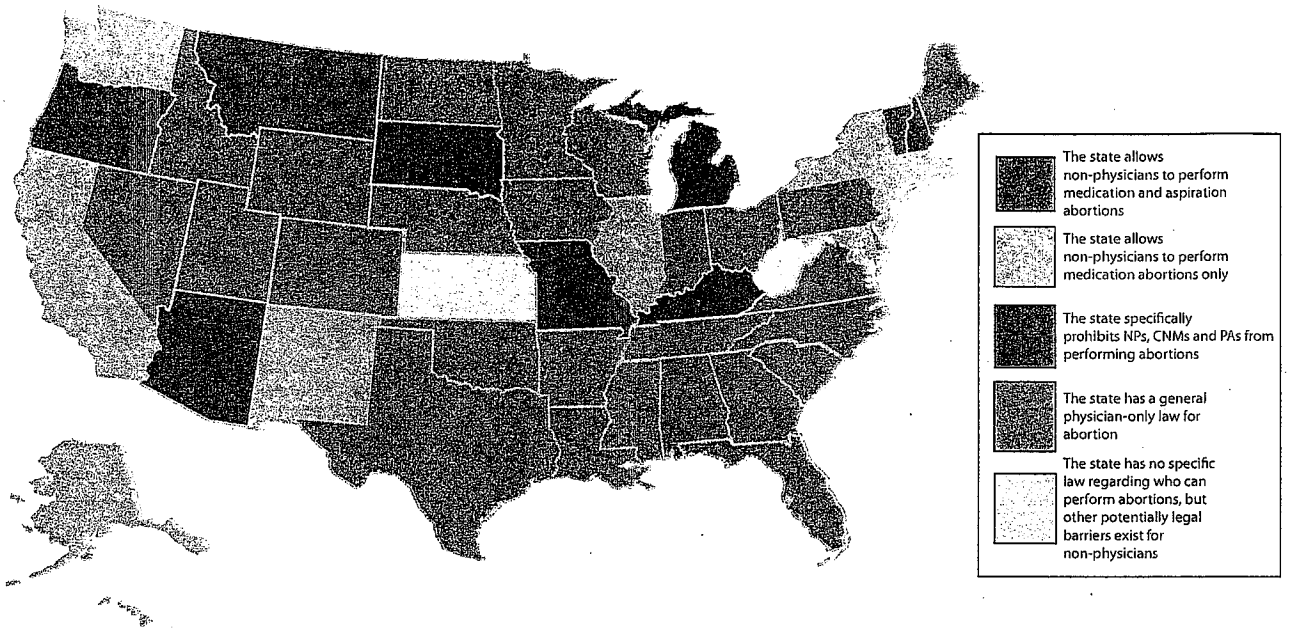
Increased access to early abortion is a pressing public health need. By 2005, the number of abortion care facilities in the United States had decreased 38% from its peak in 1982.[1] Although the number has since remained stable, the proportion of US counties with no facility remains high at 87%; more than one third of women aged 15 to 44 years live in these counties.[2] Additionally, a large proportion of US facilities are hospitals that perform abortions only in cases of serious medical and fetal indications or facilities that offer medical abortions only up to 9 weeks of pregnancy.[2]

Many women face difficulties finding a facility, resulting in delayed care.[3] Increasing access is critical because abortions at later gestations are associated with a higher risk of complications[4] and higher costs.[2] Research has also found that many women would prefer to obtain their abortions earlier[5] Finally, traditionally underserved populations experience the greatest barriers to abortion care, resulting in higher rates of procedures after the first trimester.[6,7]

In California, more than half of the 58 counties lack a facility that provides 400 or more abortions (R. K. Jones, personal communication). Low-income and minority women are most likely to be served by public health departments or community health centers,[8] most of which do not provide abortions. These women are also more likely to be cared for by nurse practitioners (NPs) and physician assistants (PAs) than by obstetricians and gynecologists.[9]

One potential solution to improve access is to increase the number and types of health care professionals who offer early abortion care.[10–12] Increased emphasis has been placed on task sharing to better meet women's health needs in the context of health care workforce shortages.[13] In the United States, health professions are regulated through a patchwork of state regulations[14,15] that determine who can perform abortions, a power reaffirmed by several US Supreme Court decisions.[16–18] Currently, nonphysician clinicians can perform aspiration abortions legally in only 4 states—Montana, Oregon, New Hampshire, and Vermont. Two additional states (Kansas and West Virginia) do not limit the performance of abortions to physicians, but nonphysician clinicians have never tried to provide abortion care. Of the remaining 44 states (Figure 1), some allow nonphysician clinicians to perform medical (but not aspiration) abortions under decisions by attorneys general or health departments, and 1 state—California—passed statutory authority for that care. As part of a larger effort to limit abortion access, several states have recently promulgated laws that specifically prohibit nonphysician clinicians from performing abortions.[19] For example, a 2009 Arizona law (HB 2564 and SB 1175) that precluded NPs from providing abortions resulted in the discontinuation of abortion care at several facilities that had previously been staffed exclusively by NPs.[20]

Limited clinical evidence is available to inform policymakers about whether physician-only legal restrictions on abortion are evidence-based.[21–24] Our study was designed to provide this evidence to policymakers; it answers the question "What would be the impact on patient safety if NPs, PAs, and certified nurse midwives (CNMs) were permitted to provide aspiration abortions in California?" (We use the term *aspiration abortion* to refer to what is commonly called *surgical abortion* because the technique does not meet the technical definition of surgery.[25]) We used a noninferiority design to compare the incidence of abortion-related complications between groups because we anticipated a slightly higher number of complications among newly trained NPs, CNMs, and PAs than among the experienced physicians.



Note. CNM = certified nurse midwife; NP = nurse practitioner; PAs = physician assistants.

FIGURE 1—Landscape of health professional regulation of abortion provision in the United States.

METHODS

In 2005, study investigators applied to the California Office of Statewide Health Planning and Development (OSHPD) for a waiver of legal statutes that limit the completion of surgical abortion to physicians.[26–28] Following a public meeting, hearing, and extensive input from stakeholders, the State of California granted approval for Health Workforce Pilot Project No. 171 in March 2007, followed by approval of 4 subsequent extensions. The study received institutional review board approvals from the University of California, San Francisco; Ethical and Independent Review Services; and Kaiser Permanente of Northern California (KPNC).

In this prospective, observational cohort study, NPs, CNMs, and PAs from 5 partner organizations (4 Planned Parenthood affiliates and KPNC) were trained to competence in the provision of aspiration abortion (a minimum of 40 procedures over 6 clinical days, with competence assessed by an authorized physician trainer). To be qualified for training, NPs, CNMs, and PAs had to have a California professional license, basic life support certification, and 12 months or more of clinical experience, including 3 months or more experience in medication abortion provision. Physicians employed by the facility served as the comparison group. A total of 28 NPs, 5 CNMs, and 7 PAs (n = 40) and 96 physicians (with training in either family medicine or obstetrics and gynecology) completed procedures during the study period. Physicians had a mean of 14 years of experience providing abortions compared with a mean of 1.5 years among NPs, CNMs, and PAs. This analysis did not include procedures performed by NPs, CNMs, and PAs during their training phase.

Patients were enrolled at 22 clinical facilities between August 2007 and August 2011. Patients were eligible for the study if they were aged 16 years or older (18 years at Planned Parenthood affiliates), were seeking a first-trimester aspiration abortion (facilities self-defined this as ≤ 12 or ≤ 14 weeks' gestation by ultrasound), and could speak English or Spanish. Patients were excluded if they requested general anesthesia or did not meet the health-related criteria (unexplained historical, physical, or laboratory findings or known or suspected cervical or uterine abnormalities).

Study Procedures

Eligible patients reviewed a consent form with a facility staff member. If a patient agreed to participate, she was asked whether she was willing to have her abortion done by an NP, CNM, or PA; if so, the aspiration was performed by the NP, CNM, or PA on duty. Patients in this group were routed to a physician if clinical flow necessitated reorganizing patients. Patients were also routed to a physician if they were unwilling to have their abortions performed by an NP, CNM, or PA or arrived for care when only a physician was present.

Each patient received $5 and a follow-up survey about medical problems after the abortion to capture any delayed postprocedure complications. If patients did not return the survey, clinic staff made at least 3 attempts to administer the survey by phone. If the patient experienced postabortion problems, she was asked a defined set of questions to obtain medical details. Additionally, staff conducted patient chart abstractions 2 to 4 weeks after abortion to ensure delayed complications were

captured. For all outcomes other than an uncomplicated recovery, an incident report was generated and reviewed by the site medical director, study investigators, and the study's Data and Clinical Safety Monitoring Committee. Additional monitoring of outcomes and study procedures included annual Office of Statewide Health Planning and Development–sponsored site visits; quarterly reviews of participant recruitment, patient experience, and clinical outcomes; and routine communication between facility and UCSF study staff.

Study Outcomes

Unlike a superiority analysis, a noninferiority study design determines whether the effect of a new treatment is not worse than that of an active control by more than a specified clinically acceptable margin.[29–32] We selected a noninferiority design because we were seeking not to replace physicians as abortion providers or to determine whether NPs, CNMs, and PAs were better than current providers of care but to identify additional, comparably safe providers to supplement the provider pool. Because NPs, CNMs, and PAs who are newly trained in aspiration abortion have less experience, we expected to find a statistically significant higher rate of complications among this group than among more experienced physicians. However, we also anticipated a low overall incidence of complications from procedures across both groups. Therefore, a noninferiority design provided a more clinically relevant analysis. Given a low expected complication rate in both provider groups, we prespecified the margin of noninferiority as a change of 2%, which was determined before the start of the study by a panel of researchers and clinicians and approved by the Data and Clinical Safety Monitoring Committee, who considered ethical and clinical issues and previous US-based studies, which showed abortion-related complication rates ranging from 1.3% to 4.4%.[21,22,33–38]

The primary outcome was the difference in incidence of complications within 4 weeks of the aspiration abortion between NPs, CNMs, and PAs and physicians. Complications were categorized as immediate (occurring before leaving the facility) and delayed (occurring ≤ 4 weeks after the procedure). Additionally, complications were classified as major if the patient required hospital admission, surgery, or a blood transfusion and minor if they were treated at home or in an outpatient setting. This classification schema is consistent with that used in other studies of abortion-related morbidity.[34–37]

Statistical Analysis

We based sample size calculations for this study on an expected complication rate of 2.5%, which was based on mean complication rates cited in the published literature[21,22,33–38] and powered at 90% to detect a 1.0% or greater difference in complication incidence between groups ($\alpha = .025$, 1-tailed test). The study was powered specifically for a noninferiority analysis. Although we set a clinically acceptable margin of difference at 2.0%, we took a conservative approach and powered the study to detect an even smaller difference. We then further increased the sample size per group by 15% to adjust for clustering effects at the provider and clinic levels.

We compared sociodemographic characteristics of patients seen by NPs, CNMs, and PAs and those seen by physicians using mixed-effects logistic regression for dichotomous variables, mixed-effects multinomial logistic regression for categorical variables, and mixed-effects linear regression for continuous variables, all of which included random effects for facility. Incidence of a complication was coded as a dichotomous variable. Complication incidence was calculated by provider group. We fit a mixed-effects logistic regression model with crossed random effects to obtain odds ratios that account for the lack of independence between abortions performed by the same clinician and within the same facility and cross-classification of providers across facilities. We included variables associated with complications in bivariate analyses at $P < .05$ in the multivariate model in addition to other clinically relevant covariates to adjust for potential confounders.

To mitigate selection bias resulting from the lack of randomization, we replicated the analysis in a propensity score–matched sample, a method used to achieve balance between study groups in observational or nonrandomized studies using the predicted probability of group membership (NP, CNM, or PA vs physician group) on the basis of observed predictors.[39–41] We used the Stata module pscore to develop the propensity scores based on a logistic regression model that included patient characteristics that potentially influenced to which provider type the patient was assigned (age, race/ethnicity, insurance type, gestational age, parity, history of cesarean delivery, history of miscarriages, history of abortions, screening for sexually transmitted infections, positive test for a sexually transmitted infection, selection of a clinical contraceptive method, and presence of risk factors). Patients with similar propensity scores in the 2 provider groups were matched using nearest neighbor matching. After testing that the balancing property of the propensity score was satisfied, we selected a matched sample composed of 78.3% of the original sample, among which we replicated our mixed-effects analysis. We used predictive probabilities to calculate risk differences and 95% confidence intervals (CIs) for all models. We used STATA version 12 (StataCorp LP, College Station, TX) for all analyses.

RESULTS

A total of 21 095 women were screened for eligibility. Of these, 3837 did not meet the eligibility criteria, most commonly because of patient age and gestational age. Among the 17 258 eligible women, 13 807 agreed to participate in the study. Of these, 2320 had procedures performed by NPs, CNMs, and PAs during their training phase and were therefore not included in this analysis. As a result of a protocol violation at 1 site, 79 patients in the physician group were excluded. Follow-up data were available for 69.5% of patients, and follow-up rates were nondifferential between provider groups. Patients who did not return the follow-up survey were retained in the analytic sample because we found that they contacted the facility when they did experience a complication (n = 41), which we also discovered via medical chart abstraction, suggesting a low likelihood of missing complications among this group. Additionally, in a sensitivity analysis, complication incidence and risk differences were similar when we excluded patients who did not return the

TABLE 1—Baseline Characteristics of Patient Study Participants by Provider Type at 22 California Clinical Facilities: August 2007–August 2011

Patient Characteristic	Physicians (n = 5812), % or Mean ±SD	NPs-CNMs-PAs (n = 5675), % or Mean ±SD	P[a]
Age, y	25.7 ±6.1	25.6 ±5.9	.01
16–19	12.9	13.5	.73
20–24 (Ref)	39.0	39.0	
25–34	36.9	37.4	.83
≥35	11.2	10.1	.06
Race/ethnicity[b]			
White, non-Hispanic (Ref)	29.3	29.5	
Black, non-Hispanic	12.1	13.8	.03
Hispanic	40.6	40.4	.87
Asian, non-Hispanic	8.3	6.6	.01
Other, non-Hispanic	8.7	8.5	.83
Insurance type			
No coverage (Ref)	24.7	26.5	
Medi-Cal[c]	56.3	54.1	.68
Private	11.9	14.1	.67
Other	7.1	5.3	<.001
Gestational age, d			
<36 (Ref)	2.5	2.7	
36–49	31.5	33.3	.26
50–63	32.1	33.1	.36
≥64	33.9	30.9	.93
Gravidity			
≤1 (Ref)	27.2	26.9	
2	20.6	21.5	.25
3	18.3	17.4	.55
≥4	33.9	34.1	.59
Parity[d]			
0 (Ref)	44.2	44.9	
1	24.8	24.1	.63
≥2	30.8	30.7	.97
Previous cesarean deliveries			
0 (Ref)	86.5	86.7	
≥1	13.5	13.3	.21
Previous miscarriages[e]			
0 (Ref)	82.3	82.7	
1	13.9	13.2	.2
≥2	3.5	3.6	.99
Previous induced abortions[f]			
0 (Ref)	52.3	51.5	
1	28.0	28.6	.46
≥2	19.5	19.6	.7
Tested positive for an STI	3.6	3.4	.77

Continued

follow-up survey. Patients without follow-up data were more likely to have no insurance, have fewer risk factors, be multigravida, and be at less than 5 weeks gestation than were those with follow-up data ($P<.05$; not shown). The final analytic sample size was 11 487; of these procedures, 5812 were performed by physicians and 5675 were performed by NPs, CNMs, or PAs.

Patient Characteristics

The majority of women in both groups had had 3 or more pregnancies; no previous cesarean deliveries, miscarriages, or induced abortions; and no history of medical risk factors (Table 1). Women in the NP–CNM–PA group were more likely to be younger ($P<.01$), less likely to be Asian than White ($P<.01$), and more likely to be non-Hispanic Black than White ($P<.03$). Women were similar on all other sociodemographic characteristics across provider groups.

Outcomes

Overall, complications were rare (Table 2). Out of 11 487 aspiration abortions, 1.3% (n = 152; 95% CI = 1.11, 1.53) resulted in a complication; 1.8% of NP-, CNM-, and PA-performed aspirations and 0.9% of physician-performed aspirations resulted in a complication. The majority of complications (146/152, or 96%) were minor (1.3% of all abortions) and included cases of incomplete abortion (n = 9 among physicians, n = 24 among NPs, CNMs, and PAs), failed abortion (n = 7 among physicians, n = 11 among NPs, CNMs, and PAs), bleeding not requiring transfusion (n = 2 among NPs, CNMs, and PAs), hematometra (n = 3 among physicians, n = 16 among NPs, CNMs, and PAs), infection (n = 7 among physicians, n = 7 among NPs, CNMs, and PAs), endocervical injury (n = 2 among physicians, n = 2 among NPs, CNMs, and PAs), anesthesia-related reactions (n = 1 among physicians, n = 1 among NPs, CNMs, and PAs), and uncomplicated uterine perforation (n = 3 among NPs, CNMs, and PAs). We classified complications without clear etiology but accompanied by patient symptoms as symptomatic intrauterine material (n = 16 among physicians, n = 24 among NPs, CNMs, and PAs). We classified 11 minor complications as "other"; 4 were from physician-performed procedures

TABLE 1—*Continued*

Risk factors[g]			
Extreme obesity (BMI > 40 kg/m^2)	2.3	2.2	.33
Existing chronic illness	5.0	4.9	.72
Placenta previa (16-18 wk)	0.0	0.0	.32
Psychiatric condition	3.3	3.2	.61

Note. BMI = body mass index; CNM = certified nurse midwife; NP = nurse practitioner; PA = physician assistant; STI = sexually transmitted infection. Physicians had completed a residency in either obstetrics and gynecology or family medicine. Missing data on age (n = 18), patient insurance (n = 35), cesarean delivery history (n = 82), and gravidity (n = 7) were recoded to mean age, no insurance, no history of cesarean delivery, and median gravidity, respectively. Missing data on gestational age by ultrasound (n = 85) were recoded to gestational age by last menstrual period; where those data were also missing, they were recoded to the mean gestational age by ultrasound. For other missing variables, we created a new variable for missing.

[a]*P* values are based on a significance level of .05 and were calculated using mixed-effects logistic regression for dichotomous variables, mixed-effects multinomial logistic regression for categorical variables, and mixed-effects linear regression models for continuous variables, all of which included random effects for facility.

[b]Data missing for 70 women in the NP-CNM-PA group and 56 in the physician group.

[c]California's Medicaid program.

[d]Data missing for 11 women in each provider group.

[e]Data missing for 25 women in the NP-CNM-PA group and 20 in the physician group.

[f]Data missing for 17 women in the NP-CNM-PA group and 18 in the physician group.

[g]All risk factor variables are dichotomous (no-yes). "No" is the reference category (not shown in table).

(1 urinary tract infection, 1 possible false passage, 1 probable gastroenteritis, 1 unspecified allergic reaction), and 7 were from NP-, CNM-, or PA-performed procedures (1 fever of unknown origin, 1 intrauterine device–related bleeding, 3 sedation drug errors, 1 inability to urinate, 1 vaginitis).

Only 6 major complications occurred (3 in each provider group), which included 2 uterine perforations, 3 infections, and 1 hemorrhage. We found no difference in risk of major complications between provider groups: 0.001% (95% CI = −0.08, 0.09).

The overall unadjusted risk difference for total complications between NPs, CNMs, and PAs and physicians was 0.87% (95% CI = 0.45, 1.29). The risk difference in immediate complications (n = 9 for physicians; n = 20 for NPs, CNMs, and PAs) was 0.20% (95% CI = 0.01, 0.38); for delayed complications (n = 43 for physicians; n = 80 for clinicians), it was 0.67% (95% CI = 0.29, 1.10).

Abortions by NPs, CNMs, and PAs were 1.92 (95% CI = 1.36, 2.72) times as likely to result in a complication as those performed by physicians after adjusting for potential confounders (see table available as a supplement to the online version of this article at http://www.ajph.org). Among the propensity score–matched sample, complications were 2.12 (95% CI = 1.33, 3.37) times as likely to result from abortions by NPs, CNMs, and PAs as by physicians. The corresponding risk differences were 0.70% (95% CI = 0.29, 1.10) in overall complications between provider groups in the adjusted model and 0.83% (95% CI = 0.33, 1.33) in the propensity score–matched sample. The estimated 95% CIs for risk differences in unadjusted, adjusted, and propensity score–matched analyses all fell well within the predetermined margin of noninferiority, and therefore complication rates from aspiration abortions performed by recently trained NPs, CNMs, and PAs were statistically no worse than those from those performed by the more experienced physician group (Figure 2).

DISCUSSION

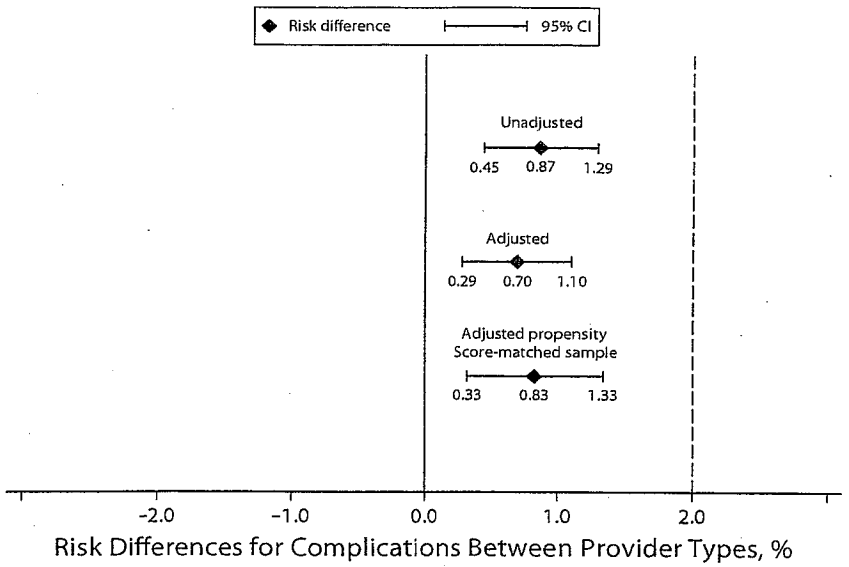
In 2008, 1.21 million abortions took place in the United States, with more 200 000 (18%) in the State of California.[2] Nationally, 92% of abortions take place in the first trimester,[7] but Black, uninsured, and low-income women have less access to this care.[6] In California, only 87% of women using state Medicaid insurance obtain abortions in the first trimester.[42] Because the average cost of a second-trimester abortion is substantially higher than that of a first-trimester procedure, shifting the population distribution of abortions to earlier gestations would result in safer, less costly care. Increasing the types of health care professionals involved in abortion care is one way to reduce this health care disparity.

Our study was designed to examine the effect of removing the physician-only requirement for aspiration abortion provision in California. We found that the care provided by newly trained NPs, CNMs, and PAs was not inferior to that provided by experienced physicians. We estimate that only 1 additional complication would occur for every 120 procedures as a consequence of having an NP, CNM, or PA as the abortion provider. Additionally, the 0.83% risk difference was mainly

TABLE 2—Overall and Major and Minor Complication Rates by Provider Type at 22 California Clinical Facilities: August 2007–August 2011

	Physicians (n = 5812)		NPs-CNMs-PAs (n = 5675)		Total (n = 11 487)		Risk Difference Between Provider Groups (n = 11 487)
Complication Type	Rate/100 (95% CI)	No.	Rate/100 (95% CI)	No.	Rate/100 (95% CI)	No.	Difference in Rate/100 (95% CI)
Major	0.05 (−0.01, 0.11)	3	0.05 (−0.01, 0.11)	3	0.05 (0.01, 0.09)	6	0.001 (−0.08, 0.09)
Minor	0.84 (0.61, 1.08)	49	1.71 (1.37, 2.05)	97	1.27 (1.07, 1.48)	146	0.87 (0.46, 1.28)
Total	0.89 (0.65, 1.14)	52	1.76 (1.42, 2.10)	100	1.32 (1.11, 1.53)	152	0.87 (0.45, 1.29)

Note. CI = confidence interval; CNM = certified nurse midwife; NP = nurse practitioner; PA = physician assistant. Physicians had completed a residency in either obstetrics and gynecology or family medicine.



Note. CI = confidence interval. Both adjusted models included patient age, race/ethnicity, insurance type, gestational age, gravidity, history of cesarean section, positive test for a sexually transmitted infection, an indicator for extreme obesity, an indicator for chronic illness, and an indicator for psychiatric conditions. 2.0 is also the delta.

FIGURE 2—Unadjusted, adjusted, and adjusted propensity score–matched risk differences in overall complication rates of first-trimester aspiration abortion by nurse practitioner, certified nurse midwife, and physician assistant providers compared with physician providers in California.

the result of higher incidence of minor complications, the majority of which were from diagnoses easily treated and without consequential sequelae. Moreover, on the basis of findings in other studies, we expect this risk difference to narrow further over time.[43–45] The comparison of newly trained NPs, CNMs, and PAs with more experienced physician abortion providers suggests that the small difference found would represent the maximum variation in outcomes that might be expected immediately after a policy change.

Both provider groups had extremely low numbers of complications, less than 2% overall—well below published rates—and only 6 complications out of 11 487 procedures required hospital-based care. Because the effect size is minimal compared with the published data and within the prespecified margin of noninferiority, we conclude that the difference between the 2 groups of providers is not clinically significant.

While the reported odds ratios comparing complication rates from procedures performed by NPs, CNMs, and PAs with those from procedures performed by physicians were statistically significant, these results should be interpreted cautiously. The study was powered specifically for a noninferiority analysis, which necessitated a larger sample size than a superiority analysis would. Therefore the significance we see may be a result of the study being overpowered.

These findings support the adoption of policies that increase access to abortion by expanding the number and type of health care professionals who can perform early aspiration abortions. The benefits of expanding access to abortion for California's women outweigh the small initial difference in risk, particularly because it would likely move many secondnd-trimester abortions into the first trimester, significantly decreasing the overall risk of complications, which increases with gestational age.[4] Expanded access is also likely to afford more women the opportunity to obtain care without the additional indirect costs associated with traveling to a geographically distant abortion provider.

The strengths of this study are its statistical power, the large number of providers, and its setting in multiple facilities. A limitation of the study is its nonrandomized design, although the use of propensity score matching allowed for statistical adjustments to address this limitation. Additionally, this study had a low follow-up rate (70%), but this was not unexpected because of the sensitive nature of abortion, which may have deterred women from continuing participation in the study after the procedure. This follow-up rate is also similar to those in other US abortion-related studies with comparable follow-up periods (14–28 days).[22,37,46] Although postprocedure complications may have been missed among patients for whom we did not have follow-up data, given the nondifferential follow-up rates between provider groups, we would expect unidentified complications to be equally distributed between groups, leaving the risk difference unaffected. A further limitation of the study is that the health care provider who initially identified a complication was not blinded to the type of provider who performed the abortion. However, we hypothesize that complaints from patients cared for by newly trained NPs, CNMs, and PAs would be more aggressively evaluated if the provider type was known to the health care provider evaluating the patient. Therefore, any bias caused by lack of blinding would have resulted in an overestimate of the risk difference.

Our results confirm existing evidence from smaller studies that the provision of abortion by NPs, CNMs, and PAs is safe[21,22] and from larger international[13] and national[47] reviews that have found these clinicians to be safe and qualified health care providers. The value of this study extends beyond the question of who can safely perform aspiration abortion services in California because it provides an example of how research can be used to answer relevant health workforce policy issues. As the demand for health care providers increases under US health care reform,[48] one part of the solution for all health care, including abortion care, is to allow all

qualified professionals to perform clinical care to the fullest extent of their education and competency.[49,50]

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Contributors

T. A. Weitz and D. Taylor developed the study concept and design. T. A. Weitz, D. Taylor, and E. A. Drey supervised the overall study and analyzed the interpretation of results. S. Desai oversaw the acquisition of data. U. D. Upadhyay and S. Desai analyzed the data and provided statistical expertise. T. A. Weitz, U. D. Upadhyay, S. Desai, and E. A. Drey drafted the article, and J. Waldman advised on critical revision of the article for intellectual content. M. F. Battistelli provided administrative, technical, and material support.

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Human Participant Protection

Study protocol and procedures received institutional review board approvals from the University of California, San Francisco; Ethical and Independent Review Services; and Kaiser Permanente of Northern California.

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AB 186

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 186
Author:	Maienschein
Bill Date:	April 1, 2013, amended
Subject:	Military Spouses: Temporary Licenses
Sponsor:	Author

STATUS OF BILL:

This bill is in Assembly Business, Professions and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow spouses of military personnel that have moved to California based upon active duty orders of the military spouse, and who have a physician and surgeon license in another state, to receive an 18 month provisional license, if they meet the licensing requirements, complete an application and provide specified information.

ANALYSIS:

Existing law requires boards in the Department of Consumer Affairs (DCA) to expedite the licensure process for applicants if they supply evidence satisfactory to the Board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders, and if they hold a current license in another state in the profession or vocation for which he or she seeks a license from the Board.

This bill would require all boards under DCA, including the Medical Board of California (Board), to issue a 18-month provisional license to applicants that qualify for an expedited license if the applicant has not committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license and if the applicant has not been disciplined by a licensing entity in another jurisdiction and is not the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction. This bill would require the applicant to submit an application that includes an affidavit that the information submitted in the application is accurate and that verification documentation form the other jurisdiction has been requested. The provisional license would expire 18 months after issuance, or upon issuance of the expedited license. This bill would allow the Board to adopt necessary regulations.

The fact sheet on this bill states that according to a recent study by the California Research Bureau, California has about 72,500 military spouses residing in this state, and over one third of these individuals are involved in a profession that requires some sort of licensing requirement. According to the author's office, this bill will allow military spouses to immediately look for employment to help support their families, while taking all the necessary steps to apply and receive a license from the state..

This bill would require the applicant to meet all licensing requirements in existing law and would require fingerprints to be cleared, would require license verification through the American Medical Association and/or the National Practitioner's Data bank, and verification from the state the applicant is licensed in before the provisional license could be issued. However, Board staff is suggesting that the Board oppose this bill unless it is amended to include language that would specify if the information on the applicant's application is found to be inaccurate, contrary to the affidavit, that the Board could require the individual that has been issued a provisional license to immediately cease practice, in order to ensure consumer protection.

FISCAL: Minor and absorbable

SUPPORT: National Military Family Association
Department of Defense, State Liaison's Office

OPPOSITION: None on file

POSITION: Recommendation: Oppose unless amended to include a cease practice provision

AMENDED IN ASSEMBLY APRIL 1, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 186

Introduced by Assembly Member Maienschein
(Principal coauthor: Assembly Member Hagman)
(Coauthors: Assembly Members Dahle, Donnelly, Beth Gaines, Harkey, Olsen, and Patterson)
(Coauthors: Senators Fuller and Huff)

January 28, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

of the United States who is assigned to a duty station in California under official active duty military orders.

This bill would authorize a board within the department to issue a provisional license to an applicant who qualifies for an expedited license pursuant to the above-described provision. *The bill would prohibit a provisional license from being provided to any applicant who has committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license at the time the act was committed, or has been disciplined by a licensing entity in another jurisdiction, or is the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction. The bill would require the board to approve a provisional license based on an application that includes an affidavit that the information submitted in the application is accurate and that verification documentation from the other jurisdiction has been requested.* The bill would require the provisional license to expire after 18 months *or at the issuance of the expedited license.*

By creating provisional licenses for which a fee may be collected and deposited into a continuously appropriated fund, this bill would make an appropriation.

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

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

SECTION 1. Section 115.5 of the Business and Professions Code is amended to read:

115.5. (a) A board within the department shall expedite the licensure process for an applicant who meets both of the following requirements:

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

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

(b) *(1)* For each applicant who is eligible for an expedited license pursuant to subdivision (a) *and meets the requirements in*

paragraph (2), the board ~~may~~ *shall* provide a provisional license while the board processes the application for licensure. *The board shall approve a provisional license based on an application that includes an affidavit that the information submitted in the application is accurate and that verification documentation from the other jurisdiction has been requested.* The provisional license shall expire 18 months after issuance *or upon issuance of the expedited license.*

(2) (A) The applicant shall not have committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license under this code at the time the act was committed.

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

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

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AB 496

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 496
Author: Gordon
Bill Date: April 10, 2013, amended
Subject: Medicine: Sexual Orientation, Gender Identity, and Gender Expression
Sponsor: Equality California

STATUS OF BILL:

This bill is in Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would reauthorize the Task Force on Culturally and Linguistically Competent Physicians and Dentists in order to expand the Task Force's membership and charge to include the lesbian, gay, bisexual and transgender (LGBT) community. This bill would require the reconstituted Task Force to report its findings to the Legislature by January 1, 2016. This bill would also expand the definition of cultural competency.

ANALYSIS:

This bill would reauthorize the Task Force on Culturally and Linguistically Competent Physicians and Dentists to consist of the following members: The Deputy Director of the Office of Health Equity or his or her designee and the Director of the Department of Consumer Affairs (DCA) or his or her designee to serve as co-chairs; the Executive Director of the Medical Board of California (Board) or his or her designee; the Executive Director of the Dental Board of California or his or her designee; one member appointed by the Senate; and one member appointed by the Assembly. This bill would allow additional members to be appointed by the Director of DCA, in consultation with the Office of Health Equality, as follows: representatives of organizations that advocate on behalf of physicians and dentists; physicians and dentists who provide health services to members of language and ethnic minority groups and LGBT groups; representatives of entities that offer continuing education for physicians and dentists; representatives of California's medical and dental schools; and individuals with experience in developing, implementing, monitoring, and evaluating cultural and linguistic programs.

This bill would specify that the duties of the Task Force would be the same as before: to develop recommendations for a continuing education program that includes language proficiency standards of foreign language to meet linguistic competence; to identify key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices; and to assess the need for voluntary certification standards and examinations for cultural competency. This bill would require the Task Force to hold hearings and convene meetings to obtain input from persons belonging to language and ethnic minority groups, and this bill would add LGBT groups, to determine their needs and preferences for having culturally competent medical providers. This bill would require the hearings to be held in

communities that have large populations of language and ethnic minority groups and LGBT groups. This bill would require the Task Force to report its findings to the Legislature and appropriate licensing boards by January 1, 2016. This bill would require the Board and the Dental Board to pay the administrative costs of implementing the Task Force, the hearings, and the report.

This bill would also amend the Cultural and Linguistic Competency of Physicians Act of 2003 regarding the cultural and linguistic physician competency program that is operated by local medical societies of the California Medical Association and monitored by the Board. The program is a voluntary program consisting of educational classes. This bill would expand the program to require it to additionally address LGBT groups of interest to local medical societies. In addition, this bill would require the training programs to be formulated in collaboration with LGBT medical societies

This bill does not add to or change existing law related to the working group that has already been convened by the Board and that continues to exist, which is the Cultural and Linguistic Physician Competency Program (CLC) Workgroup. Lastly, this bill would define "cultural and linguistic competency" to include understanding and applying the roles that sexual orientation, gender identity, and gender expression play in diagnosis, treatment and clinical care.

According to the author's office, LGBT patients have reported a reluctance to reveal their sexual orientation or gender identity to their providers, despite the importance of such information for their health care. The author believes that cultural competency plays a crucial role in understanding, diagnosing, and delivering appropriate care to LGBT patients. The ability of physicians to effectively communicate with, and to create a welcoming and safe environment for their LGBT patients, has an impact on LGBT patient health outcomes and on provider-patient relationships.

Although DCA, the Board, and the Dental Board already convened and participated in the Task Force on Culturally and Linguistically Competent Physicians and Dentists, LGBT issues were not addressed at the Task Force, the hearings, or in the final report to the Legislature. This bill would reauthorize this Task Force and include LGBT issues for the Task Force to hold hearings on and include in its report to the Legislature. Since this bill does not expand the working group convened by the Board, the Board would only need to include agenda items at future meetings that address understanding and applying the roles that sexual orientation, gender identity, and gender expression play in diagnosis, treatment and clinical care. The Board's Executive Director would be required to participate in the reauthorized Task Force and the Board would be partially responsible for the costs associated with the Task Force, hearings, and the report to the Legislature. Board staff is suggesting a neutral position on this bill.

FISCAL: $43,000 (this is the Board's portion of the cost associated with the prior Task Force)

SUPPORT: Equality California (sponsor)
California Communities United Institute

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 10, 2013

AMENDED IN ASSEMBLY APRIL 2, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 496

Introduced by Assembly Member Gordon

February 20, 2013

An act to amend Sections 852, 2198, and 2198.1 of the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 496, as amended, Gordon. Medicine: sexual orientation, gender identity, and gender expression.

Existing law creates the Task Force on Culturally and Linguistically Competent Physicians and Dentists. Existing law requires the Director of Health Care Services and the Director of Consumer Affairs to serve as cochairs of the task force. *Existing law requires that the task force consist of, among other people, the Executive Director of the Medical Board of California and the Executive Director of the Dental Board of California.* Existing law *additionally* requires the Director of Consumer Affairs, in consultation with the Director of Health Care Services, to appoint as task force members, among other people, California licensed physicians and dentists ~~that~~ *who* provide health services to members of language and ethnic minority groups and representatives of organizations that advocate on behalf of, or provide health services to, members of language and ethnic minority groups. Existing law required the task force to report its findings to the Legislature and appropriate licensing boards by January 1, 2003.

This bill would replace the Director of Health Care Services with the Deputy Director of the Office of Health Equity, *or his or her designee,* as cochair of the task force. The bill would also instead require the appointment of members to be made in consultation with the Office of Health Equity. *The bill would authorize a designee of the Director of Consumer Affairs to serve as cochair of the task force and would authorize designees of the Executive Director of the Medical Board of California and the Executive Director of the Dental Board of California to serve as task force members.* The bill would require the licensed task force members and advocate task force members to ~~provide~~ *be providers of* health services to, or ~~advocate~~ *advocates* on behalf of, members of language and ethnic minority groups as well as lesbian, gay, bisexual, and transgender groups. The bill would require the task force to report its findings to the Legislature and appropriate licensing boards by January 1, 2016.

Existing law, the Cultural and Linguistic Competency of Physicians Act of 2003, establishes the cultural and linguistic physician competency program which is operated by local medical societies of the California Medical Association and is monitored by the Medical Board of California. That voluntary program consists of educational classes for all interested physicians and is designed to teach foreign language and cultural beliefs and practices that may impact patient health care practices and allow physicians to incorporate this knowledge in the diagnosis and treatment of patients who are not from the predominate culture in California. Existing law also defines "cultural and linguistic competency" for the purposes of those provisions as meaning cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including understanding and applying the roles that culture, ethnicity, and race play in diagnosis, treatment, and clinical care, and awareness of how the attitudes, values, and beliefs of health care providers and patients influence and impact professional and patient relations.

This bill would additionally require the program to address lesbian, gay, bisexual, and transgender groups of interest to local medical societies. The bill would require the training programs to be formulated in collaboration with California-based lesbian, gay, bisexual, and transgender medical societies. The bill would also redefine the term "cultural and linguistic competency" as understanding and applying the roles that culture, ethnicity, race, sexual orientation, gender identity, and gender expression play in diagnosis, treatment, and clinical care,

and awareness of how the attitudes, values, and beliefs of health care providers, patients, and society influence and impact professional and patient relations. The bill would also make related technical, nonsubstantive changes.

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

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

SECTION 1. Section 852 of the Business and Professions Code is amended to read:

852. (a) The Task Force on Culturally and Linguistically Competent Physicians and Dentists is hereby created and shall consist of the following members:

(1) The Deputy Director of the Office of Health Equity, *or his or her designee,* and the Director of Consumer Affairs, *or his or her designee,* who shall serve as cochairs of the task force.

(2) The Executive Director of the Medical Board of California, *or his or her designee.*

(3) The Executive Director of the Dental Board of California, *or his or her designee.*

(4) One member appointed by the Senate Committee on Rules.

(5) One member appointed by the Speaker of the Assembly.

(b) Additional task force members shall be appointed by the Director of Consumer Affairs, in consultation with the Office of Health Equity, as follows:

(1) Representatives of organizations that advocate on behalf of California licensed physicians and dentists.

(2) California licensed physicians and dentists ~~that~~ *who* provide health services to members of language and ethnic minority groups, as well as lesbian, gay, bisexual, and transgender groups.

(3) Representatives of organizations that advocate on behalf of, or provide health services to, members of language and ethnic minority groups, as well as lesbian, gay, bisexual, and transgender groups.

(4) Representatives of entities that offer continuing education for physicians and dentists.

(5) Representatives of California's medical and dental schools.

(6) Individuals with experience in developing, implementing, monitoring, and evaluating cultural and linguistic programs.

(c) The duties of the task force shall include the following:

(1) Developing recommendations for a continuing education program that includes language proficiency standards of foreign language to be acquired to meet linguistic competency.

(2) Identifying the key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices.

(3) Assessing the need for voluntary certification standards and examinations for cultural and linguistic competency.

(d) The task force shall hold hearings and convene meetings to obtain input from persons belonging to language and ethnic minority groups, as well as lesbian, gay, bisexual, and transgender groups, to determine their needs and preferences for having culturally competent medical providers. These hearings and meetings shall be convened in communities that have large populations of language and ethnic minority groups, as well as lesbian, gay, bisexual, and transgender groups.

(e) The task force shall report its findings to the Legislature and appropriate licensing boards on or before January 1, 2016.

(f) The Medical Board of California and the Dental Board of California shall pay the state administrative costs of implementing this section.

(g) Nothing in this section shall be construed to require mandatory continuing education of physicians and dentists.

SEC. 2. Section 2198 of the Business and Professions Code is amended to read:

2198. (a) This article shall be known and may be cited as the Cultural and Linguistic Competency of Physicians Act of 2003. The cultural and linguistic physician competency program is hereby established and shall be operated by local medical societies of the California Medical Association and shall be monitored by the Medical Board of California.

(b) This program shall be a voluntary program for all interested physicians. As a primary objective, the program shall consist of educational classes which shall be designed to teach physicians the following:

(1) A foreign language at the level of proficiency that initially improves their ability to communicate with non-English speaking patients.

(2) A foreign language at the level of proficiency that eventually enables direct communication with the non-English speaking patients.

(3) Cultural beliefs and practices that may impact patient health care practices and allow physicians to incorporate this knowledge in the diagnosis and treatment of patients who are not from the predominate culture in California.

(c) The program shall operate through local medical societies and shall be developed to address the ethnic language minority groups, as well as lesbian, gay, bisexual, and transgender groups, of interest to local medical societies.

(d) In dealing with Spanish language and cultural practices of Mexican immigrant communities, the cultural and linguistic training program shall be developed with direct input from physician groups in Mexico who serve the same immigrant population in Mexico. A similar approach may be used for any of the languages and cultures that are taught by the program or appropriate ethnic medical societies may be consulted for the development of these programs.

(e) Training programs shall be based and developed on the established knowledge of providers already serving target populations and shall be formulated in collaboration with the California Medical Association, the Medical Board of California, and other California-based ethnic medical societies, as well as lesbian, gay, bisexual, and transgender medical societies.

(f) Programs shall include standards that identify the degree of competency for participants who successfully complete independent parts of the course of instruction.

(g) Programs shall seek accreditation by the Accreditation Council for Continuing Medical Education.

(h) The Medical Board of California shall convene a workgroup including, but not limited to, representatives of affected patient populations, medical societies engaged in program delivery, and community clinics to perform the following functions:

(1) Evaluation of the progress made in the achievement of the intent of this article.

(2) Determination of the means by which achievement of the intent of this article can be enhanced.

(3) Evaluation of the reasonableness and the consistency of the standards developed by those entities delivering the program.

(4) Determination and recommendation of the credit to be given to participants who successfully complete the identified programs. Factors to be considered in this determination shall include, at a minimum, compliance with requirements for continuing medical education and eligibility for increased rates of reimbursement under Medi-Cal, the Healthy Families Program, and health maintenance organization contracts.

(i) Funding shall be provided by fees charged to physicians who elect to take these educational classes and any other funds that local medical societies may secure for this purpose.

(j) A survey for language minority patients shall be developed and distributed by local medical societies, to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency provided under this section. Local medical societies shall also develop an evaluation survey for physicians to assess the quality of educational or training programs on cultural and linguistic competency. This information shall be shared with the workgroup established by the Medical Board of California.

SEC. 3. Section 2198.1 of the Business and Professions Code is amended to read:

2198.1. For purposes of this article, "cultural and linguistic competency" means cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including, but not limited to, the following:

(a) Direct communication in the patient-client primary language.

(b) Understanding and applying the roles that culture, ethnicity, race, sexual orientation, gender identity, and gender expression play in diagnosis, treatment, and clinical care.

(c) Awareness of how the attitudes, values, and beliefs of health care providers, patients, and society influence and impact professional and patient relations.

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AB 512

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 512
Author:	Rendon
Bill Date:	February 20, 2013, Introduced
Subject:	Sponsored Health Care Events: Sunset Extension
Sponsor:	Los Angeles County

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would extend the sunset date in existing law, from 2014 to 2018, for provisions that authorize health care practitioners who are licensed or certified in other states to provide health care services on a voluntary basis to uninsured or underinsured individuals in California at sponsored free health care events.

ANALYSIS

AB 2699 (Bass, Chapter 270, Statutes of 2010) allows health care practitioners, including physicians, who are not licensed to practice in California, but that hold a valid license or certificate in good standing in good standing, to volunteer to provide health care services at sponsored free health care events, under specified circumstances. The bill required that all appropriate boards under the Department of Consumer Affairs (DCA) promulgate regulations before the bill could be implemented. The Medical Board was the first board under DCA to develop regulations, which became effective on August 20, 2012. Physicians licensed in other states are required to submit a request for authorization to practice without a California license at a sponsored free health care event to the Board and must also submit fingerprints before they can participate. The authorization period may not be for more than 10 days.

Existing law would sunset the ability for out-of-state health care practitioners to participate in sponsored free health care events in 2014. Although the Medical Board has promulgated regulations, many boards under DCA have not. The author and sponsor would like to extend the sunset date in existing law to allow health care practitioners to participate in sponsored free health care events and give the program more time to demonstrate its success. According to Los Angeles County, an extension of the sunset date in existing law will allow California to continue to provide access to needed health care and dental services to uninsured and underinsured consumers in this state.

Although the Board has only issued one physician permit under the authorization program that was created by AB 2699, the Board has already done the work to promulgate regulations; as such, it seems reasonable to extend the sunset date to allow more individuals to volunteer health care services at sponsored free health care events in California. This bill would enable all boards to collect data and track the number of out-of-state health care practitioners that request authorization to participate in sponsored free health care events. This bill would help to ensure these events have enough providers to serve more uninsured and underinsured consumers in California; Board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: Los Angeles County (Sponsor)
Association of Healthcare Districts

OPPOSITION: California Nurses Association
American Nurses Association of California

POSITION: Recommendation: Support

ASSEMBLY BILL No. 512

Introduced by Assembly Member Rendon

February 20, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

AB 512, as introduced, Rendon. Healing arts: licensure exemption.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which he or she is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.

Existing law provides, until January 1, 2014, an exemption from the licensure and regulation requirements for a health care practitioner, as defined, licensed or certified in good standing in another state or states, who offers or provides health care services for which he or she is licensed or certified through a sponsored event, as defined, (1) to uninsured or underinsured persons, (2) on a short-term voluntary basis, (3) in association with a sponsoring entity that registers with the applicable healing arts board, as defined, and provides specified information to the county health department of the county in which the health care services will be provided, and (4) without charge to the recipient or a 3rd party on behalf of the recipient, as specified. Existing law also requires an exempt health care practitioner to obtain prior authorization to provide these services from the applicable licensing

board, as defined, and to satisfy other specified requirements, including payment of a fee as determined by the applicable licensing board.

This bill would delete the January 1, 2014, date of repeal, and instead allow the exemption to operate until January 1, 2018.

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

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

SECTION 1. Section 901 of the Business and Professions Code is amended to read:

901. (a) For purposes of this section, the following provisions apply:

(1) "Board" means the applicable healing arts board, under this division or an initiative act referred to in this division, responsible for the licensure or regulation in this state of the respective health care practitioners.

(2) "Health care practitioner" means any person who engages in acts that are subject to licensure or regulation under this division or under any initiative act referred to in this division.

(3) "Sponsored event" means an event, not to exceed 10 calendar days, administered by either a sponsoring entity or a local government, or both, through which health care is provided to the public without compensation to the health care practitioner.

(4) "Sponsoring entity" means a nonprofit organization organized pursuant to Section 501(c)(3) of the Internal Revenue Code or a community-based organization.

(5) "Uninsured or underinsured person" means a person who does not have health care coverage, including private coverage or coverage through a program funded in whole or in part by a governmental entity, or a person who has health care coverage, but the coverage is not adequate to obtain those health care services offered by the health care practitioner under this section.

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

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

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

(B) Satisfies the following requirements:

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

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

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

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

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

(A) To uninsured or underinsured persons.

(B) On a short-term voluntary basis, not to exceed a 10-calendar-day period per sponsored event.

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

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

(c) The board may deny a health care practitioner authorization to practice without a license if the health care practitioner fails to

comply with this section or for any act that would be grounds for denial of an application for licensure.

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

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

(A) The name of the sponsoring entity.

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

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

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

(E) Any additional information required by the board.

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

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

(f) Within 15 calendar days of the provision of health care services pursuant to this section, the sponsoring entity shall file a report with the board and the county health department of the county in which the health care services were provided. This report shall contain the date, place, type, and general description of the care provided, along with a listing of the health care practitioners who participated in providing that care.

(g) The sponsoring entity shall maintain a list of health care practitioners associated with the provision of health care services under this section. The sponsoring entity shall maintain a copy of each health care practitioner's current license or certification and shall require each health care practitioner to attest in writing that

his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The sponsoring entity shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.

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

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

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

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

(3) A health care practitioner whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless and until a subsequent request for authorization has been approved by the board. A health care practitioner who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of the applicable provisions of this division, and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.

(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall

not affect other provisions or applications that can be given effect without the invalid provision or application.

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

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AB 565

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 565
Author: Salas
Bill Date: April 10, 2013, amended
Subject: California Physician Corps Program
Sponsor: California Medical Association

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would tighten the guidelines for selection of applicants to the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP) and would expand on the definition of practice settings for this program.

ANALYSIS:

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

AB 565 would amend the STLRP guidelines to require applicants to have three years of experience providing health care services to medically underserved populations in a federally designated health professional shortage area or medically underserved area. Existing law only requires applicants to have three years of experience working in medically underserved areas or with medically underserved populations. This bill would also delete the existing guideline that would seek to place the most qualified applicants in the areas with the greatest need and replace it with a guideline that would give preference to applicants who agree to practice in a federally designated health professional shortage area or medically underserved area, and who agree to serve a medically underserved population.

For purposes of the STLRP, this bill would also add to the definition of a "practice setting" a private practice that provides primary care located in a medically underserved area and has a minimum of 30 percent uninsured, Medi-Cal, or other publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

According to the author, California faces a misdistribution of physicians and there are shortages of primary care physicians in 74 percent of counties in California. In the last five years, only one physician has been selected to practice in Kings and Kern counties under the STLRP. The author and stakeholders have recognized the STLRP's high demand and the need to tighten the criteria to ensure that scarce resources are going to the most medically underserved communities.

Adding federally designated health professional shortage areas to the guidelines will help to ensure that STLRP applicants are serving in the areas with the most need; Board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: California Medical Association (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 10, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 565

Introduced by Assembly Member Salas

February 20, 2013

An act to amend ~~Section 128553~~ *Sections 128552 and 128553* of the Health and Safety Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 565, as amended, Salas. California Physician Corps Program.

Existing law establishes the Steven M. Thompson Physician Corps Loan Repayment Program in the California Physician Corps Program within the Health Professions Education Foundation, which provides financial incentives, as specified, to a physician and surgeon for practicing in a medically underserved community. Existing law authorizes the Office of Statewide Health Planning and Development to adopt guidelines by regulation and requires the foundation to use guidelines for selection and placement of program applicants. These guidelines provide priority consideration to applicants who meet specified criteria, including that the applicant has 3 years of experience working in medically underserved areas or with medically underserved populations. The guidelines also must seek to place the most qualified applicants in the areas with the greatest need.

This bill would *delete the requirement that the guidelines seek to place the most qualified applicants in the areas of greatest need. The bill would* require the guidelines for the selection and placement of program applicants to include criteria that would give priority consideration to program applicants who have 3 years of experience providing health care services to medically underserved populations in

a federally designated health professional shortage area or medically underserved area, and *to applicants* who agree to practice in those areas and serve a medically underserved population.

Existing law defines "practice setting," for these purposes, to include a community clinic, as defined, a clinic owned and operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role to serve its indigent population and that is located in a medically underserved area and has at least 50% of its patients from that population.

This bill would include a private practice that provides primary care located in a medically underserved area and has a minimum of 30% uninsured, Medi-Cal, or other publicly funded program that serves patients who earn less than 250% of the federal poverty level, within this definition of "practice setting."

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

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

SECTION 1. Section 128552 of the Health and Safety Code is amended to read:

128552. For purposes of this article, the following definitions shall apply:

(a) "Account" means the Medically Underserved Account for Physicians established within the Health Professions Education Fund pursuant to this article.

(b) "Foundation" means the Health Professions Education Foundation.

(c) "Fund" means the Health Professions Education Fund.

(d) "Medi-Cal threshold languages" means primary languages spoken by limited-English-proficient (LEP) population groups meeting a numeric threshold of 3,000, eligible LEP Medi-Cal beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal beneficiaries residing in two contiguous ZIP Codes.

(e) "Medically underserved area" means an area defined as a health professional shortage area in Part 5 of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist

as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225.

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

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

(h) "Physician Volunteer Program" means the Physician Volunteer Registry Program established by the Medical Board of California.

(i) "Practice setting" means either of the following:

(1) A community clinic as defined in subdivision (a) of Section 1204 and subdivision (c) of Section 1206, a clinic owned or operated by a public hospital and health system, ~~or~~ a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role pursuant to Section 17000 of the Welfare and Institutions Code, which is located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population, *or a private practice that provides primary care located in a medically underserved area and has a minimum of 30 percent uninsured, Medi-Cal, or other publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.*

(2) A medical practice located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

(j) "Primary specialty" means family practice, internal medicine, pediatrics, or obstetrics/gynecology.

(k) "Program" means the Steven M. Thompson Physician Corps Loan Repayment Program.

(*l*) "Selection committee" means a minimum three-member committee of the board, that includes a member that was appointed by the Medical Board of California.

~~SECTION 1.~~

SEC. 2. Section 128553 of the Health and Safety Code is amended to read:

128553. (a) Program applicants shall possess a current valid license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act.

(b) The foundation, in consultation with those identified in subdivision (b) of Section 123551, shall use guidelines developed by the Medical Board of California for selection and placement of applicants until the office adopts other guidelines by regulation. The foundation shall interpret the guidelines to apply to both osteopathic and allopathic physicians and surgeons.

(c) The guidelines shall meet all of the following criteria:

(1) Provide priority consideration to applicants that are best suited to meet the cultural and linguistic needs and demands of patients from medically underserved populations and who meet one or more of the following criteria:

(A) Speak a Medi-Cal threshold language.

(B) Come from an economically disadvantaged background.

(C) Have received significant training in cultural and linguistically appropriate service delivery.

(D) Have three years of experience providing health care services to medically underserved populations in a federally designated health professional shortage area or medically underserved area.

(E) Have recently obtained a license to practice medicine.

(2) Include a process for determining the needs for physician services identified by the practice setting and for ensuring that the practice setting meets the definition specified in subdivision (h) of Section 128552.

(3) Give preference to applicants who have completed a three-year residency in a primary specialty.

(4) Give preference to applicants who agree to practice in a federally designated health professional shortage area or medically underserved area, and who agree to serve a medically underserved population.

(5) Include a factor ensuring geographic distribution of placements.

(6) Provide priority consideration to applicants who agree to practice in a geriatric care setting and are trained in geriatrics, and who can meet the cultural and linguistic needs and demands of a diverse population of older Californians. On and after January 1, 2009, up to 15 percent of the funds collected pursuant to Section 2436.5 of the Business and Professions Code shall be dedicated to loan assistance for physicians and surgeons who agree to practice

in geriatric care settings or settings that primarily serve adults over the age of 65 years or adults with disabilities.

(d) (1) The foundation may appoint a selection committee that provides policy direction and guidance over the program and that complies with the requirements of subdivision (*l*) of Section 128552.

(2) The selection committee may fill up to 20 percent of the available positions with program applicants from specialties outside of the primary care specialties.

(e) Program participants shall meet all of the following requirements:

(1) Shall be working in or have a signed agreement with an eligible practice setting.

(2) Shall have full-time status at the practice setting. Full-time status shall be defined by the board and the selection committee may establish exemptions from this requirement on a case-by-case basis.

(3) Shall commit to a minimum of three years of service in a medically underserved area. Leaves of absence shall be permitted for serious illness, pregnancy, or other natural causes. The selection committee shall develop the process for determining the maximum permissible length of an absence and the process for reinstatement. Loan repayment shall be deferred until the physician is back to full-time status.

(f) The office shall adopt a process that applies if a physician is unable to complete his or her three-year obligation.

(g) The foundation, in consultation with those identified in subdivision (b) of Section 128551, shall develop a process for outreach to potentially eligible applicants.

(h) The foundation may recommend to the office any other standards of eligibility, placement, and termination appropriate to achieve the aim of providing competent health care services in approved practice settings.

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AB 635

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 635
Author:	Ammiano
Bill Date:	April 11, 2013, Introduced
Subject:	Drug Overdose Treatment: Liability
Sponsor:	Harm Reduction Coalition
	California Society of Addiction Medicine

STATUS OF BILL:

This bill is in the Senate.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would amend the civil code to allow a licensed health care provider that is authorized by law to prescribe an opioid antagonist, to prescribe and subsequently dispense or distribute an opioid antagonist to a person at risk of on opioid-related overdose or a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose. This bill would allow the licensed health care provide to issue standing orders for the administration of the opioid antagonist. This bill would require a person who is prescribed an opioid antagonist or possesses it pursuant to a standing order to receive specified training. This bill would specify that if health care provider or person who possesses, distributes, or administers an opioid antagonist pursuant to a prescription or order acts with reasonable care, they shall not be subject to professional review, be found liable in a civil action, or be subject to criminal prosecution for issuing a prescription or order or possessing, distributing, or administering the opioid antagonist.

BACKGROUND (taken from the fact sheet)

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

In 2008, SB 797 (Ridley-Thomas, Chapter 477, Statutes of 2007) established a three-year overdose prevention pilot project. This bill granted immunity from civil and criminal penalties to licensed health care providers in seven counties (Alameda, Fresno, Humboldt, Los Angeles, Mendocino, San Francisco, and Santa Cruz) who worked with opioid overdose prevention and treatment training programs, if the provider acted with reasonable care when prescribing, dispensing, or distributing naloxone. The pilot was extended in 2010 and

extended liability protection to third party administrators of naloxone. This pilot is now scheduled to sunset on January 1, 2016.

California's longest running naloxone prescription program in San Francisco has provided over 3,600 take-home naloxone prescriptions since 2003 through collaboration with the San Francisco Department of Public Health. To date, 916 lives have been saved by laypersons trained by this program who administered the take-home naloxone during an overdose. According to the most recent data released by the Centers for Disease Control and Prevention (CDC), in 2008 there were 36,450 drug overdose deaths in the United States. According to CDC, overdose prevention programs in the United States distributing naloxone have trained over 50,000 lay persons to revive someone during an overdose, resulting in over 10,000 overdose reversals using naloxone

ANALYSIS

This bill will allow health care providers to prescribe, dispense, and issue standing orders for an opioid antagonist to persons at risk of overdose, or their family member, friend, or other person in a position to assist persons at risk, without making them professionally, civilly or criminally liable, if acting within reasonable care. It would also extend this same liability protection to individuals assisting in dispensing, distributing, or administering the opioid antagonist during an overdose.

This bill would require a person who is prescribed an opioid antagonist or possesses it pursuant to a standing order to receive training provided by an opioid overdose prevention and treatment training program. An opioid overdose prevention and treatment training program is defined in the bill as a program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in the following: the causes of an opiate overdose; mouth to mouth resuscitation; how to contact appropriate emergency medical services; and how to administer an opioid antagonist.

Language in existing law for the pilot project only provides civil and criminal liability, it does not exclude health care providers from "professional review". According to the author's office, the intent of the professional review language is to make it clear that the action of prescribing an opioid antagonist by standing order cannot be grounds for disciplinary action. Many states that have similar law include this type of language. Kentucky's statute says that a practitioner operating under the law shall not "be subject to disciplinary or other adverse action under any professional licensing statute". Illinois statute contains the same language, while Washington's statute says that actions under the law "shall not constitute unprofessional conduct". Massachusetts law declares that a naloxone script "shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice".

Drug overdoses are now the leading cause of injury death in the United States, surpassing motor vehicle crash deaths. According to the author's office, this bill will protect licensed health care providers and encourage them to begin prescribing naloxone to patients on chronic opioid pain medications in order to help address the prescription drug overdose epidemic, as well as make it easier for providers to participate in comprehensive drug overdose prevention programs that prescribe opioid antagonists. This is one element of many to address the issue of drug related overdose deaths in California.

The Executive Committee voted to recommend that the Board support this bill in concept until staff consulted with the author's office regarding the meaning of professional review. This was done and the author's office confirmed it means disciplinary review, and similar language is included in statute in other states that have similar laws. This bill will help to further the Board's mission of consumer protection, staff is suggesting that the Board support this bill.

FISCAL: None

SUPPORT: Harm Reduction Coalition (sponsor)
California Society of Addiction Medicine (sponsor)
California Attorneys for Criminal Justice
California Opioid Maintenance Providers
California Public Defenders Association
Civil Justice Association of California

OPPOSITION: None on file

POSITION: Executive Committee Recommendation: Support in Concept
Staff Recommendation (after consulting with the author's office): Support

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™

Morbidity and Mortality Weekly Report (*MMWR*)

Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010

Weekly
February 17, 2012 / 61(06);101-105

Drug overdose death rates have increased steadily in the United States since 1979. In 2008, a total of 36,450 drug overdose deaths (i.e., unintentional, intentional [suicide or homicide], or undetermined intent) were reported, with prescription opioid analgesics (e.g., oxycodone, hydrocodone, and methadone), cocaine, and heroin the drugs most commonly involved (*1*). Since the mid-1990s, community-based programs have offered opioid overdose prevention services to persons who use drugs, their families and friends, and service providers. Since 1996, an increasing number of these programs have provided the opioid antagonist naloxone hydrochloride, the treatment of choice to reverse the potentially fatal respiratory depression caused by overdose of heroin and other opioids (*2*). Naloxone has no effect on non-opioid overdoses (e.g., cocaine, benzodiazepines, or alcohol) (*3*). In October 2010, the Harm Reduction Coalition, a national advocacy and capacity-building organization, surveyed 50 programs known to distribute naloxone in the United States, to collect data on local program locations, naloxone distribution, and overdose reversals. This report summarizes the findings for the 48 programs that completed the survey and the 188 local programs represented by the responses. Since the first opioid overdose prevention program began distributing naloxone in 1996, the respondent programs reported training and distributing naloxone to 53,032 persons and receiving reports of 10,171 overdose reversals. Providing opioid overdose education and naloxone to persons who use drugs and to persons who might be present at an opioid overdose can help reduce opioid overdose mortality, a rapidly growing public health concern.

Overdose is common among persons who use opioids, including heroin users. In a 2002–2004 study of 329 drug users, 82% said they had used heroin, 64.6% had witnessed a drug overdose, and 34.6% had experienced an unintentional drug overdose (*4*). In 1996, community-based programs began offering naloxone and other opioid overdose prevention services to persons who use drugs, their families and friends, and service providers (e.g., health-care providers, homeless shelters, and substance abuse treatment programs). These services include education regarding overdose risk factors, recognition of signs of opioid overdose, appropriate responses to an overdose, and administration of naloxone.

To identify local program locations and assess the extent of naloxone distribution, in October 2010 the Harm Reduction Coalition e-mailed an online survey to staff members at the 50 programs then known to distribute naloxone. Follow-up e-mails and telephone calls were used to encourage participation, clarify responses, and obtain information on local, community-based programs. The survey included questions about the year the program began distributing naloxone, the number of persons trained in overdose prevention and naloxone administration, the number of overdose reversals reported, and whether the totals were estimates or based on program data. The survey also asked questions regarding the naloxone formulations currently distributed, any recent difficulties in obtaining naloxone, and the program's experience with naloxone distribution.

Staff members at 48 (96%) of the 50 programs completed the online survey. Since the first program began distributing naloxone in 1996, through June 2010, the 48 responding programs reported providing training and distributing naloxone to an estimated 53,032 persons (program range: zero to 16,220; median: 102.5; mean: 1,104.8).* From the first naloxone distribution in 1996 through June 2010, the programs received reports of 10,171 overdose reversals using naloxone (range: zero to 2,385; median: 32; mean: 211.9).† During a recent 12-month period, respondents distributed an estimated 38,860 naloxone vials (Table).§ Using data from the survey, the number of programs beginning naloxone distribution each year during 1996–2010 was compared with the annual crude rates of unintentional drug overdose deaths per 100,000 population from 1979 to 2008 (Figure 1) (*1*).

The 48 responding programs were located in 15 states and the District of Columbia. Four responding programs provided consolidated data for multiple local, community-based programs. Three state health departments, in New York, New Mexico, and Massachusetts, provided data for 129 local programs (65, 56, and eight, respectively); a nongovernmental organization in Wisconsin provided data on a statewide operation with 16 local programs. In all, the 48 responding programs provided data for 188 local opioid overdose prevention programs that distributed naloxone (Figure 2). Nineteen (76.0%) of the 25 states with 2008 drug overdose death rates higher than the median and nine (69.2%) of the 13 states in the highest quartile (*1*) did not have a community-based opioid overdose prevention program that distributed naloxone (Figure 2).

For a recent 12-month period, the 48 responding programs reported distributing 38,860 naloxone vials, including refills (range: zero to 12,070; median: 97; mean: 809.6).¶ Overdose prevention programs were characterized as small, medium, large, or very large, based on the number of naloxone vials distributed during that period. The six responding programs in the large and very large categories distributed 32,812 (84.4%) of the naloxone vials (Table).

Twenty-one (43.7%) responding programs reported problems obtaining naloxone in the "past few months" before the survey. The most frequently reported reasons for difficulties obtaining naloxone were the cost of naloxone relative to available funding and the inability of suppliers to fill orders.**

Reported by

Eliza Wheeler, MPA, Drug Overdose Prevention and Education (DOPE) Project, Harm Reduction Coalition, Oakland; Peter J. Davidson, PhD, Univ of California, San Diego, California. T. Stephen Jones, MD, T. Stephen Jones Public Health Consulting, Florence; Kevin S. Irwin, MA, Tufts Univ, Medford, Massachusetts. Corresponding contributor: Eliza Wheeler, wheeler@harmreduction.org, 510-444-6969.

Editorial Note

The findings in this report suggest that distribution of naloxone and training in its administration might have prevented numerous deaths from opioid overdoses. Syringe exchange and harm reduction programs for injection-drug users were early adopters of opioid overdose prevention interventions, including providing naloxone (*5,6*). More noninjection opioid users might be reached by opioid overdose prevention training and (where feasible) provision of naloxone in jails and prisons, substance abuse treatment programs, parent support groups, and physician offices (Maya Doe-Simkins, MPH, Boston Medical Center, personal communication, 2011). Reaching users of prescription opioid analgesics is important because a large proportion of drug overdose deaths have been associated with these drugs (*1,7*).

Widespread concern about the substantial increases in opioid drug overdose deaths has prompted adoption of various other prevention measures, including 1) education of patients, clinicians, pharmacists, and emergency department staff members; 2) issuing opioid prescribing guidelines; 3) prescription drug monitoring programs; 4) legal and administrative efforts to reduce illegal

prescribing; 5) prescription drug take-back programs; and 6) improved access to substance abuse treatment (*8,9*). Programs such as Project Lazarus and Operation OpioidSAFE in North Carolina include clinicians prescribing naloxone to patients receiving opioid analgesic prescriptions who meet criteria for higher overdose risk (*8*) (Anthony Dragovich, MD, Womack Army Medical Center, Fort Bragg, North Carolina, personal communication, 2011).

In the United States, naloxone is provided to participants in different ways, including through onsite medical professionals and the use of standing orders. Recognizing the potential value of providing naloxone to laypersons, some states (e.g., California, Illinois, New Mexico, New York, and Washington) have passed laws and changed regulations to provide limited liability for prescribers who work with programs providing naloxone to laypersons. In addition, Washington, Connecticut, New Mexico, and New York have enacted Good Samaritan laws providing protection from arrest in an effort to encourage bystanders at a drug overdose to call 911 and use naloxone when available (*9*). Because of high overdose mortality among persons who use drugs, the Global Fund to Fight AIDS, Tuberculosis, and Malaria recommends naloxone distribution as a component of comprehensive services for drug users (*10*).

In this analysis, the majority (76.0%) of the 25 states with 2008 age-adjusted drug overdose death rates higher than the median did not have a community-based opioid overdose prevention program that distributed naloxone. High death rates provide one measure of the extent of drug overdoses; however, the number of deaths also should be considered. For example, in 2008, West Virginia had the highest drug overdose death rate (25.8) in the United States, and Texas (8.6) had one of the lowest. However, the West Virginia rate was based on 459 deaths, whereas the Texas rate was based on 2,053 deaths. States might consider both death rates and number of deaths in their intervention planning.

The findings in this report are subject to at least three limitations. First, other naloxone distribution programs might exist that were unknown to the Harm Reduction Coalition. Second, all data are based on unconfirmed self-reports from the 48 responding programs. Finally, the numbers of persons trained in naloxone administration and the number of overdose reversals involving naloxone likely were underreported because of incomplete data collection and unreported overdose reversals. However, because not all untreated opioid overdoses are fatal, some of the persons with reported overdose reversals likely would have survived without naloxone administration (*2*).

In this report, nearly half (43.7%) of the responding opioid overdose programs reported problems obtaining naloxone related to cost and the supply chain. Price increases of some formulations of naloxone appear to restrict current program activities and the possibility of new programs. Economic pressures on state and local budgets could decrease funding of opioid overdose prevention activities (Daniel Bigg, Chicago Recovery Alliance, personal communication, 2011). To address the substantial increases in opioid-related drug overdose deaths, public health agencies could consider comprehensive measures that include teaching laypersons how to respond to overdoses and administer naloxone to those in need.

Acknowledgments

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* The number of participants to whom naloxone was distributed was estimated by 29 responding programs (26.5% of total) and based on program data for 19 respondents (73.5%).

† The number of opioid overdose reversals was estimated by 26 responding programs (25.4% of total) and based on program data for 22 respondents (74.6%).

§ The number of vials distributed to participants during 2009 or July 2009–June 2010 was estimated by 21 program respondents (6.5% of total) and based on program data for 27 respondents (93.5%).

¶ Responding programs provide naloxone for injection in multidose (10 mL) and single-dose (1 mL) vials with concentrations of 0.4 mg/mL. Vials that are adapted for intranasal use (using a mucosal atomization device) are single-dose 2 mL vials with concentration of 1 mg/mL. Typically, respondents provide 1 multidose or 2 single-dose vials in an overdose rescue kit. Forty-two (87.5%) of 48 reported providing only injectable naloxone (63.0% of total vials), four (8.3%) provided only intranasal naloxone (33.1%), and four (8.3%) provided both injectable and intranasal naloxone (3.9%).

** The two most commonly reported reasons for difficulties obtaining naloxone were the cost of naloxone relative to available funding (seven responding programs) and inability of suppliers to fill orders (13 respondents). Four respondents reported interruptions because they did not have a qualified medical provider to either order naloxone from suppliers or prescribe naloxone to users. Five reported two of the three reasons for interruptions.

What is already known on this topic?

From 1990 to 2008, drug overdose death rates increased threefold in the United States, and the number of annual deaths increased to 36,450. Opioids (including prescription opioid medications and heroin) are major causes of drug overdose deaths. Naloxone is the standard of care for treatment of potentially fatal respiratory depression caused by opioid overdose.

What is added by this report?

In October 2010, at least 188 local opioid overdose prevention programs that distributed naloxone existed. During 1996–2010, these programs in 15 states and the District of Columbia reported training and providing naloxone to 53,032 persons, resulting in 10,171 drug overdose reversals using naloxone. However, many states with high drug overdose death rates have no opioid overdose prevention programs that distribute naloxone.

What are the implications for public health practice?

To address the high rates of opioid drug overdose deaths, public health agencies could, as part of a comprehensive prevention program, implement community-based opioid drug overdose prevention programs, including training and providing naloxone to potential overdose witnesses, and systematically assess the impact of these programs.

TABLE. Number of opioid overdose programs/local programs, naloxone vials provided in a recent 12-month period, program participants overall, and overdose reversals, by program size — United States, 1996–2010

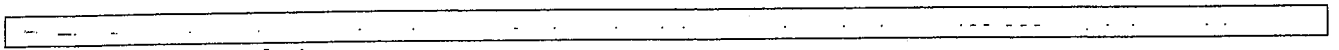
Program size (by no. of vials of naloxone provided during a recent 12-month period)	No. of program respondents	No. of local programs	No. of naloxone vials provided to participants during a recent 12-month period*		No. of program participants from beginning of program through June 2010†		Reported opioid overdose reversals from beginning of program through June 2010§	
			No.	(%)	No.	(%)	No.	(%)
Small <100	24	24	754	(1.9)	1,646	(3.1)	371	(3.6)
Medium 101–1,000	18	18	5,294	(13.6)	13,214	(24.9)	3,241	(31.9)
Large 1,001–10,000	4	74	9,792	(25.3)	26,213	(49.4)	5,648	(55.5)
Very large >10,000	2	72	23,020	(59.2)	11,959	(22.6)	1,091	(10.7)
Total	**48**	**188**	**38,860**	**(100.0)**	**53,032**	**(100.0)**	**10,171**	**(100.0)**

* Units of naloxone (including number of vials or intranasal doses and refills) distributed to participants during 2009 or July 2009–June 2010. Estimated by 21 program respondents (2,524 units, 6.5% of total) and based on program data for 27 respondents (36,336 units, 93.5%).

† Number of participants to whom naloxone was distributed from the start of program through June 2010. Estimated by 29 respondents (14,066 participants, 26.5% of total) and based on program data for 19 respondents (38,966 participants, 73.5%).

§ Number of opioid overdose reversals reported using the naloxone provided by the program from the start of the program through June 2010. Estimated by 26 respondents (2,582 reversals, 25.4% of total) and based on program data for 22 respondents (7,589 reversals, 74.6%).

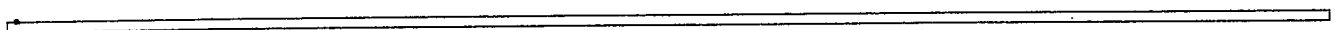
FIGURE 1. Annual crude rates* of unintentional drug overdose deaths and number of overdose prevention programs distributing naloxone — United States, 1979–2010



* Per 100,000 population.

Alternate Text: The figure above shows the annual crude rates of unintentional drug overdose deaths per 100,000 population and the number of overdose prevention programs distributing naloxone in the United States during 1979-2010.

FIGURE 2. Number (N = 188) and location* of local drug overdose prevention programs providing naloxone in 2010 and age-adjusted rates† of drug overdose deaths§ in 2008 — United States



* Not shown in states with fewer than three local programs.

† Per 100,000 population.

§ **Source:** National Vital Statistics System. Available at http://www.cdc.gov/nchs/nvss.htm. Includes intentional, unintentional, and undetermined.

Alternate Text: The figure above shows the number (N = 188) and location of local overdose prevention programs providing naloxone in 2010 and age-adjusted rates of drug overdose deaths, by state, in the United States during 2008. In all, the 48 responding programs provided data for 188 local opioid overdose prevention programs that distributed naloxone. Nineteen (76.0%) of the 25 states with 2008 drug overdose death rates higher than the median and nine (69.2%) of the 13 states in the highest quartile did not have a community-based opioid overdose prevention program that distributed naloxone.

Page last reviewed: February 17, 2012
Page last updated: February 17, 2012

AMENDED IN ASSEMBLY APRIL 11, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 635

Introduced by Assembly Member Ammiano

February 20, 2013

An act to amend Section 1714.22 of the Civil Code, relating to drug overdose treatment.

LEGISLATIVE COUNSEL'S DIGEST

AB 635, as amended, Ammiano. Drug overdose treatment: liability.

Existing law authorizes a physician and surgeon to prescribe, dispense, or administer prescription drugs, including prescription-controlled substances, to an addict under his or her treatment, as specified. Existing law prohibits, except in the regular practice of his or her profession, any person from knowingly prescribing, administering, dispensing, or furnishing a controlled substance to or for any person who is not under his or her treatment for a pathology or condition other than an addiction to a controlled substance, except as specified.

Existing law authorizes, until January 1, 2016, and only in specified counties, a licensed health care provider, who is already permitted pursuant to existing law to prescribe an opioid antagonist, as defined, and who is acting with reasonable care, to prescribe and subsequently dispense or distribute an opioid antagonist in conjunction with an opioid overdose prevention and treatment training program, as defined, without being subject to civil liability or criminal prosecution. Existing law requires a local health jurisdiction that operates or registers an opioid overdose prevention and treatment training program to collect prescribed data and report it to the Senate and Assembly Committees on Judiciary by January 1, 2015.

Existing law authorizes, until January 1, 2016, and only in specified counties, a person who is not licensed to administer an opioid antagonist to do so in an emergency without fee if the person has received specified training information and believes in good faith that the other person is experiencing a drug overdose. Existing law prohibits that person, as a result of his or her acts or omissions, from being liable for any violation of any professional licensing statute, or subject to any criminal prosecution arising from or related to the unauthorized practice of medicine or the possession of an opioid antagonist.

This bill would revise and recast these provisions to instead authorize a licensed health care provider who is permitted by law to prescribe an opioid antagonist and is acting with reasonable care to prescribe and subsequently dispense or distribute an opioid antagonist for the treatment of an opioid overdose to a person at risk of an opioid-related overdose or a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose. The bill would authorize these licensed health care providers to issue standing orders for the distribution of an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist the person at risk. The bill would authorize these licensed health care providers to issue standing orders for the administration of an opioid antagonist by a family member, friend, or other person in a position to assist a person experiencing or suspected of experiencing an opioid overdose. The bill would provide that a person who acts with reasonable care and issues a prescription for, or an order for the administration of, an opioid antagonist to a person experiencing or suspected of experiencing an opioid overdose is not subject to professional review, liable in a civil action, or subject to criminal prosecution for issuing the prescription or order. The bill would also delete the repeal date and reporting requirements and expand the applicability of these provisions statewide.

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

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

SECTION 1. Section 1714.22 of the Civil Code is amended to read:

1714.22. (a) For purposes of this section, ~~"opioid~~ *the following definitions shall apply:*

(1) "Opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of an opioid overdose.

(2) "Opioid overdose prevention and treatment training program" means any program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in all of the following:

(A) The causes of an opiate overdose.

(B) Mouth to mouth resuscitation.

(C) How to contact appropriate emergency medical services.

(D) How to administer an opioid antagonist.

(b) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may, if acting with reasonable care, prescribe and subsequently dispense or distribute an opioid antagonist to a person at risk of an opioid-related overdose or *to* a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose.

(c) (1) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may issue standing orders for the distribution of an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose.

(2) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may issue standing orders for the administration of an opioid antagonist to a person at risk of an opioid-related overdose by a family member, friend, or other person in a position to assist a person experiencing or reasonably suspected of experiencing an opioid overdose.

(d) A person who is prescribed an opioid antagonist or possesses it pursuant to a standing order shall receive the training provided by an opioid overdose prevention and treatment training program.

~~(d)~~

(e) A licensed health care provider who acts with reasonable care shall not be subject to professional review, be found liable in a civil action, or be subject to criminal prosecution for issuing a prescription or order pursuant to subdivision (b) or (c).

~~(e)~~

(f) Notwithstanding any other law, a person who possesses or distributes an opioid antagonist pursuant to a prescription or standing order shall not be subject to professional review, be found liable in a civil action, or be subject to criminal prosecution for this possession or distribution. Notwithstanding any other law, a person who acts with reasonable care and administers an opioid antagonist to a person who is experiencing or is suspected of experiencing an overdose shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for this administration.

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AB 809

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 809
Author: Logue
Bill Date: April 3, 2013, amended
Subject: Healing Arts: Telehealth
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Health Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would revise the existing requirement on health care providers that they must verbally inform and document consent of the patient prior to delivery of health care services via telehealth and would replace it with a requirement that the provider must obtain a waiver for treatment involving telehealth services, as specified.

ANALYSIS:

The Telehealth Advancement Act of 2011 was signed into law as a result of AB 415 (Logue, Chapter 547). This bill would delete the requirement included in that Act that is now in existing law that requires physicians, prior to the delivery of health care via telehealth, to verbally inform the patient at the originating site that telehealth may be used and obtain verbal consent from the patient for this use. This bill would also delete the requirement for the verbal consent to be documented in the patient's medical records. This bill would instead require the health care provider, prior to the delivery of health care via telehealth, to provide the patient at the originating site with a waiver for the course of treatment involving telehealth services and to obtain informed consent for the agreed upon course of treatment. This bill would require the signed waiver to be contained in the patient's medical record. This bill would also provide that it does not preclude a patient from receiving in-person health care delivery services during a course of treatment after agreeing to receive services via telehealth.

According to the author, under existing law, in order to ensure that both physicians and patients understood that telehealth may be used to treat the patient, a physician is required to obtain verbal consent for each and every visit with the patient. Physicians have reported that this constant requirement is burdensome on their ability to treat patients effectively. This was a requirement added to statute from AB 415 (Logue, Chapter 547, Statutes of 2011). The author of this bill, who also authored AB 415, believes that the requirement included in his bill in 2011 eliminates efficiencies achieved in rendering telehealth services and was an unintended consequence that is inconsistent with the intent and principles of his bill.

The California Association of Physician Groups supports this bill because telehealth is a critical component of expanding access to care and this bill is an important clean up provision.

Board staff suggests that the Board support this bill in order to allow the Telemedicine Advancement Act of 2011 to be better implemented, which will help to improve access to care via telehealth.

FISCAL: None

SUPPORT: Association of California Healthcare Districts
California Association of Physician Groups

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 3, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 809

Introduced by Assembly Member Logue

February 21, 2013

An act to amend Sections 1626.2, 2290.5, 4980.01, 4982, 4989.54, 4992.3, 4996, and 4999.90 of the Business and Professions Code, relating to telehealth, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 809, as amended, Logue. Healing arts: telehealth.

Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct.

This bill would ~~delete those provisions~~ *instead require the health care provider at the originating site to provide the patient with a waiver for the course of treatment involving telehealth services to obtain informed consent for the agreed upon course of treatment. The bill would require the signed waiver to be contained in the patient's medical record.* The bill would make additional conforming changes.

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

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

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

SECTION 1. Section 1626.2 of the Business and Professions Code is amended to read:

1626.2. A dentist licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5.

SEC. 2. Section 2290.5 of the Business and Professions Code is amended to read:

2290.5. (a) For purposes of this division, the following definitions shall apply:

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means a person who is licensed under this division.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

(6) "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider at the originating site shall provide the patient with a waiver for the course of treatment involving telehealth services

to obtain informed consent for the agreed upon course of treatment. The signed waiver shall be contained in the patient's medical record.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a course of treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

~~(b)~~

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

~~(c)~~

(f) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

~~(d)~~

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

~~(e)~~

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

SEC. 3. Section 4980.01 of the Business and Professions Code is amended to read:

4980.01. (a) Nothing in this chapter shall be construed to constrict, limit, or withdraw the Medical Practice Act, the Social Work Licensing Law, the Nursing Practice Act, the Licensed Professional Clinical Counselor Act, or the Psychology Licensing Act.

(b) This chapter shall not apply to any priest, rabbi, or minister of the gospel of any religious denomination when performing counseling services as part of his or her pastoral or professional duties, or to any person who is admitted to practice law in the state, or who is licensed to practice medicine, when providing counseling services as part of his or her professional practice.

(c) (1) This chapter shall not apply to an employee working in any of the following settings if his or her work is performed solely under the supervision of the employer:

(A) A governmental entity.

(B) A school, college, or university.

(C) An institution that is both nonprofit and charitable.

(2) This chapter shall not apply to a volunteer working in any of the settings described in paragraph (1) if his or her work is performed solely under the supervision of the entity, school, or institution.

(d) A marriage and family therapist licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5.

(e) Notwithstanding subdivisions (b) and (c), all persons registered as interns or licensed under this chapter shall not be exempt from this chapter or the jurisdiction of the board.

SEC. 4. Section 4982 of the Business and Professions Code is amended to read:

4982. The board may deny a license or registration or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime

in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using of any of the dangerous drugs specified in Section 4022, or of any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing marriage and family therapy services.

(d) Gross negligence or incompetence in the performance of marriage and family therapy.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(h) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client, or a former client within two years following termination of therapy, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a marriage and family therapist.

(*l*) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any trainee or registered intern under supervision to perform, any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in

this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of any registered intern, associate clinical social worker, or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(t) Permitting a trainee or registered intern under one's supervision or control to perform, or permitting the trainee or registered intern to hold himself or herself out as competent to perform, professional services beyond the trainee's or registered intern's level of education, training, or experience.

(u) The violation of any statute or regulation governing the gaining and supervision of experience required by this chapter.

(v) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(w) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(x) Failure to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(y) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(z) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the

act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(aa) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of an examination as described in Section 123.

SEC. 5. Section 4989.54 of the Business and Professions Code is amended to read:

4989.54. The board may deny a license or may suspend or revoke the license of a licensee if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) Conviction of a crime substantially related to the qualifications, functions, and duties of an educational psychologist.

(1) The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.

(2) The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee under this chapter.

(3) A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee under this chapter shall be deemed to be a conviction within the meaning of this section.

(4) The board may order a license suspended or revoked, or may decline to issue a license when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under

Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty or setting aside the verdict of guilty or dismissing the accusation, information, or indictment.

(b) Securing a license by fraud, deceit, or misrepresentation on an application for licensure submitted to the board, whether engaged in by an applicant for a license or by a licensee in support of an application for licensure.

(c) Administering to himself or herself a controlled substance or using any of the dangerous drugs specified in Section 4022 or an alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to himself or herself or to any other person or to the public or to the extent that the use impairs his or her ability to safely perform the functions authorized by the license. The board shall deny an application for a license or revoke the license of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing educational psychology.

(d) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee.

(g) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action imposed by another state or territory or possession of the United States or by any other governmental agency, on a license, certificate, or registration to practice educational psychology or any other healing art. A certified copy of the disciplinary action, decision, or judgment shall be conclusive evidence of that action.

(h) Revocation, suspension, or restriction by the board of a license, certificate, or registration to practice as an educational psychologist, a clinical social worker, professional clinical counselor, or marriage and family therapist.

(i) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(j) Gross negligence or incompetence in the practice of educational psychology.

(k) Misrepresentation as to the type or status of a license held by the licensee or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(*l*) Intentionally or recklessly causing physical or emotional harm to any client.

(m) Engaging in sexual relations with a client or a former client within two years following termination of professional services, soliciting sexual relations with a client, or committing an act of sexual abuse or sexual misconduct with a client or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a licensed educational psychologist.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients.

(p) Failing to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(q) Performing, holding himself or herself out as being able to perform, or offering to perform any professional services beyond the scope of the license authorized by this chapter or beyond his or her field or fields of competence as established by his or her education, training, or experience.

(r) Reproducing or describing in public, or in any publication subject to general public distribution, any psychological test or other assessment device the value of which depends in whole or in part on the naivete of the subject in ways that might invalidate the test or device. An educational psychologist shall limit access to the test or device to persons with professional interests who can be expected to safeguard its use.

(s) Aiding or abetting an unlicensed person to engage in conduct requiring a license under this chapter.

(t) When employed by another person or agency, encouraging, either orally or in writing, the employer's or agency's clientele to utilize his or her private practice for further counseling without the approval of the employing agency or administration.

(u) Failing to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(v) Failing to comply with the elder and adult dependent abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(w) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(x) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(y) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of the examination as described in Section 123.

(z) Impersonation of another by any licensee or applicant for a license, or, in the case of a licensee, allowing any other person to use his or her license.

(aa) Permitting a person under his or her supervision or control to perform, or permitting that person to hold himself or herself out as competent to perform, professional services beyond the level of education, training, or experience of that person.

SEC. 6. Section 4992.3 of the Business and Professions Code is amended to read:

4992.3. The board may deny a license or a registration, or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter is a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022 or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a

registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person who uses or offers to use drugs in the course of performing clinical social work. This provision does not apply to any person also licensed as a physician and surgeon under Chapter 5 (commencing with Section 2000) or the Osteopathic Act who lawfully prescribes drugs to a patient under his or her care.

(d) Incompetence in the performance of clinical social work.

(e) An act or omission that falls sufficiently below the standard of conduct of the profession as to constitute an act of gross negligence.

(f) Violating, attempting to violate, or conspiring to violate this chapter or any regulation adopted by the board.

(g) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity. For purposes of this subdivision, this misrepresentation includes, but is not limited to, misrepresentation of the person's qualifications as an adoption service provider pursuant to Section 8502 of the Family Code.

(h) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(i) Aiding or abetting any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(j) Intentionally or recklessly causing physical or emotional harm to any client.

(k) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(*l*) Engaging in sexual relations with a client or with a former client within two years from the termination date of therapy with the client, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that

act or solicitation is substantially related to the qualifications, functions, or duties of a clinical social worker.

(m) Performing, or holding one's self out as being able to perform, or offering to perform or permitting, any registered associate clinical social worker or intern under supervision to perform any professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(n) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(o) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(p) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (o).

(q) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(r) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device. A licensee shall limit access to that test or device to persons with professional interest who are expected to safeguard its use.

(s) Any conduct in the supervision of any registered associate clinical social worker, intern, or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(t) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(u) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(v) Failure to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(w) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(x) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(y) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of the examination as described in Section 123.

SEC. 7. Section 4996 of the Business and Professions Code is amended to read:

4996. (a) Only individuals who have received a license under this article may style themselves as "Licensed Clinical Social Workers." Every individual who styles himself or herself or who holds himself or herself out to be a licensed clinical social worker, or who uses any words or symbols indicating or tending to indicate that he or she is a licensed clinical social worker, without holding his or her license in good standing under this article, is guilty of a misdemeanor.

(b) It is unlawful for any person to engage in the practice of clinical social work unless at the time of so doing that person holds a valid, unexpired, and unrevoked license under this article.

(c) A clinical social worker licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5.

SEC. 8. Section 4999.90 of the Business and Professions Code is amended to read:

4999.90. The board may refuse to issue any registration or license, or may suspend or revoke the registration or license of any intern or licensed professional clinical counselor, if the applicant, licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a

license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022, or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing licensed professional clinical counseling services.

(d) Gross negligence or incompetence in the performance of licensed professional clinical counseling services.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee or registrant, allowing any other person to use his or her license or registration.

(h) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client, or a former client within two years following termination of therapy, soliciting sexual relations with a client, or committing an act of sexual abuse, or

sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a licensed professional clinical counselor.

(*l*) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any trainee, applicant, or registrant under supervision to perform, any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional clinical counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of a registered intern, associate clinical social worker, or clinical counselor trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience. This

subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(t) Permitting a clinical counselor trainee or intern under one's supervision or control to perform, or permitting the clinical counselor trainee or intern to hold himself or herself out as competent to perform, professional services beyond the clinical counselor trainee's or intern's level of education, training, or experience.

(u) The violation of any statute or regulation of the standards of the profession, and the nature of the services being rendered, governing the gaining and supervision of experience required by this chapter.

(v) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(w) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(x) Failing to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(y) Repeated acts of negligence.

(z) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(aa) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of an examination as described in Section 123.

(ab) Revocation, suspension, or restriction by the board of a license, certificate, or registration to practice as a professional clinical counselor, clinical social worker, educational psychologist, or marriage and family therapist.

(ac) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

SEC. 9. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the health and safety of the public due to a lack of access to health care providers in rural and urban medically underserved areas of California, the increasing strain on existing providers expected to occur with the implementation of the federal Patient Protection and Affordable Care Act, and the assistance that further implementation of telehealth can provide to help relieve these burdens, it is necessary for this act to take effect immediately.

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AB 831

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 831
Author:	Bloom
Bill Date:	April 3, 2013, Amended
Subject:	Drug Overdoses
Sponsor:	Drug Policy Alliance

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill makes findings and declarations related to the prevalence of fatal drug overdoses and proven interventions. This bill would require the California Health and Human Services Agency (CHHS) to convene a temporary working group to develop a state plan to reduce the rate of fatal drug overdose in California. This bill would also appropriate $500,000 from the General Fund to fund a grants program to local governments and community based organizations to implement overdose prevention efforts suited to local needs.

ANALYSIS

This would require CHHS to convene a temporary working group to develop a plan to reduce the rate of fatal drug overdoses in California. The bill would allow experts and staff from the Emergency Medical Services Authority, State Department of Alcohol and Drug Programs, State Department of Public Health, Office of AIDS, and any other staff that the Secretary of CHHS designates may participate in the working group. This bill would also allow staff from the Medical Board of California (Board) and the Board of Pharmacy to participate for the purpose of identifying promising practices to reduce accidental drug overdose among patients and other at-risk groups. This bill would require the working group to make recommendations to the Chair of the Senate Committee on Health and the Chair of the Assembly Committee on Health on or before January 1, 2015. This bill would sunset the working group on January 1, 2016.

This bill would appropriate $500,000 from the General Fund for fiscal year 2014/15 and in later years if included in CHHS' budget. This bill would require CHHS to make grants to local agencies from the $500,000 appropriation for the following purposes:

- Drug overdose prevention, recognition, and response education projects in jails, prisons, drug treatment centers, syringe exchange programs, clinics, programs serving veterans or military personnel, and other organizations that work with or have access to people who misuse prescription or illegal drugs, their families, and communities.

- Drug overdose prevention, recognition, and response training for patients and their families when the patient is prescribed opiate-based medications for which there is a significant risk of overdose.
- Naloxone hydrochloride prescription or distribution projects.
- Development and implementation of policies and projects to encourage people, including people misusing prescription or illegal drugs, to call the 911 emergency response system when they witness potentially fatal drug overdoses.
- Programs to educate Californians over 65 years of age about the risks associated with using opiate-based medications, ways to prevent overdose, and how to respond if they witness an overdose.
- The production and distribution of targeted or mass media materials on drug overdose prevention and response.
- Education and training projects on drug overdose response and treatment for emergency services and law enforcement personnel, including, but not limited to, volunteer fire and emergency services.
- Parent, family, and survivor education and mutual support groups, distributing, or administering the opioid antagonist during an overdose.

This bill would allow CHHS to set guidelines regarding the prioritization of applications and the types of organizations or entities that may apply in a given year. This bill would allow CHHS to adopt emergency regulations needed to implement this bill.

Drug overdoses are now the leading cause of injury death in the United States, surpassing motor vehicle crash deaths. According to the author's office, California should implement evidence-based interventions to reduce the rate of fatal drug overdoses. This bill would make a small investment in reducing the suffering of California families, and the Author's office believes this bill will significantly reduce hospitalization and emergency room costs.

This bill will help to protect consumers and save lives in California, which will further the Board's mission of consumer protection; staff is suggesting that the Board support this bill. The Executive Committee also voted to recommend that the Board support this bill.

FISCAL: None

SUPPORT: Drug Policy Alliance (Sponsor); A New Parents for Addiction Treatment & Healing; All of Us or None, Los Angeles/Long Beach - A New Way of Life Reentry Project; Broken No More; California Hepatitis Alliance; California Opioid Maintenance Providers; Center for Living and Learning; Center on Juvenile and Criminal Justice; Children's Hospital Los Angeles; Clean Needles Now; Glide Health Services; Harm Reduction Coalition; HealthRIGHT360; Homeless Health Care Los Angeles; La Ventana Treatment Programs; Los Angeles

Community Action Network; Los Angeles Community Health Outreach Project; Los Angeles County Board of Supervisors; Mission Neighborhood Health Center; Mothers Against Prescription Drug Abuse; Mothers With a Purpose; National Coalition Against Prescription Drug Abuse; Safer Alternatives Thru Networking and Education; San Francisco Hepatitis C Task Force; and Several individuals

OPPOSITION: None on file

POSITION: Executive Committee Recommendation: Support

AMENDED IN ASSEMBLY APRIL 3, 2013

AMENDED IN ASSEMBLY MARCH 18, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 831

Introduced by Assembly Member Bloom

February 21, 2013

An act to add Section 11758.08 to, and to add and repeal Section 11758.07 of, the Health and Safety Code, relating to drugs, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 831, as amended, Bloom. Drug overdoses.

Existing law establishes various programs for the control of illegal drugs in California and requires the State Department of Alcohol and Drug Programs to place on its Internet Web site specified information on drug overdose trends in California, including county and state death rates, from existing data, in order to ascertain changes in the causes or rates of fatal and nonfatal drug overdoses for the preceding 5 years.

This bill, until January 1, 2016, would establish, within the California Health and Human Services Agency, a temporary working group, as specified, to develop a plan to reduce the rate of fatal drug overdoses in the state. The bill would require the temporary working group to make recommendations to the Chair of the Senate Committee on Health and the Chair of Assembly Committee on Health on or before January 1, 2015.

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The bill would *also* establish a grant program within the California Health and Human Services Agency to provide funds for programs

related to drug overdose prevention, recognition, and response education, as specified. The bill would appropriate $500,000 from the General Fund for this purpose in the 2014–15 fiscal year.

The bill would also make related legislative findings and declarations.

Vote: 2/3. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares the following:

(a) According to the United States Centers for Disease Control and Prevention (CDC), a fatal drug overdose occurs in the United States every 14 minutes and drug overdose deaths are up for the 11th consecutive year. Drug overdose rates have tripled since 1990 and have never been higher.

(b) In recent years, over 3,500 Californians have died annually from drug overdose, or approximately 10 people each day, on average. In 2009, more Californians died of drug overdoses than in car accidents, and 1,000 more Californians died from drug overdoses than from gun homicides.

(c) There are cost-effective, proven interventions to reduce the number of drug overdoses caused by prescription analgesics and illegal drugs. An evaluation published by the CDC in 2012 identified 50 overdose prevention and education programs operating in 19 states, including California. These programs provide overdose prevention and recognition and response training to laypersons, including first responders, law enforcement officers, pain patients, family members, and at-risk drug users, and, when appropriate, prescriptions for the overdose reversal medication naloxone. These programs have reported over 50,000 doses of opiate overdose antidote prescribed and over 10,000 life-saving reversals of an overdose.

(d) According to an economic analysis published in the January 2013 edition of the Annals of Internal Medicine, community-level reductions of overdose death ranged from 37 percent to 90 percent in various cities that have implemented overdose prevention education projects that include naloxone prescriptions. The authors concluded, "[n]aloxone distribution to heroin users is likely to reduce heroin death and is cost-effective, even under markedly conservative assumptions."

(e) Between 2003 and 2011, the Drug Overdose Prevention and Education project, in partnership with the San Francisco County Department of Health, has recorded over 600 "saves" by laypersons providing first aid and administering naloxone to persons experiencing opiate overdose. The antidote was provided by prescription, with training by staff.

(f) Since the implementation of the drug overdose prevention project in San Francisco, emergency room visits for drug overdose have dropped by approximately 50 percent, resulting in significant savings to the healthcare system.

(g) Medical personnel at Fort Bragg Army Base in North Carolina implemented a comprehensive program to serve Unites States Army personnel. The base had suffered an unacceptably high rate of fatal drug overdoses, at an average of eight deaths per month, fueled by the misuse of pain medication and treatments for war-related injuries, including traumatic brain injury and post-traumatic stress disorder. Several programmatic steps were taken, including careful monitoring of prescription practices. However, the supervising physicians credited naloxone prescriptions as being the lynchpin that prevented any further overdoses, fatal or nonfatal, among United States Army personnel being treated at Fort Bragg Army Base.

(h) Project Lazarus, a community-level intervention that worked with physicians, patients, and family members of prescription analgesic pain medication patients, achieved a 38 percent reduction in overdose deaths in rural Wilkes County, North Carolina.

(i) The State of Massachusetts implemented a project to provide prevention education and response training, including the use of naloxone by prescription, to law enforcement personnel and laypersons who are likely to witness a potentially fatal drug overdose. Between December 2007 and September 2011, over 10,000 persons were trained and over 1,100 opioid overdose reversals were recorded.

(j) A study of the Massachusetts program published by the British Medical Journal in January of 2013 described overdose education and naloxone distribution by laypersons as "an effective public health intervention to address increasing mortality in the opioid overdose epidemic by training potential bystanders to prevent, recognize, and respond to opioid overdoses."

(k) The American Medical Association resolved on June 19, 2012, that it "(1) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (2) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; (3) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (4) will continue to monitor the progress of such initiatives and respond as appropriate."

(l) The American Public Health Association resolved on October 30, 2012, to "[e]ncourage local and state health departments to increase public and health professional awareness of the signs and symptoms of overdose; improve awareness of and facilitate access to naloxone; and support entry into treatment and recovery for those individuals seeking such services."

(m) The United Nations Commission on Narcotic Drugs resolved on March 16, 2012, that it "[e]ncourages all Member States to include effective elements for the prevention and treatment of drug overdose, in particular opioid overdose, in national drug policies, where appropriate, and to share best practices and information on the prevention and treatment of drug overdose, in particular opioid overdose, including the use of opioid receptor antagonists such as naloxone."

(n) In enacting this act, it is the intent of the Legislature that overdose prevention programs be conducted in the most cost-effective manner possible, while coordinating state efforts across agencies and supporting culturally appropriate local programs in areas of high need in a manner consistent with local needs and values.

~~SECTION 1.~~

SEC. 2. Section 11758.07 is added to the Health and Safety Code, to read:

11758.07. (a) The California Health and Human Services Agency shall convene a temporary working group within the agency to develop a plan to reduce the rate of fatal drug overdoses in the state. Experts and staff from the ~~Office of~~ Emergency *Medical* Services *Authority*, State Department of Alcohol and Drug Programs, State Department of Public Health, Office of

AIDS, and any other staff that the Secretary of California Health and Human Services designates may participate in the temporary working group. Additionally, staff from the Medical Board of California and California State Board of Pharmacy may also participate for the purpose of identifying promising practices to reduce accidental drug overdose among patients and other at-risk groups.

(b) The secretary may invite other experts to participate in the temporary working group. Their participation shall be uncompensated.

(c) The temporary working group shall make recommendations to the Chair of the Senate Committee on Health and the Chair of the Assembly Committee on Health on or before January 1, 2015.

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

~~SEC. 2.~~

SEC. 3. Section 11758.08 is added to the Health and Safety Code, to read:

11758.08. (a) The California Health and Human Services Agency shall make grants to local agencies from funds appropriated pursuant to this section for any of the following purposes:

(1) Drug overdose prevention, recognition, and response education projects in jails, prisons, drug treatment centers, syringe exchange programs, clinics, *programs serving veterans or military personnel,* and other organizations that work with or have access to ~~drug users,~~ *people who misuse prescription or illegal drugs,* their families, and communities.

(2) Drug overdose prevention, recognition, and response training for patients and their families when the patient is prescribed opiate-based medications for which there is a significant risk of overdose.

(3) Naloxone hydrochloride prescription or distribution projects.

(4) Development and implementation of policies and projects to encourage people, including ~~drug users,~~ *people misusing prescription or illegal drugs,* to call the 911 emergency response system when they witness potentially fatal drug overdoses.

(5) Programs to educate Californians over 65 years of age about the risks associated with using opiate-based medications, ways to

prevent overdose, ~~or~~ *and* how to respond if they witness an overdose.

(6) The production and distribution of targeted or mass media materials on drug overdose prevention and response.

(7) Education and training projects on drug overdose response and treatment for emergency services and law enforcement personnel, including, but not limited to, volunteer fire and emergency services.

(8) Parent, family, and survivor education and mutual support groups.

(b) In order to control budgets and appropriately limit the number of possible applications, the agency may set guidelines regarding the prioritization of applications and the types of organizations or entities that may apply in a given year.

(c) The adoption and one readoption of regulations to implement this section shall be deemed to be an emergency necessary for the immediate preservation of *the* public peace, health, ~~and~~ safety, or ~~the~~general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the agency is hereby exempted from the requirement that it describe specific facts showing the need for immediate action and from review by the Office of Administrative Law.

(d) There is hereby appropriated from the General Fund, in the 2014–15 fiscal year, five hundred thousand dollars ($500,000) for the purpose of funding the grants provided in subdivision (a). Additional funds necessary for the implementation of this section in the 2014–15 fiscal year and in later fiscal years may be included in the budget appropriation for the California Health and Human Services Agency.

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AB 860

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 860
Author: Perea
Bill Date: April 8, 2013, amended
Subject: Medical School Scholarships
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would provide that $600,000 from the Managed Care Administrative Fines and Penalties Fund (Fund) shall be transferred to the Steven M. Thompson Medical School Scholarship Program (STMSSP) Account within the Health Professions Education Foundation (HPEF) for purposes of funding the STMSSP.

ANALYSIS:

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

AB 589 (Perea, Chapter 339, Statutes of 2012) created the STMSSP within the HPEF. STMSSP participants are required to commit in writing to three years of full-time professional practice in direct patient care in an eligible setting. The maximum amount per total scholarship is $105,000 per recipient, to be distributed over the course of medical school. The committee charged with selecting scholarship recipients must use guidelines that provide priority consideration to applicants who are best suited to meet the cultural and linguistic needs and demands of patients from medically underserved populations and who meet specified criteria. The selection committee must give preference to applicants who have committed to practicing in a primary specialty and who will serve in a practice setting in a super-medically underserved area. The selection committee must also include a factor ensuring geographic distribution of placements.

The STMSSP would have originally been funded by funds transferred from the Managed Care Administrative Fines and Penalties Fund that are in excess of the first $1,000,000, including accrued interest, as the first $1,000,000 funds the STLRP. However, the bill was amended to take these provisions out and the STMSSP is currently funded by federal or private funds only and cannot be implemented until HPEF determines that there are sufficient funds available in order to implement STMSSP. The Board had a support position on AB 589.

This bill would now require $600,000 from the Managed Care Fund to be transferred to the Steven M. Thompson Medical School Scholarship Program (STMSSP) Account within the Health Professions Education Foundation (HPEF) for purposes of funding the STMSSP. This bill would not affect the amount transferred to the STLRP, as the statute still specifies that the first $1 million dollars is set aside to fund the STLRP in HPEF.

The purpose of this bill is to fund the STMSSP to make medical school more financially accessible for students who are willing to pursue careers in primary care. According to the author's office, this bill will help to address the geographical disparity of physician supply in California, as well as the increasing cost of medical education. The author's office believes that by funding the STMSSP, this bill will provide underserved communities with greater access to medical care. This bill is consistent with the mission of the Medical Board of promoting access to care. Board staff suggests that the Board support this bill.

FISCAL: None to the Board

SUPPORT: American College of Emergency Physicians, California Chapter
California Academy of Family Physicians

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 8, 2013

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 860

Introduced by Assembly Members Perea and Bocanegra
(Coauthor: Assembly Member Bonta)
(Coauthor: Senator Rubio)

February 21, 2013

An act to amend Section 1341.45 of the Health and Safety Code, relating to health professions.

LEGISLATIVE COUNSEL'S DIGEST

AB 860, as amended, Perea. Medical school scholarships.

Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and imposes certain requirements on health care service plans. Existing law imposes various fines and administrative penalties for certain violations of these provisions that are deposited in the Managed Care Administrative Fines and Penalties Fund. Existing law requires the first $1,000,000 in the fund to be transferred each year to the Medically Underserved Account for Physicians for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. Existing law requires all remaining funds to be transferred each year to the Major Risk Medical Insurance Fund for purposes of the Major Risk Medical Insurance Program.

Existing law establishes within the Health Professions Education Foundation the Steven M. Thompson Medical School Scholarship Program (STMSSP), managed by the foundation and the Office of Statewide Health Planning and Development to promote the education

of medical doctors and doctors of osteopathy, as specified. ~~Existing law provides up to $105,000 per recipient in scholarships to selected participants who agree in writing prior to completing an accredited medical or osteopathic school based in the United States to serve in an eligible setting.~~ Existing law establishes the Steven M. Thompson Medical School Scholarship Account within the Health Professions Education Fund, which consists of private moneys donated to the STMSSP.

This bill would~~, beginning January 1, 2014~~, require that, *after* the first $1,000,000,~~ be~~ *is* transferred each year from the Managed Care Administrative Fines and Penalties Fund to the Medically Underserved Account for Physicians,~~ for purposes of the STMSSP, as specified, upon appropriation by the legislature. This bill would, beginning January 1, 2014, require that no less than $1,000,000~~ *$600,000* be transferred each year from the ~~Managed Care Administrative Fines and Penalties Fund, provided that the fund has $2,000,000 or more in it,~~ *fund* to the Steven M. Thompson Medical School Scholarship Account, for purposes of the STMSSP~~, upon appropriation by the Legislature. The bill would provide that if the Managed Care Administrative Fines and Penalties Fund has a balance of less than $2,000,000, the first $1,000,000 be transferred to the Medically Underserved Account for Physicians and the remainder, if any, to the Steven M. Thompson Medical School Scholarship Account~~. The bill would require that any amount remaining over the amounts transferred to~~ the Medically Underserved Account for Physicians and the Steven M. Thompson Medical School Scholarship Account~~ *those two accounts* be transferred each year to the Major Risk Medical Insurance Fund for purposes of the Major Risk Medical Insurance Program.

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

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

SECTION 1. Section 1341.45 of the Health and Safety Code is amended to read:

1341.45. (a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.

(b) The fines and administrative penalties collected pursuant to this chapter, on and after September 30, 2008, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.

(c) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, beginning September 1, 2009, and annually thereafter, as follows:

(1) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) ~~or~~ *of* Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(2) ~~Beginning January 1, 2014, if the Managed Care Administrative Fines and Penalties Fund has two million dollars ($2,000,000) or more, no less than one million dollars ($1,000,000)~~ *Six hundred thousand dollars ($600,000)* shall be transferred to the Steven M. Thompson Medical School Scholarship Account within the Health Professions Education Fund, ~~created pursuant to Section 128580, and shall, upon appropriation by the Legislature, be used by the Office of Statewide Health Planning and Development~~ for *purposes of* the Steven M. Thompson Medical School Scholarship Program ~~for the purposes~~, *as* specified in Article 6 (commencing with Section 128560) of Chapter 5 of Part 3 of Division 107.

(3) Any amount over the amounts that are subject to transfer as specified in paragraphs (1) and (2), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund created pursuant to Section 12739 of the Insurance Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 12739.1 of the Insurance Code.

~~(4) If the Managed Care Administrative Fines and Penalties Fund has a balance of less than two million dollars ($2,000,000), the first one million dollars ($1,000,000), shall be transferred pursuant to paragraph (1), and the remainder, if any, shall be transferred to the Steven M. Thompson Medical School Scholarship Account and shall, upon appropriation by the Legislature, be used for the purposes described in paragraph (2).~~

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

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AB 916

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 916
Author:	Eggman
Bill Date:	February 22, 2013, Introduced
Subject:	Healing Arts: False or Misleading Advertising
Sponsor:	California Society of Plastic Surgeons

STATUS OF BILL:

This bill is in the Assembly Business, Professions and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would prohibit physicians from using the terms "board", "certified" or "certification" when advertising unless the terms are used in connection to a specific certifying board and that board has been approved by the American Board of Medical Specialties (ABMS), is a board or association with equivalent requirements approved by the Medical Board of California (Board), or is a board or association with an Accreditation Council for Graduate Medical Education (ACGME)-approved postgraduate training program that provides complete training in that specialty or subspecialty.

ANALYSIS

Existing law prohibits physicians from advertising in public communications that they are "board certified" unless the board advertised is a member of ABMS, or the board or association with equivalent requirements is approved by the Board, or a board or association with an Accreditation Council for Graduate Medical Education (ACGME)-approved postgraduate training program that provides complete training in that specialty or subspecialty.

According to the author's office, there are some physicians misrepresenting themselves and their qualifications by providing misleading statements in public communications. Physicians can imply that they are "board certified", by using the terms "board", "certified", or "certification" in their advertising. When these terms are used, it circumvents the prohibition in existing law, because they aren't using the term "board certified".

This bill would prohibit physicians from using the terms "board", "certified" or "certification" when advertising unless the terms are used in connection to a specific certifying board and that board has been approved by the American Board of Medical Specialties (ABMS), is a board or association with equivalent requirements approved by the Medical Board of California (Board), or is a board or association with an Accreditation Council for

Graduate Medical Education (ACGME)-approved postgraduate training program that provides complete training in that specialty or subspecialty.

According to the author's office, some patients may choose a physician based on misleading terms, believing that the physician is "board certified" when that is not the case. This bill clarifies existing law to further protect the public and to ensure that patients better understand the training and qualifications of physicians from whom they are seeking care. This bill does not address the proposal included in the Board's sunset report that would remove the provision in existing law that requires the Board to recognize equivalent boards or associations.

This bill will allow patients to make informed decisions when choosing a health care provider and tighten existing law related to advertising, which will help to ensure consumer protection. The Executive Committee voted to recommend that the Board support this bill.

FISCAL: None

SUPPORT: California Society of Plastic Surgeons (Sponsor)

OPPOSITION: None on file

POSITION: Executive Committee Recommendation: Support

ASSEMBLY BILL No. 916

Introduced by Assembly Member Eggman

February 22, 2013

An act to amend Section 651 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 916, as introduced, Eggman. Healing arts: false or misleading advertising.

Existing law provides for the licensure and regulation of the practice of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law makes it unlawful for those practitioners to disseminate a false, fraudulent, misleading, or deceptive statement and defines those terms for its purposes. Existing law prohibits a physician and surgeon from making a statement in public communications that he or she is board certified unless that board meets certain requirements.

This bill would further prohibit the use of additional terms by a physician or surgeon with respect to board of certification, except as provided. The bill would also make findings and declarations regarding the need for legislation pertaining to misleading advertisements and statements by physicians and surgeons.

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

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

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

(a) Existing law prohibits a physician and surgeon from advertising in public communications that he or she is board certified unless that board is a member of the American Board of Medical Specialties, a board or association with equivalent requirements approved by the Medical Board of California, or a board or association with an Accreditation Council for Graduate Medical Education-approved postgraduate training program that provides complete training in that specialty or subspecialty.

(b) The intent of these laws is to protect the public from being misled or endangered as a result of false or misleading advertisements by practitioners who claim board certification by boards not meeting the above requirements, and to enhance the quality of care and safety afforded to patients.

(c) Unfortunately, these laws have been widely circumvented by the dissemination of public communications by physicians and surgeons, or on their behalf by boards that do not meet the above requirements, that do not include the exact phrase "board certified" but contain similar terms that strongly imply board certification.

(d) Further clarification of existing law is needed to further protect the public and to ensure that patients better understand the training and qualifications possessed by physicians and surgeons from whom they are seeking care.

SEC. 2. Section 651 of the Business and Professions Code is amended to read:

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

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

(1) Contains a misrepresentation of fact.

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

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

(B) Use of any photograph or other image of a model without clearly stating in a prominent location in easily readable type the fact that the photograph or image is of a model is a violation of subdivision (a). For purposes of this paragraph, a model is anyone other than an actual patient, who has undergone the procedure being advertised, of the licensee who is advertising for his or her services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

name of the certifying board is also used and given comparable prominence with the ~~term~~ *terms "board," "certified," "certification," or* "board certified" in the statement *and unless the term or terms are used in reference to a certifying board meeting at least one of the criteria described in clause (i), (ii), or (iii).*

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the Medical Board of California, for certifying medical doctors and other health care professionals that is based on the applicant's education, training, and experience.

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

The Medical Board of California shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this subparagraph. The fee shall not exceed the cost of administering this subparagraph. Notwithstanding Section 2 of Chapter 1660 of the Statutes of 1990, this subparagraph shall become operative July 1, 1993. However, an administrative agency or accrediting organization may take any action contemplated by this subparagraph relating to the establishment or approval of specialist requirements on and after January 1, 1991.

(D) A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or

association with the Council on Podiatric Medical Education approved postgraduate training programs that provide training in podiatric medicine and podiatric surgery. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification.

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

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

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

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

(8) A statement of publications authored by the practitioner.

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

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

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

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

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

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

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

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

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

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

Each of the healing arts boards and committees and examining committees within Division 2 shall, by regulation, define those efficacious services to be advertised by businesses or professions under their jurisdiction for the purpose of determining whether advertisements are false or misleading. Until a definition for that service has been issued, no advertisement for that service shall be disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not,

by regulation, unreasonably prevent truthful, nondeceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.

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

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

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AB 1000

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1000
Author:	Wieckowski
Bill Date:	March 21, 2013, amended
Subject:	Physical Therapists: Direct Access to Services:
Sponsor:	California Physical Therapy Association

STATUS OF BILL:

This bill is in the Assembly Business, Professions and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physical therapist (PT) to make a physical therapy diagnosis. This bill would allow a patient to directly access PT services, without being referred by a physician, provided that the treatment is within the scope of a PT as long as specified conditions are met.

ANALYSIS:

This bill would allow a PT to make a "physical therapy diagnosis", which is defined as a systemic examination process that culminates in assigning a diagnostic label identifying the primary dysfunction toward with physical therapy treatment will be directed, but shall not include a medical diagnosis or a diagnosis of a disease.

This bill would also allow a patient to directly access PT services, without being referred by a physician, provided that the treatment is within the scope of a PT and the following conditions are met:

- If the PT has reason to believe the patient has signs or symptoms of a condition that requires treatment beyond the scope of practice of a PT, the PT shall refer the patient to a physician, an osteopathic physician, or to a dentist, podiatrist or chiropractor.
- The PT shall disclose to the patient any financial interest in treating the patient.
- The PT shall notify the patient's physician, with the patient's written authorization, that the PT is treating the patient.

This bill would specify that it does not expand or modify the scope of practice of a PT, including the prohibition on a PT to diagnose a disease. This bill would also specify that it does not require a health care service plan or insurer to provide coverage for direct access to treatment by a PT.

This bill changes the scope of practice of a PT by allowing a PT to make a "physical therapy diagnosis" and allowing a PT to treat patients without a referral from a physician. The Board has taken oppose positions in the past on bills that allowed for direct patient access to PT services. The Board was opposed to these bills because they expanded the scope of practice for PT's by allowing them to see patients directly, without having the patients first seen by a physician, which puts patients at risk. A patient's condition cannot be accurately determined without first being examined by a physician, as PTs are not trained to make these comprehensive assessments and diagnoses. Because this bill will compromise patient care and consumer protection, staff is suggesting that the Board oppose this bill. The Executive Committee deferred to the Full Board on the position for this bill.

FISCAL: None

SUPPORT: California Physical Therapy Association (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Oppose

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1000

Introduced by Assembly Member Wieckowski

February 22, 2013

An act to amend ~~Section 2630 of~~ *Sections 2620 and 2660 of, and to add Section 2620.1 to,* the Business and Professions Code, relating to physical therapy.

LEGISLATIVE COUNSEL'S DIGEST

AB 1000, as amended, Wieckowski. ~~Physical therapy.~~ *Physical therapists: direct access to services.*

Existing law, the Physical Therapy Practice Act, creates the Physical Therapy Board of California and makes it responsible for the licensure and regulation of physical therapists. The act defines the term "physical therapy" for its purposes as, among other things, including physical therapy evaluation, treatment planning, instruction, and consultative services. The act makes it a crime to violate any of its provisions. The act authorizes the board to suspend, revoke, or impose probationary conditions on a license, certificate, or approval issued under the act for unprofessional conduct, as specified.

This bill would revise the definition of "physical therapy" to instead include examination and evaluation to determine a physical therapy diagnosis, as defined, prognosis, treatment plan, instruction, or consultative service.

This bill would specify that patients may access physical therapy treatment directly and would, in those circumstances, require a physical therapist to refer his or her patient to another specified healing arts practitioner if the physical therapist has reason to believe the patient

has a condition requiring treatment or services beyond that scope of practice, to disclose to the patient any financial interest he or she has in treating the patient, and, with the patient's written authorization, to notify the patient's physician and surgeon, if any, that the physical therapist is treating the patient. The bill would provide that failure to comply with these provisions constitutes unprofessional conduct subject to disciplinary action by the board.

Because the bill would specify additional requirements under the Physical Therapy Practice Act, the violation of which would be a crime, it 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.

~~Existing law, until January 1, 2014, establishes the Physical Therapy Board of California, which oversees the licensing and regulation of physical therapists. Existing law prohibits any person or persons from practicing or offering to practice physical therapy in this state for compensation, or to hold himself or herself out as a physical therapist, unless he or she holds a valid license, as specified.~~

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

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

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

SECTION 1. The Legislature finds and declares that an individual's access to early intervention to physical therapy treatment may decrease the duration of a disability, reduce pain, and lead to a quicker recovery.

SEC. 2. Section 2620 of the Business and Professions Code is amended to read:

2620. (a) Physical therapy means the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive

exercise, and shall include *examination and evaluation to determine a* physical therapy ~~evaluation,~~ *diagnosis, prognosis,* treatment ~~planning, instruction and~~ *plan, instruction, or* consultative ~~services.~~ *service.* The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions. The use of roentgen rays and radioactive materials, for diagnostic and therapeutic purposes, and the use of electricity for surgical purposes, including cauterization, are not authorized under the term "physical therapy" as used in this chapter, and a license issued pursuant to this chapter does not authorize the diagnosis of disease.

(b) For the purposes of this section, "physical therapy diagnosis" means a systematic examination process that culminates in assigning a diagnostic label identifying the primary dysfunction toward which physical therapy treatment will be directed, but shall not include a medical diagnosis or a diagnosis of disease.

~~(b)~~

(c) Nothing in this section shall be construed to restrict or prohibit other healing arts practitioners licensed or registered under this division from practice within the scope of their license or registration.

SEC. 3. Section 2620.1 is added to the Business and Professions Code, to read:

2620.1. (a) In addition to receiving wellness and evaluation services from a physical therapist, a person may initiate physical therapy treatment directly from a licensed physical therapist if the treatment is within the scope of practice of physical therapists, as defined in Section 2620, and all of the following conditions are met:

(1) If, at any time, the physical therapist has reason to believe that the patient has signs or symptoms of a condition that requires treatment beyond the scope of practice of a physical therapist, the physical therapist shall refer the patient to a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California or to a person licensed to practice dentistry, podiatric medicine, or chiropractic.

(2) The physical therapist shall disclose to the patient any financial interest he or she has in treating the patient.

(3) With the patient's written authorization, the physical therapist shall notify the patient's physician and surgeon, if any, that the physical therapist is treating the patient.

(b) The conditions in paragraphs (1), (2), and (3) of subdivision (a) do not apply to a physical therapist when providing evaluation or wellness physical therapy services to a patient as described in subdivision (a) of Section 2620.

(c) This section does not expand or modify the scope of practice for physical therapists set forth in Section 2620, including the prohibition on a physical therapist diagnosing a disease.

(d) This section does not require a health care service plan or insurer to provide coverage for direct access to treatment by a physical therapist.

SEC. 4. Section 2660 of the Business and Professions Code is amended to read:

2660. The board may, after the conduct of appropriate proceedings under the Administrative Procedure Act, suspend for not more than 12 months, or revoke, or impose probationary conditions upon any license, certificate, or approval issued under this chapter for unprofessional conduct that includes, but is not limited to, one or any combination of the following causes:

(a) Advertising in violation of Section 17500.

(b) Fraud in the procurement of any license under this chapter.

(c) Procuring or aiding or offering to procure or aid in criminal abortion.

(d) Conviction of a crime that substantially relates to the qualifications, functions, or duties of a physical therapist or physical therapist assistant. The record of conviction or a certified copy thereof shall be conclusive evidence of that conviction.

(e) Habitual intemperance.

(f) Addiction to the excessive use of any habit-forming drug.

(g) Gross negligence in his or her practice as a physical therapist or physical therapist assistant.

(h) Conviction of a violation of any of the provisions of this chapter or of the Medical Practice Act, or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or of the Medical Practice Act.

(i) The aiding or abetting of any person to violate this chapter or any regulations duly adopted under this chapter.

(j) The aiding or abetting of any person to engage in the unlawful practice of physical therapy.

(k) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of a physical therapist or physical therapist assistant.

(*l*) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood-borne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Public Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the California Board of Podiatric Medicine, the Dental Board of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians of the State of California, to encourage appropriate consistency in the implementation of this subdivision.

The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of blood-borne infectious diseases.

(m) The commission of verbal abuse or sexual harassment.

(n) Failure to comply with the provisions of Section 2620.1.

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.

~~SECTION 1. Section 2630 of the Business and Professions Code is amended to read:~~

~~2630. It is unlawful for any person or persons to practice, or offer to practice, physical therapy in this state for compensation received or expected, or to hold himself or herself out as a physical therapist, unless at the time of so doing he or she holds a valid, unexpired, and unrevoked license issued under this chapter.~~

~~Nothing in this section shall restrict the activities authorized by their licenses on the part of any persons licensed under this code or any initiative act, or the activities authorized to be performed pursuant to Article 4.5 (commencing with Section 2655) or Chapter 7.7 (commencing with Section 3500).~~

~~A physical therapist licensed pursuant to this chapter may utilize the services of one aide engaged in patient-related tasks to assist the physical therapist in his or her practice of physical therapy. "Patient-related task" means a physical therapy service rendered directly to the patient by an aide, excluding non-patient-related tasks. "Non-patient-related task" means a task related to observation of the patient, transport of the patient, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions. The aide shall at all times be under the orders, direction, and immediate supervision of the physical therapist. Nothing in this section shall authorize an aide to independently perform physical therapy or any physical therapy procedure. The board shall adopt regulations that set forth the standards and requirements for the orders, direction, and immediate supervision of an aide by a physical therapist. The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as, and in proximity to, the location where the aide is performing patient-related tasks, and shall be readily available at all times to provide advice or instruction to the aide. When patient-related tasks are provided to a patient by an aide, the supervising physical therapist shall, at some point during the treatment day, provide direct service to the patient as treatment for the patient's condition, or to further evaluate and monitor the patient's progress, and shall correspondingly document the patient's record.~~

~~The administration of massage, external baths, or normal exercise not a part of a physical therapy treatment shall not be prohibited by this section.~~

AB 1003

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1003
Author:	Maienschein
Bill Date:	April 1, 2013, amended
Subject:	Professional Corporations: Healing Arts Practitioners
Sponsor:	California Medical Association (CMA)

STATUS OF BILL:

This bill is in the Assembly Business, Professions and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify that the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation does not limit employment of professional corporations to the licensed professionals listed in that section and would specify that any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act, may be employed to render professional services by a professional corporation listed in existing law. This bill would also add physical therapists, and other licensed professionals, to the listing in the Corporations Code.

ANALYSIS:

Since 1990, the Physical Therapy Board has allowed physical therapist's to be employed by medical corporations. On September 29, 2010, the California Legislative Counsel issued a legal opinion that concluded a physical therapist may not be employed by a professional medical corporation and stated that only professional physical therapy corporations or naturopathic corporations may employ physical therapists. This issue came to the Legislature's attention when existing law was amended to add naturopathic doctor corporations and physical therapists were listed as professionals allowed to be employed by these corporations. Because the medical corporation section of law did not specifically list physical therapists, the issue was brought to the forefront and to the California Legislative Counsel for an opinion. On November 3, 2010, the Physical Therapy Board voted to rescind the 1990 resolution that authorized the forming of a general corporation employing physical therapists.

Currently, due to the legal opinion, professional corporations are only allowed to employ the licensed practitioners listed in Corporations Code Section 13401.5. According to the author's office, this could result in harming quality of care by eliminating the line of

communication between physicians and the licensed professionals assisting in the patient's care and it may interrupt continuity of care and convenience of care, as well as fragmenting the delivery of care and impeding a patient's right to choose integrated, comprehensive care.

This bill would specify that the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation does not limit employment of professional corporations to the licensed professionals listed in that section and would specify that any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act, may be employed to render professional services by a professional corporation listed in existing law. This bill would also add physical therapists, and other licensed professionals, to the listing in the Corporations Code.

SB 543 (Steinberg, Chapter 448, Statutes of 2011) was signed into law and was effective from January 1, 2012 to January 1, 2013. This bill specified that no physical therapist shall be subject to discipline by the Physical Therapy Board for providing physical therapy services as a professional employee of a professional medical corporation; this provision was sunset on January 1, 2013. The language in SB 543 was added because the Physical Therapy Board was attempting to take action against physical therapists employed by a medical corporation. SB 543 put this issue in a holding pattern, until January 1, 2013; however, this issue was not addressed in legislation last year, so it still remains an issue that must be addressed.

This bill will codify the practice that has been allowed for over 20 years and allow physicians in medical corporations to employ physical therapists. The Board also supported AB 783 (Hayashi, 2011) which would have added licensed physical therapists and occupational therapists to the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation. Board staff suggests that the Board support this bill.

FISCAL: None to the Board

SUPPORT: CMA (Sponsor), California Orthopaedic Association; California Chiropractic Association; and several individuals

OPPOSITION: California Physical Therapy Association
Numerous individual Physical Therapists

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 1, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1003

Introduced by Assembly Member Maienschein

February 22, 2013

An act to amend 13401.5 of the Corporations Code, relating to professional corporations.

LEGISLATIVE COUNSEL'S DIGEST

AB 1003, as amended, Maienschein. Professional corporations: healing arts practitioners.

The Moscone-Knox Professional Corporation Act provides for the organization of a corporation under certain existing law for the purposes of qualifying as a professional corporation under that act and rendering professional services. The act defines a professional corporation as a corporation organized under the General Corporation Law or pursuant to specified law that is engaged in rendering professional services in a single profession, except as otherwise authorized in the act, pursuant to a certificate of registration issued by the governmental agency regulating the profession and that in its practice or business designates itself as a professional or other corporation as may be required by statute. The act authorizes specified listed types of healing arts practitioners to be shareholders, officers, directors, or professional employees of a designated professional corporation, subject to certain limitations relating to ownership of shares.

This bill would ~~delete professional employees from that authorization, and, instead, would provide that those provisions do not limit the employment of persons duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to render professional~~

~~services, by a designated professional corporation, to the listed licensed professionals specified in the provisions~~ *specify that those provisions do not limit the employment by a professional corporation to only those specified licensed professionals. The bill would authorize any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to be employed to render professional services by a professional corporation.*

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

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

SECTION 1. Section 13401.5 of the Corporations Code is amended to read:

13401.5. Notwithstanding subdivision (d) of Section 13401 and any other provision of law, the following licensed persons may be shareholders, officers, directors, or professional employees of the professional corporations designated in this section so long as the sum of all shares owned by those licensed persons does not exceed 49 percent of the total number of shares of the professional corporation so designated herein, and so long as the number of those licensed persons owning shares in the professional corporation so designated herein does not exceed the number of persons licensed by the governmental agency regulating the designated professional corporation:. *This section does not limit the employment by a professional corporation designated in this section to only those licensed professionals listed under each subdivision. Any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act may be employed to render professional services by a professional corporation designated in this section.*

(a) Medical corporation.

(1) Licensed doctors of podiatric medicine.

(2) Licensed psychologists.

(3) Registered nurses.

(4) Licensed optometrists.

(5) Licensed marriage and family therapists.

(6) Licensed clinical social workers.

(7) Licensed physician assistants.

(8) Licensed chiropractors.

(9) Licensed acupuncturists.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(b) Podiatric medical corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed optometrists.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(c) Psychological corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Registered nurses.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed chiropractors.
(8) Licensed acupuncturists.
(9) Naturopathic doctors.
(10) Licensed professional clinical counselors.
(d) Speech-language pathology corporation.
(1) Licensed audiologists.
(e) Audiology corporation.
(1) Licensed speech-language pathologists.
(f) Nursing corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed physician assistants.
(8) Licensed chiropractors.
(9) Licensed acupuncturists.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(g) Marriage and family therapist corporation.
(1) Licensed physicians and surgeons.

(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed professional clinical counselors.
(h) Licensed clinical social worker corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed marriage and family therapists.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed professional clinical counselors.
(i) Physician assistants corporation.
(1) Licensed physicians and surgeons.
(2) Registered nurses.
(3) Licensed acupuncturists.
(4) Naturopathic doctors.
(j) Optometric corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(k) Chiropractic corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed optometrists.
(6) Licensed marriage and family therapists.
(7) Licensed clinical social workers.
(8) Licensed acupuncturists.
(9) Naturopathic doctors.
(10) Licensed professional clinical counselors.

(*l*) Acupuncture corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed optometrists.
(6) Licensed marriage and family therapists.
(7) Licensed clinical social workers.
(8) Licensed physician assistants.
(9) Licensed chiropractors.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(m) Naturopathic doctor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed physician assistants.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Licensed physical therapists.
(8) Licensed doctors of podiatric medicine.
(9) Licensed marriage and family therapists.
(10) Licensed clinical social workers.
(11) Licensed optometrists.
(12) Licensed professional clinical counselors.
(n) Dental corporation.
(1) Licensed physicians and surgeons.
(2) Dental assistants.
(3) Registered dental assistants.
(4) Registered dental assistants in extended functions.
(5) Registered dental hygienists.
(6) Registered dental hygienists in extended functions.
(7) Registered dental hygienists in alternative practice.
(o) Professional clinical counselor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Licensed marriage and family therapists.
(5) Registered nurses.
(6) Licensed chiropractors.

(7) Licensed acupuncturists.
(8) Naturopathic doctors.

~~SECTION 1. Section 13401.5 of the Corporations Code is amended to read:~~

~~13401.5. (a) Notwithstanding subdivision (d) of Section 13401 and any other provision of law, the following licensed persons may be shareholders, officers, or directors of the professional corporations designated in this section so long as the sum of all shares owned by those licensed persons does not exceed 49 percent of the total number of shares of the professional corporation so designated herein, and so long as the number of those licensed persons owning shares in the professional corporation so designated herein does not exceed the number of persons licensed by the governmental agency regulating the designated professional corporation:~~

~~(1) Medical corporation.~~
~~(A) Licensed doctors of podiatric medicine.~~
~~(B) Licensed psychologists.~~
~~(C) Registered nurses.~~
~~(D) Licensed optometrists.~~
~~(E) Licensed marriage and family therapists.~~
~~(F) Licensed clinical social workers.~~
~~(G) Licensed physician assistants.~~
~~(H) Licensed chiropractors.~~
~~(I) Licensed acupuncturists.~~
~~(J) Naturopathic doctors.~~
~~(K) Licensed professional clinical counselors.~~
~~(2) Podiatric medical corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Registered nurses.~~
~~(D) Licensed optometrists.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(3) Psychological corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Registered nurses.~~
~~(D) Licensed optometrists.~~

~~(E) Licensed marriage and family therapists.~~
~~(F) Licensed clinical social workers.~~
~~(G) Licensed chiropractors.~~
~~(H) Licensed acupuncturists.~~
~~(I) Naturopathic doctors.~~
~~(J) Licensed professional clinical counselors.~~
~~(4) Speech-language pathology corporation.~~
~~(A) Licensed audiologists.~~
~~(5) Audiology corporation.~~
~~(A) Licensed speech-language pathologists.~~
~~(6) Nursing corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Licensed optometrists.~~
~~(E) Licensed marriage and family therapists.~~
~~(F) Licensed clinical social workers.~~
~~(G) Licensed physician assistants.~~
~~(H) Licensed chiropractors.~~
~~(I) Licensed acupuncturists.~~
~~(J) Naturopathic doctors.~~
~~(K) Licensed professional clinical counselors.~~
~~(7) Marriage and family therapist corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Licensed clinical social workers.~~
~~(D) Registered nurses.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(H) Licensed professional clinical counselors.~~
~~(8) Licensed clinical social worker corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Licensed marriage and family therapists.~~
~~(D) Registered nurses.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(H) Licensed professional clinical counselors.~~

~~(9) Physician assistants corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Registered nurses.~~
~~(C) Licensed acupuncturists.~~
~~(D) Naturopathic doctors.~~
~~(10) Optometric corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Registered nurses.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(11) Chiropractic corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Registered nurses.~~
~~(E) Licensed optometrists.~~
~~(F) Licensed marriage and family therapists.~~
~~(G) Licensed clinical social workers.~~
~~(H) Licensed acupuncturists.~~
~~(I) Naturopathic doctors.~~
~~(J) Licensed professional clinical counselors.~~
~~(12) Acupuncture corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Registered nurses.~~
~~(E) Licensed optometrists.~~
~~(F) Licensed marriage and family therapists.~~
~~(G) Licensed clinical social workers.~~
~~(H) Licensed physician assistants.~~
~~(I) Licensed chiropractors.~~
~~(J) Naturopathic doctors.~~
~~(K) Licensed professional clinical counselors.~~
~~(13) Naturopathic doctor corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Registered nurses.~~

~~(D) Licensed physician assistants.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Licensed physical therapists.~~
~~(H) Licensed doctors of podiatric medicine.~~
~~(I) Licensed marriage and family therapists.~~
~~(J) Licensed clinical social workers.~~
~~(K) Licensed optometrists.~~
~~(L) Licensed professional clinical counselors.~~
~~(14) Dental corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Dental assistants.~~
~~(C) Registered dental assistants.~~
~~(D) Registered dental assistants in extended functions.~~
~~(E) Registered dental hygienists.~~
~~(F) Registered dental hygienists in extended functions.~~
~~(G) Registered dental hygienists in alternative practice.~~
~~(15) Professional clinical counselor corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Licensed clinical social workers.~~
~~(D) Licensed marriage and family therapists.~~
~~(E) Registered nurses.~~
~~(F) Licensed chiropractors.~~
~~(G) Licensed acupuncturists.~~
~~(H) Naturopathic doctors.~~
~~(b) This section does not limit the employment of persons duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to render professional services, by a professional corporation designated in the section, to the licensed professionals listed under each paragraph of subdivision (a).~~

O

AB 1176

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1176
Author: Bocanegra and Bonta
Bill Date: March 21, 2013, amended
Subject: Medical Residency Training Program Grants
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Graduate Medical Education Fund that would be funded by a $5.00 annual fee that would be assessed for each covered life to health insurers and health care plans that provide health coverage in California, for purposes of awarding grants to fund new and existing graduate medical education (GME) residency slots.

ANALYSIS:

This bill would establish the Graduate Medical Education Fund (Fund) that would be funded by a $5.00 annual fee that would be assessed for each covered life to health insurers and health care plans that provide health coverage in California. This fee would not apply to dental-only, vision-only, or Medicare supplement plans or policies or to coverage provided under any public program, including, but not limited to, Medi-Cal or the Healthy Families Program. Moneys in the fund would have to be appropriated by the Legislature and could only be used for the purpose of funding grants to GME residency programs in California.

This bill would require the Office of Statewide Health Planning and Development (OSHPD), in consultation with the California Healthcare Workforce Policy Commission, to develop criteria for distribution of available moneys in the Fund. In developing the criteria, OHSPD would be required to give priority to programs that meet the following specifications:

- Are located in medically underserved areas.
- Place an emphasis on training primary care providers.
- Place an emphasis on training physician specialties that are most needed in the community in which the program is located.

The Fund could be used to fund existing GME residency slots, as well as new GME residency slots. OSHPD would be required to utilize moneys in the Fund to provide a match for available federal funds for GME, when applicable.

According to the author, California's current shortage of primary care physicians is projected to reach a crisis level by 2015, and will likely increase as more people become insured through the Affordable Care Act. The author believes that the additional funding for GME residency slots created by this bill will stabilize and expand medical residency training in California and help to ensure that every Californian has access to a physician when and where they need one. This bill is consistent with the mission of the Medical Board of promoting access to care. Board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: California Academy of Family Physicians
California Medical Association

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1176

Introduced by Assembly ~~Member~~ *Members* Bocanegra *and Bonta*

February 22, 2013

~~An act to amend Section 92655.1 of the Education Code, relating to postsecondary education.~~ *An act to add Article 4 (commencing with Section 128310) to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, relating to health care.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1176, as amended, Bocanegra. ~~University of California: health professions education outreach.~~ *Medical residency training program grants.*

Existing law, the Song-Brown Family Physician Training Act, declares the intent of the Legislature to increase the number of students and residents receiving quality education and training in the specialty of family practice and as primary care physician's assistants and primary care nurse practitioners. Existing law establishes, for this purpose, a state medical contract program with accredited medical schools, programs that train primary care physician's assistants, programs that train primary care nurse practitioners, registered nurses, hospitals, and other health care delivery systems.

Existing law establishes the California Healthcare Workforce Policy Commission and requires the commission to, among other things, identify specific areas of the state that have unmet priority needs, and review and make recommendations to the Director of the Office of Statewide Health Planning and Development concerning the funding of those programs that are submitted to the Health Professions

Development Program for participation in the state medical contract program.

The bill would establish the Graduate Medical Education Fund in the State Treasury to consist of annual assessments, on insurers or health care services plans that provide prescribed health care coverage, of $5 per covered life. The bill would require that moneys in the fund be used, upon appropriation by the Legislature, to fund grants to graduate medical residency training programs. The bill would require the Office of Statewide Health Planning and Development, in consultation with the California Healthcare Workforce Policy Commission, to develop criteria for distribution of available funds.

This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of ⅔ of the membership of each house of the Legislature.

~~Existing law establishes the University of California, administered by the Regents of the University of California, as one of the 3 segments of public postsecondary education in the state and provides the university with exclusive jurisdiction in public postsecondary education over graduate instruction in the professions of medicine, dentistry, and veterinary medicine. Existing law requests the regents to use existing resources to establish dental, medical, and optometric health professions outreach and exposure programs.~~

~~This bill would make nonsubstantive changes to that provision.~~

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

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

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

Article 4. Medical Residency Training Program Grants

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

(b) Moneys in the fund shall, upon appropriation by the Legislature, be used solely for the purpose of funding grants to graduate medical education residency programs in California.

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

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

(1) All assessments received pursuant to Section 128311.

(2) Any interest that accrues on amounts in the fund.

(e) The Office of Statewide Health Planning and Development, in consultation with the California Healthcare Workforce Policy Commission, shall develop criteria for distribution of available moneys in the fund. In developing the criteria, the office shall give priority to programs that meet the following specifications:

(1) Are located in medically underserved areas, as defined in Section 128552.

(2) Have a proven record of placing graduates in those medically underserved areas.

(3) Place an emphasis on training primary care providers.

(4) Place an emphasis on training physician specialties that are most needed in the community in which the program is located.

(f) Moneys appropriated from the fund may also be used to fund existing graduate medical education residency slots as well as new graduate medical education residency slots.

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

128311. (a) Every health insurer or health care service plan that provides health care coverage in this state shall pay an annual graduate medical education assessment of five dollars ($5.00) for each covered life to the California Healthcare Workforce Policy Commission for deposit into the Graduate Medical Education Fund for the purposes of this article.

(b) This section shall not apply to dental-only, vision-only, or Medicare supplement plans or policies or to coverage provided under any public program, including, but not limited to, Medi-Cal or the Healthy Families Program.

~~SECTION 1. Section 92655.1 of the Education Code is amended to read:~~

~~92655.1. The Legislature requests the Regents of the University of California, to the extent possible, to use existing resources to establish dental, medical, and optometric health professions~~

~~outreach and exposure programs for elementary and high school pupils and undergraduate students, including community college students.~~

O

AB 1288

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1288
Author: Perez, V.
Bill Date: April 11, 2013, amended
Subject: Medical Board: Licensing: Application Processing
Sponsor: California Medical Association

STATUS OF BILL:

This bill is currently in the Assembly Business, Professions, and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board of California (Board) to develop a process to give priority review status to the application of an applicant who can demonstrate that he or she intends to practice in a medically underserved area or population. This bill would allow an applicant to demonstrate his or her intent to practice in a medically underserved area by providing proper documentation, including a letter from the employer.

ANALYSIS:

Currently, the Board is completing an initial review of applications within 45 calendar days, well under the statutorily mandated 60 business days. However, many times the application does not have all the required information and primary source documentation at the time of initial review; only about 10% of applications are complete at initial review. The Board does not currently request any information on the application regarding where the applicant is planning on working once licensed.

This bill would require the Board to develop a process to give priority review status to an applicant who can demonstrate that he or she intends to practice in a medically underserved area or serve a medically underserved population as defined in existing law. This bill would allow an applicant to demonstrate his or her intent to practice in a medically underserved area or serve a medically underserved population by providing proper documentation, including but not limited to, a letter from the employer indicating that the applicant has accepted employment and including the start date.

The Board does not currently have a process for priority review of applications and the application does not currently request information on where an applicant plans on practicing. However, the Board would be able to review these applications on a priority basis, but would need to revise the application to ask applicants to provide this additional information. The priority review process could be established, but it still would require the applicant to provide all the original source documentation, and this seems to be the

The purpose of this bill is to ensure that applicants who intend on serving in an underserved area or serve an underserved population are licensed in a timely manner. The Board currently does not have any backlog processing applications, and many times the initial review of the application is done before all the primary source documents are received. However, this bill may help to ensure that applicants planning on serving in underserved areas are licensed in a timely manner. Board staff suggests that the Board take a neutral position on this bill.

FISCAL: Minimal and absorbable costs to develop a process for priority review status and to revise the licensing application.

SUPPORT: California Medical Association (sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 11, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1288

Introduced by Assembly Member V. Manuel Pérez

February 22, 2013

An act to ~~amend Sections 14085.7 and 14085.8 of~~ *add Section 2092 to* the ~~Welfare and Institutions~~ *Business and Professions* Code, relating to ~~health, and making an appropriation therefor.~~ *healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1288, as amended, V. Manuel Pérez. ~~Medi-Cal: supplemental hospital funding.~~ *Medical Board of California: licensing: application processing.*

Existing ~~law, operative until June 30, 2013, establishes the Medi-Cal Medical Education Supplemental Payment Fund and the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund. Moneys in those funds are continuously appropriated to the State Department of Health Care Services to make supplemental payments to eligible teaching hospitals to reflect additional costs incurred by those hospitals for services rendered to Medi-Cal beneficiaries.~~ *law, the Medical Practice Act, provides for licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law establishes the California Healthcare Workforce Policy Commission and requires the commission to, among other things, identify specific areas of the state where unmet priority needs for primary care exist.*

~~433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.~~

~~(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.~~

~~(3) Any amounts appropriated to the fund by the Legislature.~~

~~(4) Any interest that accrues on amounts in the fund.~~

~~(b) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.~~

~~(c) The department shall have the discretion to accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.~~

~~(d) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (c). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.~~

~~(e) (1) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, payments from this fund shall be negotiated between the California Medical Assistance Commission and hospitals contracting under this article that meet the definition of university teaching hospitals or major (nonuniversity) teaching hospitals as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall~~

~~(4) Any interest that accrues on amounts in the fund.~~

~~(d) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.~~

~~(e) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.~~

~~(f) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (g). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.~~

~~(g) (1) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, contracts for payments from the fund may, at the discretion of the California Medical Assistance Commission, be negotiated between the commission and hospitals contracting under this article that are defined as either of the following:~~

~~(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.~~

~~(B) A children's hospital pursuant to Section 10727 and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.~~

AB 1308

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1308
Author:	Bonilla
Bill Date:	March 21, 2013, Amended
Subject:	Midwifery
Sponsor:	American Congress of Obstetricians and Gynecologists, District IX

STATUS OF BILL:

This bill is in the Assembly Business, Professions, and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a licensed midwife (LM) to directly obtain supplies, order testing, and receive reports that are necessary to the LM's practice of midwifery and consistent with the scope for practice for a LM. This bill would also require the Medical Board of California (Board) to adopt regulations by July 1, 2015 defining the appropriate standard of care and level of supervisions required for the practice of midwifery and identifying complications necessitating referral to a physician. This bill would require a LM to disclose in oral and written form to a prospective client the specific arrangement for the referral of complications to a physician and surgeon.

ANALYSIS

Current law requires the Board to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery. Due to the inability to reach consensus on the supervision issue, the Board bifurcated this requirement and in 2006 adopted Standards of Care for Midwifery. Three previous attempts to resolve the physician supervision issue via legislation and/or regulation have been unsuccessful due to the widely divergent opinions of interested parties and their inability to reach consensus.

This bill would allow a LM to directly obtain supplies, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with the scope for practice for a LM. This bill would also require the Board to adopt regulations by July 1, 2015 defining the appropriate standard of care and level of supervision required for the practice of midwifery and identifying complications necessitating referral to a physician and surgeon. This bill would require a LM to disclose in oral and written form to a prospective client the specific arrangement for the referral of complications to a physician.

Although required by law, physician supervision is essentially unavailable to LMs performing home births, as California physicians are generally prohibited by their malpractice insurance companies from providing supervision of LMs who perform home births. According to these companies, if a physician supervises or participates in a home birth the physician will lose insurance coverage resulting in loss of hospital privileges. The physician supervision requirement creates numerous barriers to care, in that if the LM needs to transfer a patient/baby to the hospital, many hospitals will not accept a patient transfer from a LM as the primary provider who does not have a supervising physician. California is currently the only state that requires physician supervision of LMs. Among states that regulate midwives, most require some sort of collaboration between the midwife and a physician.

LMs have difficulty securing diagnostic lab accounts, even though they are legally allowed to have lab accounts. Many labs require proof of physician supervision. In addition, LMs are not able to obtain the medical supplies they have been trained and are expected to use; oxygen and medical supplies that are included in approved licensed midwifery school curriculum (CCR section 1379.30). The inability for a licensed midwife to order lab tests often means the patient will not obtain the necessary tests to help the midwife monitor the patient during pregnancy. In addition, not being able to obtain the necessary medical supplies for the practice of midwifery adds additional risk to the LM's patient and the fetus or child.

The Board, through the Midwifery Advisory Council (MAC) has held many meetings regarding physician supervision of licensed midwives and has attempted to create regulations to address this issue. The concepts of collaboration, such as required consultation, referral, transfer of care, and physician liability have been discussed among the interested parties with little success. There is disagreement over the appropriate level of physician supervision, with licensed midwives expressing concern with any limits being placed on their ability to practice independently. The physician and liability insurance communities have concerns over the safety of midwife-assisted homebirths, specifically delays and/or the perceived reluctance of midwives to refer patients when the situation warrants referral or transfer of care.

The Board, through MAC has also held meetings regarding the lab order and medical supplies/medication issues and has attempted to create regulatory language to address this issue. However, based upon discussions with interested parties, it appears the lab order and medical supplies/medication issues will need to be addressed through the legislative process.

This bill would address one of the barriers of care by allowing a LM to directly obtain supplies, order testing and receive reports necessary to the LM's practice of midwifery, which would help to ensure consumer protection.

Board staff has asked the sponsor if "supplies" were meant to include drugs. Board staff was told by the sponsor that they do intend to amend the bill to allow LMs to obtain drugs that they are authorized to provide within their scope.

This bill would also require the Board to adopt regulations to address physician supervision and to identify complications necessitating referral to a physician; however, the Board has been unsuccessful in endeavors to adopt regulations regarding physician supervision in the past. Board staff will continue to work with the author's office and sponsors on language that will help to solve the issue of physician supervision and remove barriers to care, while at the same time help to ensure consumer protection. Board staff is suggesting that the Board support this bill if it is amended to better clarify what the supervision requirements should be in statute, versus in regulation. The Executive Committee also voted to recommend that the Board support this bill if it is amended.

FISCAL: None, as the Board is already required to adopt regulations, but has been unsuccessful as of yet.

SUPPORT: ACOG (sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Support if amended to better clarify what the supervision requirements should be in statute, versus in regulation.

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1308

Introduced by Assembly Member Bonilla

February 22, 2013

An act *to amend Sections 2507 and 2508 of the Business and Professions Code,* relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 1308, as amended, Bonilla. Midwifery.

Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensing and regulation of midwives by the Board of Licensing of the Medical Board of California. The license to practice midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, as specified, 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. *Under the act, a licensed midwife is required to make certain oral and written disclosures to prospective clients.* A violation of the act is a crime.

This bill would additionally authorize a licensed midwife to directly obtain supplies, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice and would require a licensed midwife to disclose to prospective clients the specific arrangements for referral of complications to a physician and surgeon.

~~This bill would state the intent of the Legislature to enact legislation to remove barriers to care in order to provide a more efficient and safer delivery method for mother and infant by allowing licensed midwives to practice in a manner originally intended in prior legislation.~~

Existing law requires the board, by July 1, 2003, to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery.

This bill would require the board, by July 1, 2015, to revise and adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery and identifying complications necessitating referral to a physician and surgeon.

By expanding the disclosures a licensed midwife is required to make to prospective clients, this bill would expand the scope of a crime thereby imposing a state-mandated local program.

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

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

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

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

SECTION 1. ~~(a)~~ The Legislature finds and declares the following:

~~(1)~~

(a) Licensed midwives have been authorized to practice since 1993 under Senate Bill 350 (Chapter 1280 of the Statutes of 1993), which was authored by Senator Killea. Additional legislation, Senate Bill 1950 (Chapter 1085 of the Statutes of 2002), which was authored by Senator Figueroa, was needed in 2002 to clarify certain practice issues. While the midwifery license does not specify or limit the practice setting in which licensed midwives may provide care, the reality is that the majority of births delivered by licensed midwives are planned as home births.

~~(2)~~

(b) Planned home births are safer when care is provided as part of an integrated delivery model. For a variety of reasons, this integration rarely occurs, and creates a barrier to the best and safest care possible. This is due, in part, to the attempt to fit a midwifery model of care into a medical model of care.

~~(b) It is the intent of the Legislature to enact legislation that would systematically remove unnecessary barriers to care in order to provide a more efficient and safer delivery for mother and infant by allowing licensed midwives to practice in a manner originally intended in the authorizing legislation.~~

SEC. 2. Section 2507 of the Business and Professions Code is amended to read:

2507. (a) The license to practice midwifery authorizes the holder, 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.

(b) As used in this article, the practice of midwifery constitutes the furthering or undertaking by any licensed midwife, 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. All complications shall be referred to a physician and surgeon immediately. The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.

(c) As used in this article, "supervision" shall not be construed to require the physical presence of the supervising physician and surgeon.

(d) The ratio of licensed midwives to supervising physicians and surgeons shall not be greater than four individual licensed midwives to one individual supervising physician and surgeon.

(e) A midwife is not authorized to practice medicine and surgery by this article.

(f) A midwife is authorized to directly obtain supplies, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice.

~~(f)~~

(g) The board shall, not later than July 1, ~~2003,~~ *2015, revise and* adopt in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), regulations defining the appropriate standard of care and level of supervision required for the practice of ~~midwifery.~~ *midwifery and identifying complications necessitating referral to a physician and surgeon.*

SEC. 3. Section 2508 of the Business and Professions Code is amended to read:

2508. (a) A licensed midwife shall disclose in oral and written form to a prospective client all of the following:

(1) All of the provisions of Section 2507.

(2) If the licensed midwife does not have liability coverage for the practice of midwifery, he or she shall disclose that fact.

(3) The specific arrangements for the referral of complications to a physician and surgeon.

~~(3)~~

(4) The specific arrangements for the transfer of care during the prenatal period, hospital transfer during the intrapartum and postpartum periods, and access to appropriate emergency medical services for mother and baby if necessary.

~~(4)~~

(5) The procedure for reporting complaints to the Medical Board of California.

(b) The disclosure shall be signed by both the licensed midwife and the client and a copy of the disclosure shall be placed in the client's medical record.

(c) The Medical Board of California may prescribe the form for the written disclosure statement required to be used by a licensed midwife under this section.

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

ACR 40

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: ACR 40
Author: Perez
Bill Date: April 8, 2013, amended
Subject: Donate Life California Day
Sponsor: Donate Life California

STATUS OF BILL:

This resolution has passed out of the Legislature and has been sent to enrollment.

DESCRIPTION OF CURRENT LEGISLATION:

This resolution would make findings and declarations regarding the importance of organ donation. This resolution would proclaim April 9, 2013, as Department of Motor Vehicles (DMV)/Donate Life California Day and April 2013 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 renewing a driver's license or identification card.

ANALYSIS:

This resolution makes the following findings and declarations:

- More than 117,000 individuals nationwide and more than 21,000 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.
- An 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.
- Californians by the millions are joining together to save and enhance lives by becoming registered donors and nearly nine million Californians have signed 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 honored.
- 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.

This resolution would proclaim April 9, 2013, as DMV/Donate Life California Day and April 2013 as DMV/Donate Life California Month in California. This resolution would encourage all Californian to register with the Donate Life California Registry when applying for renewing a driver's license or identification card.

The Board recently voted to be the honorary state sponsor of Donate Life California's specialized license plate, which will help to increase awareness and raise money for organ and tissue donation, education and outreach. This resolution will also help to raise awareness by proclaiming April 9, 2013 as DMV/Donate Life California Day and April 2013 as DMV/Donate Life California Month. Board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: Donate Life California (Sponsor)
DMV

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 8, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

Assembly Concurrent Resolution No. 40

Introduced by Assembly Member John A. Pérez

(Coauthors: Assembly Members Achadjian, Alejo, Allen, Ammiano, Atkins, Bigelow, Bloom, Blumenfield, Bocanegra, Bonilla, Bonta, Bradford, Brown, Buchanan, Ian Calderon, Campos, Chau, Chávez, Chesbro, Cooley, Dahle, Daly, Dickinson, Donnelly, Eggman, Fong, Fox, Frazier, Beth Gaines, Garcia, Gatto, Gomez, Gordon, Gorell, Gray, Grove, Hagman, Hall, Harkey, Roger Hernández, Holden, Jones, Jones-Sawyer, Levine, Linder, Logue, Maienschein, Medina, Melendez, Mitchell, Morrell, Mullin, Muratsuchi, Nazarian, Nestande, Olsen, Pan, Patterson, Perea, V. Manuel Pérez, Quirk, Quirk-Silva, Rendon, Salas, Skinner, Stone, Ting, Torres, Wagner, Waldron, Weber, Wieckowski, Wilk, Williams, and Yamada)

March 21, 2013

Assembly Concurrent Resolution No. 40—Relative to organ donation.

LEGISLATIVE COUNSEL'S DIGEST

ACR 40, as amended, John A. Pérez. Donate Life California Day: driver's license.

This measure would designate April 9, 2013, as DMV/Donate Life California Day in the State of California, and April 2013 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.

Fiscal committee: no.

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

WHEREAS, More than 117,000 individuals nationwide and more than 21,000 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, Californians by the millions are joining together to save and enhance lives by becoming registered donors. Nearly nine million Californians have signed 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 honored; 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; 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 9, 2013, as DMV/Donate Life California Day in the State of California, and April 2013 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

SB 20

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 20
Author: Hernandez
Bill Date: February 14, 2013, amended
Subject: Health Care: Workforce Training
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require that when the California Major Risk Medical Insurance Program (MRMIP) become inoperative, all the funds in the Managed Care Administrative Fines and Penalties Fund (Managed Care Fund) must be transferred each year to the Medically Underserved Account in the Health Professions Education Foundation (HPEF) Fund for use by the Steven M. Thompson Loan Repayment Program (STLRP).

ANALYSIS:

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

Under existing law, revenue from fines and penalties levied on health plans is deposited in the Managed Care Fund. The first $1 million is used for the STLRP, and fines and penalties above $1 million are used to augment funding for MRMIP, which provides subsidized health insurance for individuals unable to obtain coverage due to a pre-existing condition. In 2014, MRMIP will no longer be necessary due to the reforms enacted under the Affordable Care Act (ACA).

This bill would require, once MRMIP is inoperative, all funds from the Managed Care Fund to go to HPEF, for purposes of funding STLRP. This will provide the STLRP a more robust funding source by shifting monies no longer needed for MRMIP. According to the author's office, implementation of the ACA will result in a further strain on the demand for primary care physicians. This bill will help to ensure that more physicians have incentive to practice in underserved areas of California. As such, this bill promotes the Board's mission of access to care and board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: California Communities United Institute
California Hospital Association
Los Angeles Board of Supervisors

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE FEBRUARY 14, 2013

SENATE BILL **No. 20**

Introduced by Senator Hernandez

December 3, 2012

An act ~~relating to health care coverage.~~ *to amend Section 1341.45 of the Health and Safety Code, relating to health.*

LEGISLATIVE COUNSEL'S DIGEST

SB 20, as amended, Hernandez. ~~Health care coverage: basic health program.~~ *Health care: workforce training.*

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and imposes certain requirements on health care service plans. Existing law imposes, for certain violations of these provisions, various fines and administrative penalties, which are deposited in the Managed Care Administrative Fines and Penalties Fund. Existing law requires the first $1,000,000 in the fund to be transferred each year to the Medically Underserved Account for Physicians in the Health Professions Education Fund for purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. Existing law requires all remaining funds to be transferred each year to the Major Risk Medical Insurance Fund for purposes of the Major Risk Medical Insurance Program.

This bill, beginning on the date that the Major Risk Medical Insurance Program becomes inoperative, would instead require all the funds in the Managed Care Administrative Fines and Penalties Fund to be transferred each year to the Medically Underserved Account for Physicians in the Health Professions Education Fund for purposes of the Steven M. Thompson Physician Corps Loan Repayment Program.

The bill would require the Director of Finance to notify the Joint Legislative Budget Committee in that regard.

~~Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. PPACA also authorizes the establishment of a basic health program under which a state may, if specified criteria are met, enter into contracts to offer one or more standard health plans providing a minimum level of essential health benefits to eligible individuals instead of offering those individuals coverage through an exchange.~~

~~This bill would state the intent of the Legislature to enact legislation that would establish a basic health program in California as described in PPACA.~~

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

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

SECTION 1. Section 1341.45 of the Health and Safety Code is amended to read:

1341.45. (a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.

(b) The fines and administrative penalties collected pursuant to this chapter, on and after the operative date of this section, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.

(c) *(1)* The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, beginning September 1, 2009, and annually thereafter, as follows:

~~(1)~~

(A) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) ~~or~~ *of* Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555,

shall not be used to provide funding for the Physician Volunteer Program.

~~(2)~~

(B) Any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund created pursuant to Section 12739 of the Insurance Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 12739.1 of the Insurance Code.

(C) Transfers under this paragraph shall cease on the date the Managed Risk Medical Insurance Program becomes inoperative. The Director of Finance shall notify the Joint Legislative Budget Committee at the time the program becomes inoperative.

(2) Commencing on the date transfers under paragraph (1) cease, and annually thereafter, the fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

~~SECTION 1. It is the intent of the Legislature to enact legislation that would establish the basic health program described in Section 1331 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18051).~~

O

SB 21

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 27 and SB 21
Author:	Medina and Roth
Bill Date:	March 21 and 18, 2013, amended
Subject:	UC Riverside Medical School: Funding
Sponsor:	Authors

STATUS OF BILL:

AB 27 is in the Assembly Appropriations Committee and SB 21 is in the Senate Education Committee.

DESCRIPTION OF CURRENT LEGISLATION:

These bills mirror each other and would both annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California, Riverside. Both bills contain urgency clauses, which mean that the bills would take effect immediately once signed into law.

ANALYSIS:

The foundation of the School of Medicine at UC Riverside goes back to 1974, when the UC Riverside / University of California, Los Angeles (UCLA) Thomas Haider Program in Biomedical Sciences was established. This program has allowed approximately 700 students to complete their first two years of medical school at UC Riverside, and their last two years at the David Geffen School of Medicine at UCLA, which confers their medical degrees.

In July 2008, the UC Board of Regents officially approved the proposed establishment of an independent four-year School of Medicine at UC Riverside, intended to serve the medically underserved in the Inland Empire. However, in the summer of 2011, UC Riverside failed to gain accreditation for an independent four-year medical school from the Liaison Committee on Medical Education (LCME), the national accrediting body for educational programs leading to the Medical Doctor degree in United States. LCME withheld preliminary accreditation due to a lack of stable state funding support for the school. In April 2012, UC Riverside secured substantial new funding from a variety of non-state funding sources, and submitted a second accreditation application to LCME. In June 2012, a second accreditation site visit took place and in October 2012, UC Riverside received notification from LCME that its planned medical school received "preliminary accreditation." Preliminary accreditation from LCME enables prospective students to begin applying to the UC Riverside School of Medicine in order to potentially enroll in August 2013.

These bills would appropriate $15,000,000 from the General Fund in order to establish a more viable funding source for the UC Riverside School of Medicine. According to the author, the highest indicator of where a physician practices is where he or she attends medical school and the Inland

Empire trails behind much of the state in several key health indicators, including coronary heart disease and diabetes. The author believes that the establishment of a medical school in the Inland Empire will help to ensure more physicians are trained and remain in the Inland Empire. The author contends that one of the areas that will aid in the UCR School of Medicine receiving final accreditation from LCME and meeting the medical needs of the Inland Empire is for the Medical School to receive a stable funding source, which is why this bill seeks to appropriate General Fund monies.

According the Public Policy Institute of California, the Inland Empire is the fastest-growing region of the state and it is estimated that more than 300,000 residents of the Inland Empire will have health insurance coverage extended to them as a result of the Affordable Care Act. The U.S. Department of Health and Human Services' Council on Graduate Medical Education recommends that a given region have 60 to 80 primary care physicians per 100,000 residents and 85 to 105 specialists. The Inland Empire has about 40 primary care doctors and 70 specialists per 100,000 residents, which is a severe shortage.

These bills will help to increase access to care and help the Inland Empire area of California to prepare and be ready for implementation of the Affordable Care Act. Board staff suggests that the Board support this bill.

FISCAL: None to the Board

SUPPORT: California Department of Insurance; California Medical Association; City of Riverside; Enterprise Media; Riverside County Superintendent of Schools, Kenneth M. Young; Southwest California Legislative Council; University of California at Riverside; UC Riverside Alumni Association; UC Riverside Board of Trustees; and two individuals.

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE MARCH 18, 2013

SENATE BILL No. 21

Introduced by Senator Roth

December 3, 2012

An act relating to the University of California, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 21, as amended, Roth. University of California: UC Riverside Medical School: funding.

Existing provisions of the California Constitution establish the University of California as a public trust under the administration of the Regents of the University of California. The University of California system includes 10 campuses, which are located in Berkeley, Davis, Irvine, Los Angeles, Merced, Riverside, San Diego, San Francisco, Santa Barbara, and Santa Cruz.

This bill would *annually* appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation~~, without regard to fiscal year,~~ to the School of Medicine at the University of California, Riverside.

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

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

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

SECTION 1. The sum of fifteen million dollars ($15,000,000) is hereby appropriated *annually* from the General Fund to the Regents of the University of California for allocation~~, without regard to fiscal year,~~ to the School of Medicine at the University of California, Riverside.

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 provide crucial funding to launch the vital health care mission of the School of Medicine at the University of California, Riverside, it is necessary that this act take effect immediately.

O

SB 62

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 62
Author:	Price
Bill Date:	April 9, 2013, Amended
Subject:	Coroners: Reporting Requirements: Prescription Drug Use
Sponsor:	Author
Position:	Support if Amended

STATUS OF BILL:

This bill is in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a coroner to report deaths when the cause of death is determined to be the result of prescription drug use to the Medical Board of California (Board), this bill was amended to only require the reports to be filed with the Board. The initial report must include the name of the decedent, date and place of death, attending physicians, podiatrists, or physician assistants, and all other relevant information available. The initial report shall be followed, within 90 days, by copies of the coroner's report, autopsy protocol, and all other relevant information.

This bill was amended to allow the follow-up coroner's report and autopsy protocol to be filed within 90 days or as soon as possible once the coroner's final report of investigation is complete. The amendments now only require the report to be filed with the Board and only require the initial report to include specified information when that information is known. The amendments specify that the other relevant information should include any information available to identify the prescription drugs, prescribing physicians, and dispensing pharmacy.

The amendments also make similar changes to existing law on the 90-day timeline and confidentiality of the report for mandatory coroner reporting for deaths that may be the result of a physician's, podiatrists' or physician assistant's gross negligence or incompetence.

ANALYSIS:

Existing law, Business and Professions Code Section 802.5, requires a coroner to report to the Board (and the OMBC , BPM, and PAB) when he/she receives information based on findings by a pathologist indicating that a death may be the result of a physician's gross negligence or incompetence. This section requires the coroner to make a determination that the death *may* be the result of the physician's gross negligence or incompetence. Requiring coroners to make the determination, could be the reason the Board has seen a decrease in

coroners reports; the number of reports received by the Board is at an all-time low. Only four reports were received in FY 2011/12, and only one of the reports indicated a drug related death.

The Board has reason to believe that numerous death have occurred in California that are related to prescription drug overdoses. However, complaints regarding drug-related offenses are often hard for the Board to obtain. In most instances, patients who are receiving prescription drugs in a manner that is not within the standard of practice, are unlikely to make a complaint to the Board. Some complaints regarding overprescribing come from anonymous tips, which usually do not have enough information to allow forwarding to the Board's district office for investigation, as there is no patient to obtain records for or not enough information to open an investigation. Family members of patients may make a complaint to the Board; however, the Board must have a patient release in order to obtain medical records or seek a subpoena. Sometimes it is difficult to obtain evidence to warrant a subpoena, or the family is not responsive.

The Board included a proposal for required coroner reporting prescription drug related deaths in its Sunset Review Report, as a new issue for the Legislature's consideration. Requiring deaths related to prescription drug use to be reported to the Board would allow the Board to review the documentation to determine if the prescribing physician was treating in a correct or inappropriate manner. This would increase consumer protection and ensure the Board is notified of physicians who might pose a danger to the public, so action can be taken prior to another individual suffering the same outcome. If only one physician was found to be overprescribing, this could save numerous lives.

Senator Price introduced this bill in response to several articles run by the LA Times. These articles included cases of physicians prescribing opioid prescription drugs to multiple patients, which may have resulted in these patients' deaths. The Senator introduced this bill to ensure that the Board has knowledge about these types of cases in the future, so the Board can review these cases, investigate, and take appropriate disciplinary action against physicians prescribing inappropriately.

Requiring coroner reporting of all prescription drug use deaths might be overly broad and interpreted to include deaths that occurred while an individual was taking a non-opioid prescription (i.e., antibiotics). The Board voted to support SB 62 if it is narrowed to only include coroner reporting of deaths related to Schedule II and III controlled substances. Per the committee analyses, the author will be taking amendments to narrow the mandated reporting by coroners to deaths to those in which the cause of death is related to toxicity from a Schedule II, III or IV drug and Schedule II, III, or IV drugs played a contributing factor.

The Board also requested an amendment to ensure that coroners report these deaths to all boards responsible for licensing prescribers. Of note, the bill was recently amended to only require the coroner reports to go to the Board to make it more efficient for coroners, as they would only have to send their reports to one board, not multiple boards; this was a concern

raised by the coroners in meeting with the author's office. The Board could potentially share/disseminate the coroner reports that include a prescriber or dispenser licensed by another board to the appropriate regulatory board under the Department of Consumer Affairs, as is currently done as part of the complaint process.

FISCAL: Using the total data reported in the LA Times articles, the estimated workload created by this bill would result in the need for 1 additional position to handle the upfront review in the Central Complaint Unit, 4 investigators to handle the cases that go to the field for investigation, and 1 additional position in the Discipline Coordination Unit. This additional workload would also result in $441,500 in costs for expert reviewers for the upfront review, investigation, and hearing. Based upon information received by the Attorney General's (AG's) Office, the approximately 50 cases that would be referred to the AG's office would result in approximately $1,803,700 in costs (out of the 50, it is estimated that 35 would settle, or 70%, and the remaining 15 would go to hearing).

SUPPORT: Center for Public Interest Law
The Board (if amended)

OPPOSITION: California Medical Association

POSITION: Recommendation: Support

SB 62 Fiscal Methodology

The LA Times found 3,733 deaths involving prescription medications from 2006 – 2011. In 1,762 of those cases, one or more drugs prescribed for the deceased caused or contributed to the death (indicating physician prescribing).

1,762 divided by 5, equals 350 deaths per year. According to the US Census Bureau information, the 5 counties that the LA Times included in its data (Los Angeles, Orange, San Diego, and Ventura), make up 45% of California's population. This means that 350 deaths per year is only 45% of the what would be seen for California, making the total number of deaths that would be reported to the Board, approximately 700.

Using existing averages, approximately 75% of the cases do not go to the field for investigation, and 25% of the 700 would go to the field for investigation, a total of 175 cases per year.

Regarding the upfront Central Complaint Unit (CCU) review of the 700 cases, the Medical Board estimates that we would need 1 analyst to handle the upfront review of the 700 potential cases.

For the upfront CCU expert review, it equates to 2.0 hours per case for a total of 1400 hours. At the rate of $75 per hour, this equates to $105,000 for CCU expert review.

For the cases that go to the field, the Board is estimating that the workload would generate the need for 4 new investigators in the field, which equates to 40 cases per investigator (because the workload of each case may not be complex due to the known death of a patient), and 1 analyst in the discipline coordination unit (for 50 cases filed per year).

Of the 175 cases that go to the field, 25% will close at the physician interview level. Thus, 130 cases will need to be reviewed by an expert. At $150 per hour and an average of 15 hours per case, this equates to $292,500 for expert review (review medical records, listen/read physician interview, and write report).

For the 175 cases that go to the field, we are estimating that 50 of these cases, or 30% would need to go to the Attorney General's (AG's) Office for prosecution. According to current statistics, approximately 70% or 35 cases would be resolved through stipulation, and the remaining 30% or 15 cases would go to hearing. According to the AG's office for pain management cases that go to hearing, on average these take about 474 hours at $170/hr which equals $1,208,700 for the 15 cases. For the 35 cases that would result in stipulation, according to the AG's office for pain management cases, on average these take about 100 hours at $170/hr, which equals $595,000, for a total AG cost of 1,803,700.

Of the cases that go to the AG's Office, half or 25 will have not expert cost. 10 cases will go to pretrial at 4 hours expert time each, the rate for trial related expert work is $200, this equates to $8,000. 15 cases will go to hearing at 12 hours to prep the expert and for the expert to testify at the hearing at $200 per hour, equates to $36,000.

SB 62 (Price)

Total Cost for the Medical Board of California

Duty	Cost
CCU - 1 Staff Services Analyst	$ 37,000.00
DCU - 1 Assoc. Gov. Program Analyst	$ 58,000.00
Field - 4 Investigators ($60,500 per investigator)	$ 242,000.00
CCU Expert Review	$ 105,000.00
Field Expert Review	$ 292,500.00
AG Costs	$ 1,803,700.00
Expert Pre-Trial and Trial	$ 44,000.00
TOTAL	$2,582,200

AMENDED IN SENATE APRIL 9, 2013

SENATE BILL No. 62

Introduced by Senator Price

January 8, 2013

An act to amend Section 802.5 of the Business and Professions Code, relating to coroners.

LEGISLATIVE COUNSEL'S DIGEST

SB 62, as amended, Price. Coroners: reporting requirements: prescription drug use.

Existing law requires a coroner to make a report, as specified, when he or she receives information that indicates that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence. *Existing law requires the report to be followed, within 90 days, by copies of the coroner's report, autopsy protocol, and all other relevant information.*

This bill would expand those provisions to require a coroner to make a report when he or she receives information that indicates a death may be the result of prescription drug use and to require the coroner to additionally file the report with the ~~California State Board of Pharmacy~~ *Medical Board of California. The bill would also extend the time during which the coroner's report and other information may follow the report to as soon as possible once the coroner's final report of investigation is complete.* By increasing the duties of county officers, this bill creates 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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

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

SECTION 1. Section 802.5 of the Business and Professions Code is amended to read:

802.5. (a) When a coroner receives information that is based on findings that were reached by, or documented and approved by, a board-certified or ~~board-eligible~~ *California licensed* pathologist indicating that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence, a report shall be filed with the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board. The initial report shall include the name of the decedent, date and place of death, attending physicians, podiatrists, or physician assistants, and all other relevant information available. The initial report shall be followed, within 90 days *or as soon as possible once the coroner's final report of investigation is complete*, by copies of the coroner's report, autopsy protocol, and all other relevant information.

(b) A report required by this section shall be confidential. No coroner, physician and surgeon, or medical examiner, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her acting in compliance with this section. No board-certified or California licensed pathologist, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her providing information under subdivision (a) or (c).

~~(b)~~

(c) When a coroner receives information that is based on findings that were reached by, or documented and approved by, a board-certified or ~~board-eligible~~ *California licensed* pathologist indicating that ~~a death may be~~ *the cause of death is determined to be* the result of prescription drug use, a report shall be filed with

the Medical Board of California~~, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board, and shall also be filed with the California State Board of Pharmacy~~. The initial report shall include, *when known,* the name of the decedent, date and place of death, attending physicians, podiatrists, or physician assistants, and all other relevant information~~available~~, *including, but not limited to, any information available to identify the prescription drugs, prescribing physicians, and dispensing pharmacy.* The initial report shall be followed, within 90 days *or as soon as possible once the coroner's final report of investigation is complete*, by copies of the coroner's report, autopsy protocol, and all other relevant information.

~~(c) A report required by this section shall be confidential. No coroner, physician and surgeon, or medical examiner, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her acting in compliance with this section. No board-certified or board-eligible pathologist, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her providing information under subdivision (a) or (b).~~

SEC. 2. If the Commission on State Mandates determines that this act contains 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.

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SB 117

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 117
Author:	Hueso
Bill Date:	April 8, 2013, Amended
Subject:	Integrative Cancer Treatment
Sponsor:	California Citizens for Health Freedom

STATUS OF BILL:

This bill is in the Senate Health Committee. This bill was formerly AB 1278 (Hueso), Assemblyman Hueso is now a Senator, so the bill has changed to a Senate Bill.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physician to prescribe integrative cancer treatment, under specified circumstances.

ANALYSIS

Current law restricts cancer therapy exclusively to conventional drugs, surgery, and radiation (those approved by the Food and Drug Administration). This bill would allow a physician to prescribe integrative cancer treatment, under specified circumstances.

This bill defines integrative cancer treatment as the use of a combination of evidence-based substances or therapies for the purpose of reducing the size of cancer, slowing the progression of cancer, or improving the quality of life of a patient with cancer. This bill would specify that a treatment meets the evidence-based medical standard if the methods of treatment are recognized by the Physician's Data Query of the National Cancer Institute; or if the methods of treatment have been reported in at least three peer reviewed articles published in complementary and alternative medicine journals to reduce the size of cancer, slow the progression of cancer, or improve the quality of life of a patient with cancer; or if the methods have been published in at least three peer-reviewed scientific medical journals.

This bill would prohibit a physician from recommending or prescribing integrative cancer treatment, unless specified informed consent is given; the treatment meets the evidence –based medical standard; the physician complies with the patient reevaluation requirements; and the physician complies with the standards of care for integrative cancer treatment.

In order to comply with the informed consent requirements, the physician must have the patient sign a form that either includes the contact information for the physician who is providing the patient conventional care, or that the patient has declined to be under the care of

an oncologist or other physician providing conventional cancer care. The form must also include a statement that says the type of care the patient is receiving or that is being recommended is not the standard of care for treating cancer in California; that the standard of care for treating cancer in California consists of radiation, chemotherapy, and surgery; that the treatment the physician will be prescribing or recommending is not approved by the federal Food and Drug Administration for the treatment of cancer; that the care that the patient will be receiving or is being recommended is not mutually exclusive of the patient receiving conventional cancer treatment. The form must also include the following written statements:

> THE STATE DEPARTMENT OF PUBLIC HEALTH AND THE PHYSICIAN PRESCRIBING YOUR INTEGRATIVE CANCER CARE RECOGNIZE THE IMPORTANCE OF USING CONVENTIONAL CANCER TREATMENTS, INCLUDING RADIATION, CHEMOTHERAPY, AND SURGERY. IT IS HIGHLY RECOMMENDED THAT YOU SEE AN ONCOLOGIST OR ANOTHER PHYSICIAN TO PROVDE YOU WITH CONVENTIONAL CANCER CARE.
>
> ANY AND ALL MEDICAL TREATMENTS INVOLVE SOME DEGREE OF RISK OF INJURY UP TO AND INCLUDING DEATH.

This bill would require a physician prescribing integrative cancer treatment to comply with patient reevaluation requirements, as follows:

- The patient must be informed of the measurable results achieved within an established timeframe and at regular and appropriate intervals during the treatment plan.
- The physician must reevaluate the treatment when progress stalls or reverses in the opinion of the physician or the patient, or as evidenced by objective evaluations.
- The patient must be informed about and agree to any proposed changes in treatment, including but not limited to, the risks and benefits of the proposed changes, the costs associated, and the timeframe in which the proposed changes will be reevaluated.

This bill would also set forth the standards of care in prescribing integrative cancer treatment that the physician must comply with, as follows:

- The physician must provide the patient information regarding the treatment prescribed, including its usefulness in treating cancer; a timeframe and plan for reevaluation the treatment using standard and conventional means in order to assess treatment efficacy; and a cost estimate for the prescribed treatment.
- The physician must make a good faith effort to obtain all relevant charts, records and laboratory results relating to the patient's conventional cancer care, prior to prescribing or changing treatment.
- At the request of the patient, the physician must make a good faith effort to coordinate the patient's care with the physician providing conventional cancer care to the patient.

- At the request of the patient, the physician must provide a synopsis of any treatment rendered to the physician providing conventional cancer care to the patient, including subjective and objective assessment of the patient's state of health and response to the treatment.

This bill would specify that failure to comply with this bill's provisions would constitute unprofessional conduct and cause for discipline by that individual's licensing entity.

According to the author, integrative cancer treatment gives consumers options for care and helps patients cope with the common side effects of chemotherapy and radiation. Integrative treatment incorporates uses of unconventional medicines that have proven results. The author believes this bill will provide cancer patients with more options to complement conventional therapy. This bill requires integrative cancer treatment to meet an evidence-based medical standard, and includes language that encourages communication with a patient's oncologist, as well as treatment with conventional therapies.

The Executive Committee voted to recommend that the Board take a Neutral position.

FISCAL: None

SUPPORT: California Citizens for Health Freedom (sponsor)
Cancer Victors
Cancer Control Society
Bobbiey's Foundation
Several Individuals

OPPOSITION: Association of Northern California Oncologists
Medical Oncology Association of Southern California, Inc.

POSITION: Executive Committee Recommendation: Neutral

CALIFORNIA CITIZENS FOR HEALTH FREEDOM
Frank Cuny, Executive Director, Alfredo Hueso, Chairman
2362 Palermo Road, Palermo Ca 95968, WWW.CitizensHealth.org
530-534-9758

April 15, 2013

The Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815

Re: Integrative Cancer Bill, SB 117

Dear Honorable Members of Medical Board:

We are seeking your support for Senate Bill 117, the Integrative Cancer Bill. This Health care bill will enhance and not replace current law. We believe the current law is outdated and the current medical approach in the treatment of cancer is broken. The proposed legislation may improve the manner patients are treated if they are afflicted with cancer. Please refer to the Summary of AB 117, exhibit 1.

We intend to demonstrate with the documents we are providing you that the current cancer health care system is broken. Cancer statistics have changed very little in a generation. Today Cancer accounts for nearly one of every 4 deaths in the United States. Please refer to exhibit 2, Cancer Statistics. Furthermore, we are providing you with a nine page letter of an oncologist that describes better than any one else can how broken the Cancer Health care system really is in California. I shall briefly summarize some of the bullet points that are contained in his letter. Please refer to exhibit 3.

1. Patients need to understand that as long as Medicare pays fee-for service there is a potential for conflict of interest. P.8
2. Doctors are not paid to collaborate with other doctors or their patients. P.1
3. There is no effective chemotherapy treatment for a distressing number of malignancies. P.3
4. When doctors are paid to do more there is always the potential for conflict of interests. P.4
5. He learned that selling Chemotherapy was not a sustainable business plan. P.4
6. He learned that there is wide variation in treatment approaches, and other doctors and insurance companies were not interested in establishing guidelines. P.4 and 5
7. Seventy percent of earnings come from sale of chemotherapy drugs and services. P. 1
8. Financial inducements are to great, concerning sale of certain types of drugs. P.6
9. Need to re-align incentives so that Doctors will do the right things. P.8
10. The reason they have been able to grow a practice as large as ours and provide the level of service we do is because of the revenue we obtain from selling chemotherapy drugs and services. P.3
11. But we are paid more for administering the drugs than we were in the past, so it makes economic sense to administer them more often. P.3
12. I have told patients I know I can make you sick, but I am not certain I can make you better. P.3
13. I hoped that ANCO could rally docs around the idea of evidence-based medicine and take our science and good results to the insurers, who, seeing the wisdom of our arguments, would reward us for being so scientific, thoughtful and restrained. Boy, was I naïve! P.4.

This proposed law is about the what is in the best interests of the patients. The medical profession needs to do a better job of saving more lives, and the quality of life. Who cares if you kill the tumor, and then the patient ends up dieing. Our legislation will provide the framework for the patient to have a better quality of life. For example, active coordinated care handled by advance medical teams can make a world of difference in cancer or patients at risk of cancer. Please refer to exhibit 4. The problem is most doctors do not coordinate with other doctors, and patients are the ones that suffer the results of this lack of coordination.

More significant is that the current law in California violates the basic right of patient to choose the medicine of his or her choice. This basic human right was determined in a case called Schneider versus Revici in 1987, Please refer to exhibits 5. In another case, Andrews versus Ballard, Judge McDonald stated: " and it is the individual making the decision, and no one else, who if he or she survives, must live with the result of that decision. Ones health is a uniquely personal possession. The decision of how to treat that possession is of no less personal nature." Exhibit 6

For those of you that are still skeptical or don't believe any change in the law is necessary, then I challenge you to review the documents we have provided, particularly, the nine page letter of Dr. Peter Eisenberg. If when you read the letter, and you still don't think the Cancer Health care system is broken, then nothing will sway you. I know this much, that if the public saw this letter, they would be outraged by the blatant conflicts of interests, and how some doctors put their financial interests above the interests of their patients. For example, in 2009 Pfizer, a major pharmaceutical company was fined a record 2.3 Billion dollar penalty for illegal drug promotions to doctors. Please refer to exhibit 7.

CONCLUSION

The proposed Integrative cancer bill adequately protects patients, and more importantly, provides patients with the freedom of choice that is a legally protected right. We ask you to support the bill because it is the right thing to do, and it is in the best interests of patients. Thank you for your time, and if you have any questions we will be happy to address them.

Respectfully,

Alfredo Huesa
Chairman
CCFHF

Attachments:

1.Summary of SB 117
2. Cancer Statistics
3. A very Open letter from an Oncologist
4. Coordinated care helps Cancer Patients
5. Galileo's Lawyer, page 33
6. Perceived Legal implications of the decision in the Schneider v. Revici case.
7. Associated Press, Pfizer to Pay record 2.3 Billion Penalty over promotions.

SENATOR BEN HUESO, 40TH DISTRICT

SB 117 – Integrative Cancer Treatment

Summary

Senate Bill 117 provides open access for consumers to receive, and physicians to administer, Integrative Cancer Treatment in California.

Background

Integrative cancer treatment is a multidisciplinary treatment plan that brings together traditional tools for fighting cancer with complementary and alternative therapies. Treatment includes, but is not limited to, nutritional support, naturopathic medicine, homeopathic medicine, mind-body medicine, oncology rehabilitation, pain management, chiropractic care, and spiritual support. In addition, treatment incorporates uses of unconventional medicines that have proven results. For example, research has shown anti-cancer powers in Vitamin C and other natural vitamins and herbs. Some studies have shown how a compound in red grapes may prevent colon cancer and how cruciferous vegetables such as broccoli, cauliflower and cabbage contain a cancer preventing elements.

Integrative cancer treatment not only gives consumers options for care, it also helps patients cope with the common side effects of chemotherapy and radiation, which include muscle tension, aches, pains, nausea, vomiting, and fatigue. Unfortunately, the side effects associated with conventional therapies often cause patients to end their treatments prematurely, or require that doctors take a less aggressive approach. This occurrence decreases with the addition of integrative oncology services.

Furthermore, accessibility to integrative cancer treatment provides a bridge in communication for patients and doctors. According to a press release out of UC Irvine, eighty percent of cancer patients use some form of complementary or alternative medicine, and only half of them tell their doctors about it. The internet-era that we now live in contributes to the problem, making it easy for patients to do their own research and self-medicate with alternative treatments that may not be safe. Open access to integrative cancer treatment provides a safer pathway for patients to receive care and seek consult from a licensed health expert.

Why this bill is needed

California law currently restricts the use of unconventional remedy in the diagnosis, treatment, alleviation, or cure of cancer. In fact, California is the only state to statutorily restrict cancer therapy exclusively to conventional drugs, surgery, and radiation. Past reports and legislative analysis suggests that current law was established to protect the public from fraudulent, misleading, and potentially harmful therapies. It is extremely important to ensure vulnerable patients are not taken advantage of or misled. However, the stringent and outdated nature of existing statute has prevented Californians from capitalizing on new and innovative cancer therapies. Options for integrative care are limited to travel outside of our state borders or participation in a research program. And while, several academic institutions in the state have already invested in integrative treatments for cancer, such as UCLA, UCSF, Scripps, and Bastyr University, open access for consumers to integrative care is essential. California would benefit by joining the several other states and countries currently offering integrative cancer treatment to patients.

SB 117

SB 117 provides cancer patients with more options for care that best suit their needs. Integrative medicine does not replace conventional therapy, rather it is meant to complement it. This bill clarifies the ability of a physician or surgeon to administer or provide integrative cancer treatment in California. In addition, SB 117 specifies that integrative cancer treatment must meet an evidence-based medical standard, as defined in the bill, and includes language that encourages communication with a patient's oncologist, as well as treatment with conventional therapies.

Sponsor

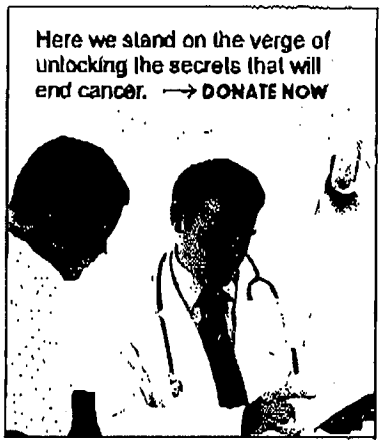
California Citizens for Health Freedom
www.citizenshealth.org

For More Information Call

Maria Garcia, Legislative Director
(916) 651-4040
maria.garcia@sen.ca.gov

CANCER STATISTICS

Cancer is a worldwide epidemic. These statistics are not just numbers. They represent our loved ones and the need to change the way that cancer research is done so that everyone diagnosed with cancer becomes a survivor.



DID YOU KNOW...

Cancer accounts for nearly 1 of every 4 deaths in the US.

DID YOU KNOW...

There are over 100 different types of cancer.

DID YOU KNOW...

In America more than 1.2 million new patients are diagnosed with cancer every year. A new cancer is diagnosed every 30 seconds in the United States.

DID YOU KNOW...

A one percent reduction in cancer deaths would be worth $500 billion, almost 2.5 times what the U.S. spends each year on the disease.

DID YOU KNOW...

This year, approximately 1.63 million Americans will be diagnosed with cancer and about 572,000 will die of the disease.

DID YOU KNOW...

...that in 2012, cancer will be the leading cause of death in the world?

DID YOU KNOW...

Every three minutes, two people in the US die from cancer.

SU2C MISSION

This is where the end of cancer begins: when we unite in one unstoppable movement and **Stand Up To Cancer.**

Read Our Mission

PARTNERS

GlaxoSmithKline

LifeExtension

gpawelski
Registered Member

Date Joined May 2001
Total Posts : 112

Posted 8/4/2009 4:01 PM (GMT -4)

A Medical Director at California Cancer Care, an oncology practice in Northern California wrote a candid letter to the Health Beat blog by Maggie Mahar. He is a member of The Century Foundation's Working Group on Medicare Reform. A very experienced and successful oncologist who has served on the board of the American Society of Clinical Oncology and the Association of Northern California Oncologists.

Dear Maggie Mahar:

I have been working on this since you asked me some questions about our practice. Maybe it is more than you asked for, but I thought that I'd put my answers in context. Just the other day Stanford University's Alain Enthoven wrote on the Opinion Page of the *New York Times* that we docs ought to be salaried. Though for 30 years I have practiced fee-for-service medicine, had a wonderful career and lived comfortably, I cannot argue! The waste associated with the inherent conflicts of interest in fee-for-service medicine is more than we can afford.

At the same time, the way reimbursement is set up, oncologists couldn't stay in business if we were not paid fee-for-service for selling chemotherapy drugs and services. Some estimate that up to 70% of our earnings come from the sale of chemo drugs.

Maggie, as you know, ***oncologists are not paid to collaborate with their patients or with other doctors. Listening to patients and chatting with them, asking other docs about a patient, going to conferences, e-mailing experts about problems and looking up stuff in a book (old way) or the net (new way) are not billable events.***

Neither is sitting for half an hour at lunchtime with our nurses, medical assistants, research director and the other docs in our office to go over tomorrow's patients, field questions about problems patients have called in, and converse about problems a patient is having. Can you imagine what this daily meeting costs in terms of salary? Can you imagine why others don't do this? Oncology is a team sport and there is evidence that collaborative practice—not only with the patient and her family, but with other docs who are caring for her as well as smart others who bring different areas of expertise to the table, can provide better care.

Do you want to go to a doc and be treated according to his treatment plan after an hour-long visit? Or would you rather that he present your case, along with the pathology slides and the imaging studies, to a group of other docs representing a number of disciplines (medical, surgical and

radiation oncology, diagnostic radiology, pathology, nursing, social work, dietetics, pain control, pulmonary, gastroenterology, etc.) to be viewed and discussed?

Smart docs are not afraid to consult with the smarter (or more experienced) docs at the university and even send patients there to get their treatment if the care is complicated and not well–known to us. But there are plenty of docs who, for one reason or another, choose not to refer their patients to another institution. Of course there are plenty of patients who would rather get their care closer to home, but as a recent article in PLOS pointed out, the doctor has an obligation to inform the patient that he might well get better care elsewhere.

We also are not paid to remember your name. Our office has a large staff because we try to serve the folks we care for. As a result, we have two nurse practitioners, one research person, and six clinical folks assisting our six doctors. Our 8 nurses and nurse practitioners plus 16 full-time staff members (medical records, front office receptionists, clerks, insurance specialists, patient care coordinator, and a CEO earn a total of $125,000 a month.

At one of our yearly retreats, we had Rachel Ramen, the author and friend of our practice, talk to us about service. We learned about the notion that one needs to find out where our patient is and start there. Our care of a patient begins before we even meet them in person. Before the appointment, Thomas, our new patient coordinator, spends 20 to 30 minutes chatting with the prospective patient on the phone obtaining all kinds of information, orienting her to our practice and explaining what to expect. It is not unusual for a new patient to ask me to meet Thomas at her first visit to thank him for his kindness.

Our front office ladies—there are 4 of them; one answers the phone, the other 3 greet and check out patients—know the name of each patient and their family members. They give each person a big hello when they arrive. This might seem silly, but almost every day a patient or family member tells me how great our front office staff is. I recently read an article that talked about how important it is to, not only honor a patient's informed wish for treatment, but to respect her as a person. Patients really don't want to be numbers.

After a patient is seen by the doc—we do the initial consultation– the Nurse-Practioners see folks in follow-up. And there begins a relationship between the patient and our office staff that is as intimate and as close as you can imagine. With anxiety being appropriately and understandable high, patients have all kinds of questions and concerns that we can't and haven't anticipated.
Our medical assistants spend literally the entire day on the phone solving problems. Our small hospital census—5.2 patients a day—is a result of our following through on patient concerns and seeing them in the office before problems become ones that can only be solved in the ER or hospital. We often use the office as an emergency room, but much more

conveniently for our patients and at a much lower price.

It is certainly possible that we are not as efficient as we could be. Our patients receive very speedy responses to their needs. It is possible that the system just cannot accommodate the level of care that we provide at the current cost.

I should point out that the only folks who can really generate revenue are the physicians, nurse practitioners, and the nurses who provide chemotherapy. Folks in the front office, our medical assistants and the hoard of employees who also "care" for our patient's cannot bill for the services they provide. Neither can I bill for innumerable phone calls and tasks I perform at my desk, when I am not sitting face to face with a patient. Similarly, e-mails to other docs asking for advice or coordinating care among other disciplines go unpaid.

The reason oncologists have been able to grow a practice as large as ours and provide the level of service we do is because of the revenue we obtain from selling chemotherapy drugs and services.

Meanwhile, the Medicare fee schedule that reimburses us for the drugs themselves has been cut. We are paid just 6% over the actual sale price (ASP.) And since we are not a 1,200 doctor practice like US Oncology, we do not get the discounts or rebates that they receive from drugmakers. In our case, sometimes the Medicare reimbursement is actually less than what we have to pay for the drug. For instance, we actually lose about $200 every time we give a shot of Neulasta, a drug to increase white blood count and prevent infection in patients receiving chemotherapy.

But we are paid more for administering the drugs than we were in the past, so it makes economic sense to administer them more often. Not every doctor is willing to do that. The practices that shows some restraint and don't treat everyone who walks through the door with chemo are the ones that are suffering.

* *The truth is that there is no clearly effective chemotherapy for a distressing number of malignances. In those cases, if I find that first line therapy isn't working, I won't automatically offer a second type of chemo. Instead, assuming the patient wants a frank appraisal of her condition, I'll explain the realistic goals and options available. In my experience, and in the community in which I live, patients seem to want to know as much as they can about their illness, even if the news is bad. Delivering terrible news is difficult, time-consuming and extraordinarily painful for all involved. But good decisions depend upon an honest and forthright discussion and providing the patient with the information and tools to make decisions.*

* *I have told patients, "I know that I can make you sick, but I am not certain that I can make you better! . . . In the foreshortened time that you have left, you need to think about what you want to do. Do you want to spend that time in this office, with me and my staff, or is there someplace else you would like to be, something else that you would like to do?"*

It has taken me a while to sort out how I feel about the drugs we use. I began practicing in the late 1970s, and I remember the increasing role and influence of chemotherapy. As more drugs became available, with more evidence that they were effective, our optimism increased --and use increased as well.

It became clear to many physicians—consciously or not--that selling chemotherapy was really the business they ought to be in as we were compensated so very well for it. The time one spent with patients was not compensated nearly as well. This is not unlike the rewards bestowed upon those who perform operations (at least historically), pass tubes into orifices (GI) or make holes for tubes (cardiology & orthopedics), purchase and use their own imaging machines etc.

When doctors are paid to "do more" there is always the potential for conflict of interest. Keep in mind that physicians are human beings with the same kinds of responses to financial incentives as everyone else. Despite our training and promise to put our patient's interest first, we succumb to incentives that often come in the form of more revenue.

As time went on and science grew, we became increasingly more successful in providing chemotherapy that actually worked, and it was a lot easier for doctors to sell chemotherapy than it was for them to spend the kind of time necessary to give patients choices.

Keep in mind that in the late '70s and '80s there was not much discussion about "shared decision-making." If a patient had cancer, and we knew that tumors responded to a certain chemotherapy regimen by shrinking, physicians assumed that patients would choose to take it, if it was offered to them. "You have cancer, you need chemo," seemed to be the mantra.

It was not until much more recently that the notion of quality of life, and the fact that just because we shrunk a tumor doesn't mean that people will actually live longer, was clear to us.

Nevertheless by the mid 1980s it occurred to me that selling chemotherapy was not a sustainable business plan. I thought that insurers would figure out that margins on drugs were too high and cut reimbursement. With that in mind, in 1990, I established the Association of Northern California Oncologists (ANCO).
I hoped that ANCO could rally docs around the idea of evidence-based medicine and take our science and good results to the insurers, who, seeing the wisdom of our arguments, would reward us for being so scientific, thoughtful and restrained. Boy, was I naïve! It seemed that docs so valued their independence—and made so much money – that they would not rally around anything.

In the late 1980s, I went to a Clinical Practice Committee Meeting of our professional society and asked them to consider establishing guidelines for treatment. At the time, I was consulting for Blue Shield of California and was impressed with the wide variation in treatments for similar conditions.

I was told under no uncertain terms that my comments and recommendations weren't welcome!

From the insurance side, there also wasn't much interest in decreasing wide variations in how doctors treated similar malignancies. I suspect that insurance companies have an easier time making it more difficult for docs to get paid rather than investing in innovative ways to collaborate with physicians. Moreover, if insurers put time and money into researching the most effective treatments, those guidelines would become public—and would benefit competing insurers.

Ultimately, the job of insurance companies is to pay claims. My sense is that they either pay them or not, and holding up payment is what they know how to do. It would have been nice both for insurers and physicains to agree on treatment pathways, but it didn't happen.

Some years later, in the mid '90s, I sponsored a meeting of 50 N.California oncologists for a weekend. We had speakers representing folks doing quality studies and electronic medical records and the insurance industry, but no docs really waned to compromise, merge practices and establish standard treatment plans.

Why is there so much variaion on how much treatent is given for similar conditoins?

If you ask doctors you'll hear a variety of answers. Here goes:

- *Patient and family expectations. Sometimes, I hear docs say the equivalent to "the patient made me do it," when justifying the administration of futile chemotherapy. But it is my experience that patients almost always want to be told the truth about their illness and its treatment and prognosis. Patients want to be offered reasonable and realistic options for treatment and they rarely choose treatments with a very small chance of success.*
- *Societal expectations. We expect that we can smoke 2 packs a day for 30 years and the doc will fix it. And when, through no fault of their own, people develop cancer, many feel certain that it must be curable. Maybe too much of Dr. Kildare and Welby. We just aren't as good as they are!*
- *The doctor's ideal as healer. After all, why did I go to med school if not to fix people? In fact, my earliest memories of contemplating medicine come from the 1950s when I was single digit years old. I remember thinking that there is nothing medical people wouldn't do or spend to help a sick person! I really did think that! Stuff was cheaper then, and we didn't have as many choices of treatment! There is lots of hype about new treatments. I can remember as a young oncologist, scouring the ASCO abstracts for a new treatment for an illness and being excited about a marginally better drug. Perhaps it is time and age that has made me more cynical, as many of the supposedly "better" treatments just did not turn out to be more effective*
- *Don't "take away hope!" The lamest of reasons for treating*

someone—especially with medicines that make them sick! Hope exists in many forms and skillful medical folks with time to spend with their patient can present alternatives other than:

- *"Take chemo = keep up hope," or*
- *"No chemo = no hope!"*

I prefer to re-frame the discussion around realistic expectations and discuss what it is that the patient is hoping for. Everyone agrees that living forever is not realistic. And talking about quality of life as opposed to quantity of life gets some traction these days, as patients and families understand Q of L better.

So, assuming the patient is open to such a discussion, I can then promise to be aggressive in controlling pain and in managing other symptoms. In the meantime, I will encourage my patient to live each day to the fullest–striving to live as well as possible rather than as long as possible.

However, rationing chemotherapy is not an issue. If, after being carefully taught that treatment is not very effective and has nasty side effects, a patient wishes to proceed with chemotherapy, I will provide it for her.

- *Real, (but sometimes small) chance of success. We do have data on many clinical situations; for example we have evidence of the benefit of first line chemo in advanced non-small cell lung cancer. We know that median survival increases by a couple months. We know that, with treatment, the chance of living a year increases from 15% - 20% to 30% - 40%.*
  But it is difficult to explain some of this material, especially to folks with poor math skills, and it is time-consuming, as well.

  So rather than making it clear that the average patient lives only a couple of month longer—and that the chances of surviving for a year are less than 50/50, it is much easier to say, "Yes, you do have a tough disease, but I think we can help you, so let's start treatment tomorrow!"

  Of course, treating Hodgkin's or another curable disease is something else. But most of the cancers we treat with chemo are not curable. Doctors need to be paid for the time it takes to explain the potential benefits as well as the downside of chemo—so that the patient can make a decision about how he wants to spend the time he has left.
- *Financial inducements. This is a really tough item to discuss, let alone prove. Most of us truly believe that we are doing good and that doing well comes with it. But, I have heard docs say the most incriminating things and do things that are clearly in their own best financial interest. For example, I have heard doctors talk about:*
  - *Treating patients with a 2 hour infusion of pamidronate (a generic drug used to treat cancer that has spread to the bone) rather than a 15 minute infusion of Zometa, because one could make $500 more on the generic pamidronate. Many*

physicians rationalized the use of the more profitable, but longer infusion drug on the basis that, "we have a business to run;" "we'd lose $40,000 a month;" "if we don't do this we will have to close our doors;" and "my patients are mostly Medicare and they don't mind hanging around the office for a longer infusion -- in fact they are really very fond of our staff and like spending time with them." A small study of 184 patients who were randomly assigned to a two hour infusion or a 15 minute infusion revealed that 92% preferred the shorter infusion. (Chern, et al, Supportive Care Cancer, 2004)

- *A physician leader of a drug purchasing group suggested that one might reasonably evaluate regimens to maximize reimbursement. For instance, for stage IV non-small cell lung cancer, he suggested using cisplatin and etoposide (given on days 1, 2 and 3 of a three week course) rather than carboplatin and Taxol (given once every three weeks). He argued that there was data to support the use of cisplatin as a better agent than carboplatin and pointed out that Carboplatin's use was the result of aggressive Bristol-Myers Squibb marketing. In addition, he noted, using cisplatin and etoposide took advantage of the increase in administration fees since patients would have to come 3 days rather than one day in a three week period.*
- *When reminbursement for Gemzar and Taxotere was less than cost, it was reported that some practices took these meds off their shelves until Medicare increased payment. When I asked one doc how he would treat bladder cancer without Gemzar, he said, "I'll use Taxol, it's almost as good!"*
- *Amgen "bundled" Aranesp and Neulasta, tying rebates for the white cell-increasing drug, Neulasta to a practice's use of the red cell-increasing drug, Aranesp. For instance, if a practice used less than 65% of its erythropoietin as Aranesp, it would lose its Neulasta rebate. A loss of this rebate resulted in the practice's purchase of Neulasta at $209 more than Medicare pays. Therefore, if the practice does not buy more than 65% of its erythropoietin from Amgen, it must come up with $209 out of its own pocket to supplement the purchase of Neulasta for its patients. Amgen capitalized on its perception that physicians will buy products that maximize their reimbursement. This was easier than trying to sell its products based on solid clinical superiority.*
- *Sometime ago, we received an e-mail from our "Leukine Sales Consultant" at Berlex who pointed out that if we "move all CSF (colony stimulating factors = meds which increase blood counts) to Leukine" we would "save" $430,000. While Leukine , like other CSFs, does increase the white count it is not FDA-approved for use with most chemotherapy regimens and clinical trials have not been done to show its equivalence*

or superiority to rival drugs.

Maggie, it is my understanding that patients expect physicians to make recommendations based on what it is best for the patient, not what is financially best for the physician. It is my contention that patients suffering from cancer would be appalled to understand that they could have received a 15 minute infusion rather than the two hour infusion but for the fact that the physician made $500 more per infusion.

I have been trying and trying to find a rationale to support the style of medicine with which I am familiar. Unfortunately, I think that the incentives are so mis-aligned and the temptations are so great that docs have a tough time making the right decisions. Look at the increase in diagnostic imaging in those practices that have purchased diagnostic imaging machines. "We have to feed the beast," I have heard.

My simple-minded solution is to re-align incentives so that the docs are paid for doing the right thing. What the right thing is, of course, can be open to interpretation. What patients think is right may be different from what the payer thinks is right. That gives me a headache!

But clearly, we need guidelines for the most effective care – and patients need to know whether their doctors are following the guidelines. Medicare needs to jump on the quality band wagon and support docs' use of quality programs such as ASCO's Quality Oncology Practice Initiative (QOPI), a voluntary program that serves to encourage oncologists to examine their practice and to compare themselves to others. Currently, over 1,500 physicians in more than 400 practice sites are registered and the American Board of Internal Medicine considers QOPI to fulfill an oncologist's requirement for quality improvement in his recertification.

Patients also need to understand that as long as Medicare pays fee-for-service there is a potential for conflict of interest. But patients really do not want to hear about doctors' incentives. An article in Health Affairs in 2000 (Miller and Horowitz) showed that:

1. *Many patients are unaware of the financial incentives their own physicians face. Only about half of the respondents wanted information about the incentives.*
2. *Trust in physicians is high; 84% of patients completely or mostly trusted their physician to put patients' interests first.*
3. *"Many patients stated that the information was not relevant to them because they trusted their physician. In fact, some stated that they would not want the information because it would raise unwelcome doubts."*
4. *"Patients also expressed confidence that they could judge the quality of their care and could change physicians if they were not satisfied."*
5. *"Many patients stated that they would want to learn if the incentives imposed any cost on them."*
6. *"In general, patients expressed strong reluctance to raise the issue [of incentives] with their physicians for a variety of reasons,*

including fear of embarrassing or angering the physician; belief that the topic is too "personal" and "intrusive" to raise; perceived irrelevance to treatment; and desire not to take valuable time away from clinical matters."

I have a real problem in placing the burden of figuring out whether a doc is looking out for a patient's best interest on an ill, frightened and anxious patient. As professionals, we have a sacred responsibility to put patients' interests first.

Ultimately, Medicare may want to reduce the fees it pays "outlier" doctors, reducing the incentive to over-treat. Meanwhile, Medicare needs to pay doctors for the time it takes to really explain the pros and cons of treatment to their patients in depth-- so that patients can make an informed choice—and not just give informed consent.

Dr. Peter Eisenberg
Medical Director
California Cancer Care

Post Edited (gpawelski) : 9/4/2009 3:16:15 PM (GMT-4)

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oscarguy
Registered Member

Date Joined Apr 2006
Total Posts : 566

Posted 9/5/2009 10:48 AM (GMT -4)

Thank you for that candid posting. It's event worse than I thought and I thought it as pretty bad.
Take Care, ...Oscar

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lhcr21

LifeExtension® Print This

Coordinated care helps cancer patients, says Providence exec

Mail Tribune (Medford, OR)

04-09-13

April 09--Active, coordinated care handled by advanced medical teams can make a world of difference for cancer patients or those at risk for cancer.

Walter Urba, director of the Providence Cancer Center in Portland, told a Chamber of Medford/Jackson County Forum audience Monday that the scope of research, prevention and treatment is rapidly changing.

So is the cost.

The reality facing men is that they have a 1 in 2 chance of dealing with cancer. For women it's one in three, and according to the American Cancer Society, cancer hits more than 20,000 people in Oregon annually. It's still the most feared diagnosis by patients, Urba said.

The 1.6 million Americans -- or one-half of 1 percent of the population -- who will get cancer this year will consume 5 percent of the country's health care spending, he said.

This year, there will be 13.7 million cancer survivors with the number -- driven by baby boom demographics -- growing to 18 million in 2020.

Cancer survivors' care cost twice as much per year, and will be a major contributor to the 27 percent increase for cancer care costs by 2020.

Of the nearly 5,200 new cancer cases Providence doctors encounter each year, about 750 come through its Medford Medical Center on the average.

"We need to manage them properly," Urba said. "We need to make sure there is access for what is available locally and to special research protocol or hospital, with perhaps physicians or equipment that local hospitals don't have. We can't all have expert doctors and nurses and multimillion dollar pieces of equipment at every hospital."

Genome research has enabled better understanding of cancer in recent years, he said.

"We now know that cancer is a genetic disease," Urba said. "It doesn't mean that you're born with it necessarily, but you can be born with genes that are predisposed to cancer. We can test for what those genes are and identify the patients that are at risk."

Activity and habits also can shed light too, as genes mutate over time.

"Whether it's smoking with lung cancer or exposure to sun with melanoma, we can see the mutations that can cause mutation or cause the cells to behave in a different manner," Urba said.

Early detection of changes is what can prevent the spread of life-theatening cells at an early stage, perhaps even before a colonoscopy is needed.

Molecular biology tests of stool or urine samples, costing "a couple hundred dollars" are considerably less expensive than colonoscopies.

"But not everybody can do those studies, so we have to get the samples to the right place," he said. "If we find out too late, that's when we all pay the price."

Patients may have a disease that looks the same for all of them under a microscope, but the subtle variations can make a big difference.

"When you look at the genetics, it's different," Urba said. "You can understand why the same three drugs given to 100 people will only give you 20 percent or 15 percent response. We think it's the same disease, but it's not. We have to be prepared from the very beginning to go to lengths to understand what makes the tumor cells different."

In the area of oral, head and neck cancer, he said, Providence has coordinated its efforts with the Earle A Chiles Research Institute in Portland, Oregon Health & Science University, New York University and the University of California-San Francisco.

"It brings together doctors to give the best patient care, teaching, services to those in need and provide research for the best possible therapy," he said. "Collaboration is really crucial for all of it."

To Richard —

GALILEO'S LAWYER

Courtroom Battles in Alternative Health, Complementary Medicine and Experimental Treatments

Richard A. Jaffe, Esq.

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in the same building as the district court, in downtown New York at Foley Square.

Then the parties write briefs in support of the appeal. The appellant, the party filing the appeal, writes the first brief. The appellee then responds. And finally, the appellant is given an opportunity to submit a reply brief. In most appeals of civil trials, the judges call for oral argument, and the judges requested it in our case.

Sam was busy with other things and could not spend any significant time on the appeal. By that time, one of Sam's good friends, an extremely able attorney named Matt Dineen, was working with us, and Cathy Helwig was still helping out. Matt, Cathy, and I did the briefs. We argued all kinds of issues like evidentiary errors and the Victor Herbert trick. However, the main thrust was the jury charge and, in particular, the judge's failure to give the express assumption of risk defense.

Sam did the oral argument and it went smoothly, for us anyway. The judges seemed swayed by the fact that Mrs. Schneider voluntarily chose to forgo surgery and instead chose to undergo Revici's questionable treatment. They gave Alice Collopy, who argued the appeal for Mrs. Schneider, a hard time.

In a few months, we received the decision. The Second Circuit overturned the jury verdict, holding that the trial judge committed reversible error by not giving the express assumption of risk defense as a complete bar to recovery. As the Second Circuit stated, "While a patient should be encouraged to exercise care for his own safety, we believe that an informed decision to avoid surgery and conventional chemotherapy is within the patient's right 'to determine what shall be done with his own body.'"[8]

It was a complete victory. Back then, there were not many legal victories in the alternative health community, so news of the Second Circuit's decision spread throughout the country. Sam, and to some extent our firm, was heralded as the great white hope amongst alternative health practitioners. Sam was invited to speak at conferences, and we ended up landing a number of other clients in the field, including the ever-increasingly popular diet doctor, Robert Atkins.

8 For the legally interested, *Schneider v. Revici* is reported at 817 F.2d 987 (2nd Cir. 1987).

Perceived Legal Implications of the Decision in the Schneider v. Revici Case

Catherine J. Frompovich, Ph.D.[1]

The evolution of individual human rights can be seen from 1215 when Magna Carta was signed; to 1789 when the Bastille fell; to 1787 when the U.S. Constitution was signed. In this history society has evolved to afford greater and greater protection for individual human rights. However, the right of a patient to determine his choice of health care and access to non-conventional health care has yet to be firmly articulated. In light of that, *Schneider* v. *Revici* is interesting. Possibly April 30, 1987, the date of the decision on this case, may be added to the list of historic dates of individual human rights.

One would think that because of all the other human rights campaigns fought throughout history in various countries of the world, that the right to freedom of choice in health care would be automatic and without question and/or denial. Perhaps in other countries of the world that may be true, but in the United States of America the unfortunate situation exists that individuals who wish to avail themselves of health care modalities and protocols other than those sanctioned by the American Medical Association are subject to the wrath of the law, legal problems and ultimately litigation, if one wishes to exercise the right of self-determination in health care.

However, the courts have deferred to the values and assumptions of conventional medicine and have not reinforced patients' superior rights to determine treatment of their choice or to have access to health care of their choice. In light of that, *Schneider v. Revici* is significant.

The facts in this case are that Edith Schneider was a breast cancer victim who consulted five conventional physicians all of whom advised her to have her breast amputated and be treated with conventional chemotherapy and radiation. She then having rejected that advice and aware of some of the limitations of breast cancer treatment, the issues involved and the difficulties involved in breast cancer, sought out Dr. Revici. Dr. Revici advised her to have a lumpectomy and that he would treat her with his non-toxic chemotherapy. She underwent his treatments and was in his care for nearly fourteen months. Her cancer did not subside and she ultimately was prevailed upon by family members to return to conventional care which she did; had her breasts amputated and was treated with a very harsh course of chemotherapy and radiation. She then turned around and sued Dr. Revici. The unique thing about the case was that it was not simply malpractice but also fraud. Mrs. Schneider's theory was that Dr. Revici's treatment was not accepted by the medical establishment; that it was fraudulent and malpractice per se. The case went to trial and the jury acquitted Dr. Revici of any claims of fraud or lack of informed consent because it was clear that she made a knowing choice; that she had rejected conventional therapy; and that she was informed that Dr. Revici's therapy was not conventional and that she was not defrauded by him. However, the jury was directed by the judge to find malpractice if Dr. Revici's therapy was not accepted by the medical community. Dr. Revici's lawyers argued no, that in contrast to that, the jury should be instructed that Mrs. Schneider assumed the risk of non-conventional treatment precisely because she was informed and made a choice. These two issues are in conflict: 1) Dr. Revici's obligation to practice medicine established by a medicine endorsed by the establishment versus 2) the patient's right to seek out a doctor who doesn't practice medicine endorsed by the establishment. That issue was the focus of the decision before the Court of Appeals. The Court of Appeals ruled that a patient has a right to

1. CA N.A.H., P.O. Box B-12, Richlandtown, PA 18955.

seek out non-conventional treatment and corresponding with that right then, is the responsibility that the patient assumes the risk in exercising that right.

Mr. Samuel Abady, Esq., attorney for Dr. Revici, in a telephone conversation with me said, "... are you aware that Victor Herbert, M.D., J.D., testified and that the nature of his testimony was simply calumny; that he called Dr. Revici 'one of the cruelest killers in the United States'. He also described his [Dr. Revici's treatment] as snake oil, and he really engaged in character assassination; and that the court of appeals found that this was absolutely outrageous behaviour. The court of appeals said the judge should never have countenanced this kind of testimony."

According to the information which I have been able to gather, the arguments presented by Dr. Revici's attorneys were based on some important historical points of view and challenged that *what is considered today as quackery is tomorrow's orthodox medicine.* The classic example which they had used was the case of Dr. Ignaz Semmelweiss.

In the argument presented by Dr. Revici's attorneys, they put forth that Dr. Ignaz Semmelweiss challenged the establishment and declared that the doctors should wash their hands before surgery. He was driven to suicide because at the time if someone washed their hands and then performed surgery and there was a problem, one could get the doctors to testify that Semmelweiss committed malpractice; whereas if today someone performs surgery and causes septicemia or infection because they failed to create a sterile field and had not washed their hands, on the basis of Semmelweiss you could sue for malpractice. So yesterday's quackery is today's orthodox medicine.

Dr. Revici's attorneys further had argued that since medicine had not established an understanding of the true cause of cancer or an effective cure for cancer, the law could not reify orthodox medicine's cancer treatments as if they were inviable and, therefore, that would be legally improper. They further argued that a doctor's freedom to practice is derived from a patient's rights to treatment. They also argued that it is the patient who decides what kind of treatment the patient seeks and desires and that *the physician and modality is the choice of the patient.*

The U.S. Court of Appeals handed down a decision which has set a precedent for non-conventional treatments and freedom of choice. The court stated:

> "In the case before us, appelles contend it is against public policy for a patient to expressly assume the risk of medical malpractice and thereby dissolve the physician's duty to treat a patient according to medical community standards . . .we see no reason why a patient should not be allowed to make an informed decision to go outside currently approved medical methods in search of an unconventional treatment. While a patient should be encouraged to exercise care for his own safety, we believe that an informed decision to avoid surgery and conventional chemotherapy is within the patient's right 'to determine what shall be done with his own body'."

With those words, *the Court affirmed the patient's rights as having priority over and superior to medical establishment's rights,* and that a patient can obtain non-conventional or unorthodox treatment for cancer in this case which did not include conventional surgery and chemotherapy. This then was a dramatic and resounding decision, in my opinion, in favour of several issues:

> A patient's right to choose treatment for health care regardless of the protocol, i.e., conventional or non-conventional; the ability of the physician to offer non-conventional treatments as a protocol with the patient knowing that such a treatment is not the standard orthodox procedure; and, acknowledges the position in a legal forum for *non-conventional treatment and/or therapies to be addressed as non-fraudulent practices.* The last item being the most important, in my view.

Previously the courts have established the individual's right to determination in health care.

> *Andrews* v. *Ballard* was a classic decision in which the alternate health care modality of acupuncture was the subject of legal action with the individual's right to choice of practitioner. In that case, the court ruled that an individual who was trained in

traditional acupuncture was qualified to render the treatment. In that case Judge McDonald stated:

> "And it is the individual making the decision, and no one else, who if he or she survives, must live with the result of that decision. One's health is a uniquely personal possession. The decision of how to treat that possession is of no less personal nature."

The uniqueness about the decision rendered in the *Schneider v. Revici* case, in my opinion, is the ability of a non-traditional or complementary health care treatment to withstand the rigors of the law and so to speak, land on all four feet. The judges did not refer to the non-traditional cancer therapy treatment as quackery, which is the usual tendency for medical orthodox circles and those in opposition to non-conventional treatments to do. This is a highly significant indicator, in my opinion. This speaks to me from a perspective that the courts are now not only entertaining, but listening very carefully to the issues surrounding health care freedoms and choices since previous case law has decided the individual's right to privacy and to take care of their body as they see fit. The uniqueness of the *Schneider* v. *Revici* case for me is that a precedent has been set in American case law which could have health care/legal ramifications. This case should become the legal keystone around which complementary health care can test the legal waters in great depths. I believe the *Schneider v. Revici* case has set precedents, not only for patient, physician and health care, but for ethics in medicine and law also. I see this case challenging to both plaintiff and defendant arguments. The debating skills of attorneys will be greatly taxed if they choose this case as their citation to illustrate a point of law, in my opinion. I feel this case has a uniqueness about it which can help the complementary/alternate health care treatment and modality protocols in a fashion which no case law heretofore has been able to do.

There has been no Constitutional decision saying that the right of privacy protects an individual at seeking out non-conventional care. That is precisely why *Schneider v. Revici is* an important decision. Although it is not on a Constitutional ground, it at least foreshadows the legal basis under the 1914 decision of *Schloendorf v. New York Hospital* and why perhaps it ought to have Constitutional dimensions.

The United States Court of Appeals for the Tenth Circuit in *Rutherford v. the United States* found the right of privacy protecting individual's choice of non-conventional care; the Supreme Court reversed, but not addressing that issue. The California Court of Appeals in *People* v. *Privitera,* which was a criminal case, the Court of Appeals reversed. Then the Court of Appeals found that the right of privacy protected the patient's rights to determine health care, and the California Supreme Court reversed, and said it didn't. *Schneider* v. *Revici* stands in contrast to Privitera and Rutherford. In both Privitera and Rutherford the mid-level courts of appeals, one a state court and one a federal court, found privacy protected in a cancer patient's right to choice and the Supreme Court of California and the Supreme Court of the United States said no, it didn't. *Schneider v. Revici* says it does!, but in a different context, as a matter of law generally and not in a Constitutional theory. (And that's why our coalition (CANAH) is seeking a Health Care Rights Amendment to the U.S. Constitution.)

For those of you interested in the legal citation for *Schneider* v. *Revici,* it is *817 F.2d 987 (2nd Cir. 1987).* The attorneys for Dr. Emanuel Revici are Samuel Abady and Rick Jaffe of the New York law firm of Abady and Jaffe.

I should like to acknowledge and to thank Mr. Samuel Abady for his telephone interview, legal/technical help to me in writing this article and for the splendid legal job he did in arguing this case.

In this article I have presented my personal opinions and viewpoints from my experience as a Legislative Advocate working for the legalization of alternate health care in the United States of America and as a lobbyist in Washington, D.C. working for that cause in representing the Coalition for Alternative in Nutrition and Health Care, Inc. (CANAH).

See also Book Review p. 33 The Great Medical Monopoly Wars.

Pfizer to pay record $2.3B penalty over promotions

AP Associated Press

Repeat offender Pfizer paying record $2.3B settlement for illegal drug promotions

By Devlin Barrett, Associated Press Writer
On Wednesday September 2, 2009, 3:47 pm EDT

Companies: Pfizer Inc. | Wyeth

WASHINGTON (AP) – Federal prosecutors hit Pfizer Inc. with a record-breaking $2.3 billion in fines Wednesday and called the world's largest drug maker a repeating corporate cheat for illegal drug promotions that plied doctors with free golf, massages, and resort junkets.

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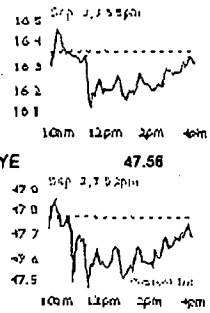

Announcing the penalty as a warning to all drug manufacturers, Justice Department officials said the overall settlement is the largest ever paid by a drug company for alleged violations of federal drug rules, and the $1.2 billion criminal fine is the largest ever in any U.S. criminal case. The total includes $1 billion in civil penalties and a $100 million criminal forfeiture.

Authorities called Pfizer a repeat offender, noting it is the company's fourth such settlement of government charges in the last decade. The allegations surround the marketing of 13 different drugs, including big sellers such as Viagra, Zoloft, and Lipitor.

As part of its illegal marketing, Pfizer invited doctors to consultant meetings at resort locations, paying their expenses and providing perks, prosecutors said.

"They were entertained with golf, massages, and other activities," said Mike Loucks, the U.S. attorney in Massachusetts.

Loucks said that even as Pfizer was negotiating deals on past misconduct, they were continuing to violate the very same laws with other drugs.

To prevent backsliding this time, Pfizer's conduct will be specially monitored by the Health and Human Service Department inspector general for five years.

In an unusual twist, the head of the Justice Department, Attorney General Eric Holder, did not participate in the record settlement, because he had represented Pfizer on these issues while in private practice.

Associate Attorney General Thomas Perrelli said the settlement illustrates ways the Justice Department "can help the American public at a time when budgets are tight and health care costs are rising."

Perrelli announced the settlement terms at a news conference with federal prosecutors and FBI, and Health and Human Services Department officials.

The settlement ends an investigation that also resulted in guilty pleas from two former Pfizer sales managers.

Officials said the U.S. industry has paid out more than $11 billion in such settlements over the past decade, but one consumer advocate voiced hope that Wednesday's penalty was so big it would curb the abuses.

"There's so much money in selling pills, that there's a tremendous temptation to cheat," said Bill Vaughan, an analyst at Consumers Union, the nonprofit publisher of Consumer Reports.

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"There's a kind of mentality in this sector that (settlements) are the cost of doing business and we can cheat. This penalty is so huge I think consumers can have some hope that maybe these guys will tighten up and run a better ship."

The government said the company promoted four prescription drugs, including the pain killer Bextra, as treatments for medical conditions different from those the drugs had been approved for by federal regulators. Authorities said Pfizer's salesmen and women created phony doctor requests for medical information in order to send unsolicited information to doctors about unapproved uses and dosages.

Use of drugs for so-called "off-label" medical conditions is not uncommon, but drug manufacturers are prohibited from marketing drugs for uses that have not been approved by the Food and Drug Administration. They said the junkets and other company-paid perks were designed to promote Bextra and other drugs, to doctors for unapproved uses and dosages, backed by false and misleading claims about safety and effectiveness.

Bextra, for instance, was approved for arthritis, but Pfizer promoted it for acute pain and surgical pain, and in dosages above the approved maximum. In 2005, Bextra, one of a class of painkillers known as Cox-2 inhibitors, was pulled from the U.S. market amid mounting evidence it raised the risk of heart attack, stroke and death.

A Pfizer subsidiary, Pharmacia and Upjohn Inc., which was acquired in 2003, has entered an agreement to plead guilty to one count of felony misbranding. The criminal case applied only to Bextra.

The $1 billion in civil penalties was related to Bextra and a number of other medicines.

A portion of the civil penalty will be distributed to 49 states and the District of Columbia, according to agreements with each state's Medicaid program.

Pfizer's top lawyer, Amy Schulman, said the settlements "bring final closure to significant legal matters and help to enhance our focus on what we do best – discovering, developing and delivering innovative medicines."

In her statement, Schulman said: "We regret certain actions taken in the past, but are proud of the action we've taken to strengthen our internal controls and pioneer new procedures."

In financial filings in January, the company had indicated that it would pay $2.3 billion over the allegations.

The civil settlement announced Wednesday covered Pfizer's promotions of Bextra, blockbuster nerve pain and epilepsy treatment Lyrica, schizophrenia medicine Geodon, antibiotic Zyvox and nine other medicines. The agreement with the Justice Department resolves the investigation into promotion of all those drugs, Pfizer said.

The government said Pfizer also paid kickbacks to market a host of big-name drugs: Aricept, Celebrex, Lipitor, Norvasc, Relpax, Viagra, Zithromax, Zoloft, and Zyrtec.

The allegations came to light thanks largely to five Pfizer employees and one Pennsylvania doctor, who will now share $102 million of the settlement money.

FBI Assistant Director Kevin Perkins praised the whistleblowers who decided to "speak out against a corporate giant that was blatantly violating the law and misleading the public through false marketing claims."

To rein in the abuses, the government's five-year monitoring will force Pfizer to notify doctors about Wednesday's agreement, encourage them to report any similar behavior, and publicly post any payments or perks it gives to doctors.

Under terms of the settlement, Pfizer must pay $1 billion to compensate Medicaid, Medicare, and other federal health care programs. Some of that money will be shared among the states: New York, for example, will receive $66 million, according to the state's attorney general, Andrew Cuomo.

When Pfizer originally disclosed the settlement figure, it also announced plans to acquire rival Wyeth for $68 billion. That deal, which would bolster Pfizer's position as the world's top drug maker by revenue, is expected to close before year's end.

Shares of Pfizer dropped 14 cents to $16.24 in midday trading.

AP Business Writer Linda A. Johnson in Trenton, N.J. contributed to this report.

AMENDED IN SENATE APRIL 8, 2013

SENATE BILL **No. 117**

Introduced by Senator ~~Rubio~~ *Hueso*

January 17, 2013

An act to amend ~~Sections 116275, 116475, and 116590~~ *Section 2234.1* of, and to ~~add~~ *repeal* Section ~~116276 to,~~ *2257 of, the Business and Professions Code, and to amend Sections 109270, 109285, 109295, 109300, 109350, and 109375 of, and to add Article 2.5 (commencing with Section 109400) to Chapter 4 of Part 4 of Division 104 of,* the Health and Safety Code, relating to ~~drinking water.~~ *health care.*

LEGISLATIVE COUNSEL'S DIGEST

SB 117, as amended, ~~Rubio~~ *Hueso*. ~~Drinking water: State Water Resources Control Board.~~ *Integrative cancer treatment.*

Existing law prohibits the sale, prescription, or administration of a drug, medicine, compound, or device to be used in the diagnosis, treatment, alleviation, or cure of cancer unless it has been approved by the federal Food and Drug Administration or by the State Department of Public Health, as specified, and makes a violation of that provision a misdemeanor. The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and requires the board to take action against a licensee who is charged with unprofessional conduct. The act immunizes a physician and surgeon from discipline for providing advice or treatment that constitutes alternative or complementary medicine if the treatment or advice meets certain requirements. The Osteopathic Act provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California and requires the board to enforce the Medical Practice Act with respect to its licensees.

This bill would prohibit a physician and surgeon, including an osteopathic physician and surgeon, from recommending, prescribing, or providing integrative cancer treatment, as defined, to cancer patients unless certain requirements are met. The bill would specify that a failure of a physician and surgeon to comply with these requirements constitutes unprofessional conduct and cause for discipline by the applicable licensing board. The bill would require the State Department of Public Health to investigate violations of these provisions and to hold hearings with respect to compliance with these provisions. The bill would make conforming changes to other related provisions.

~~Existing law, the California Safe Drinking Water Act, provides for the operation of public water systems, and imposes on the State Department of Public Health various responsibilities and duties. Existing law requires the department to conduct research, studies, and demonstration projects relating to the provision of a dependable, safe supply of drinking water, to adopt regulations to implement the California Safe Drinking Water Act, and to enforce provisions of the federal Safe Drinking Water Act.~~

~~This bill would transfer the various duties and responsibilities imposed on the department by the California Safe Drinking Water Act to the State Water Resources Control Board and make conforming changes.~~

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

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

SECTION 1. Section 2234.1 of the Business and Professions Code is amended to read:

2234.1. (a) A physician and surgeon shall not be subject to discipline pursuant to subdivision (b), (c), or (d) of Section 2234 solely on the basis that the treatment or advice he or she rendered to a patient is alternative or complementary medicine, including the treatment of persistent Lyme Disease, if that treatment or advice meets ~~all~~ *one* of the following requirements, *as applicable*:

(1) The treatment or advice is for a condition other than cancer and meets all of the following requirements:

~~(1)~~

(A) It is provided after informed consent and a good-faith prior examination of the patient, and medical indication exists for the treatment or advice, or it is provided for health or well-being.

~~(2)~~

(B) It is provided after the physician and surgeon has given the patient information concerning conventional treatment and describing the education, experience, and credentials of the physician and surgeon related to the alternative or complementary medicine that he or she practices.

~~(3)~~

(C) In the case of alternative or complementary medicine, it does not cause a delay in, or discourage traditional diagnosis of, a condition of the patient.

~~(4)~~

(D) It does not cause death or serious bodily injury to the patient.

(2) The treatment or advice is for cancer and is given in compliance with Article 2.5 (commencing with Section 109400) of Chapter 4 of Part 4 of Division 104 of the Health and Safety Code.

(b) For purposes of this section, "alternative or complementary medicine," means those health care methods of diagnosis, treatment, or healing that are not generally used but that provide a reasonable potential for therapeutic gain in a patient's medical condition that is not outweighed by the risk of the health care method.

(c) Since the National Institute of Medicine has reported that it can take up to 17 years for a new best practice to reach the average physician and surgeon, it is prudent to give attention to new developments not only in general medical care but in the actual treatment of specific diseases, particularly those that are not yet broadly recognized in California.

SEC. 2. Section 2257 of the Business and Professions Code is repealed.

~~2257. The violation of Section 109275 of the Health and Safety Code, relating to informed consent for the treatment of breast cancer, constitutes unprofessional conduct.~~

SEC. 3. Section 109270 of the Health and Safety Code is amended to read:

109270. The department shall:

(a) Prescribe reasonable regulations with respect to the administration of this article and Article 2 (commencing with Section 109300).

(b) Investigate violations of this article ~~and~~, Article 2 (commencing with Section 109300), *and Article 2.5 (commencing with Section 109400),* and report the violations to the appropriate enforcement authority.

(c) Secure the investigation and testing of the content, method of preparation, efficacy, or use of drugs, medicines, compounds, or devices proposed to be used, or used, by any individual, person, firm, association, or other entity in the state for the diagnosis, treatment, or cure of cancer, prescribe reasonable regulations with respect to the investigation and testing, and make findings of fact and recommendations upon completion of any such investigation and testing.

(d) Adopt a regulation prohibiting the prescription, administration, sale or other distribution of any drug, substance, or device found to be harmful or of no value in the diagnosis, prevention, or treatment of cancer, *except as authorized under Article 2.5 (commencing with Section 109400).*

(e) Hold hearings ~~in~~ *with* respect ~~of~~ *to* those matters involving compliance with this article ~~and~~, Article 2 (commencing with Section 109300), *and Article 2.5 (commencing with Section 109400),* and subpoena witnesses and documents. Any or all hearings may be held before the Cancer Advisory Council. Any administrative action to be taken by the department as a result of the hearings shall be taken only after receipt of the recommendations of the council. Prior to issuance of a cease and desist order under Section 109345, a hearing shall be held. The person furnishing a sample *or manufacturer contact information* under Section 109295 shall be given due notice of the hearing and an opportunity to be heard.

(f) Contract with independent scientific consultants for specialized services and advice.

In the exercise of the powers granted by this section, the department shall consult with the Cancer Advisory Council.

SEC. 4. Section 109285 of the Health and Safety Code is amended to read:

109285. For the purposes of this article ~~and~~, Article 2 (commencing with Section 109300), *and Article 2.5 (commencing with Section 109400),* "cancer" means all malignant neoplasms regardless of the tissue of origin, including malignant lymphoma, Hodgkins disease, and leukemia.

SEC. 5. Section 109295 of the Health and Safety Code is amended to read:

109295. *(a)* On written request by the department, delivered personally or by mail, any individual, person, firm, association, or other entity engaged, or representing himself, *herself,* or itself, as engaged, in the diagnosis, treatment, alleviation, or cure of cancer shall ~~furnish~~ *do all of the following:*

(1) Furnish the department with the sample as the department may deem necessary for adequate testing of any drug, medicine, compound, or device used or prescribed by the individual, person, firm, association, or other entity in the diagnosis, treatment, alleviation, or cure of ~~cancer, and shall specify~~ *cancer. The individual, person, firm, association, or other entity may alternatively furnish the department with the contact information of the manufacturer of the drug, medicine, compound, or device.*

(2) Specify the formula of any drug or compound and name all ingredients by their common or usual ~~names, and shall, upon like~~ *names.*

(3) Upon request ~~by~~ *of* the department, furnish further necessary information as ~~it~~ *the department* may request as to the composition and method of preparation of and the use that any drug, compound, or device is being put by the individual, person, firm, association, or other entity. ~~This~~

(b) This section shall apply to any individual, person, firm, association, or other entity that renders health care or services to individuals who have or believe they have cancer. This section also applies to any individual, person, firm, association, or other entity that by implication causes individuals to believe they have cancer.

~~The~~

(c) Upon the failure to ~~either~~ provide the sample *or the manufacturer's contact information,* disclose the formula, or name the ingredients as required by this section, *it* shall be conclusively presumed that the drug, medicine, compound or device that is the subject of the department's request has no value in the diagnosis, treatment, alleviation, or cure of cancer.

SEC. 6. Section 109300 of the Health and Safety Code is amended to read:

109300. The sale, offering for sale, holding for sale, delivering, giving away, prescribing, or administering of any drug, medicine,

compound, or device to be used in the diagnosis, treatment, alleviation, or cure of cancer is unlawful and prohibited unless ~~(1)~~ ~~an~~ *one of the following applies:*

(a) An application with respect thereto has been approved under Section 505 of the federal Food, Drug, and Cosmetic Act~~, or (2) there~~.

(b) The use is consistent with Article 2.5 (commencing with Section 109400).

(c) There has been approved an application filed with the board setting forth *all of the following*:

~~(a)~~

(1) Full reports of investigations that have been made to show whether or not the drug, medicine, compound, or device is safe for the use, and whether the drug, medicine, compound, or device is effective in the use;

~~(b)~~

(2) A full list of the articles used as components of the drug, medicine, compound, or device;

~~(c)~~

(3) A full statement of the composition of the drug, medicine, compound, or device;

~~(d)~~

(4) A full description of the methods used in, and the facilities and controls used for, the manufacture, processing, and packing of the drug, medicine, or compound or in the case of a device, a full statement of its composition, properties, and construction and the principle or principles of its operation;

~~(e)~~

(5) Such samples of the drug, medicine, compound, or device and of the articles used as components of the drug, medicine, compound, or device as the board may require; and

~~(f)~~

(6) Specimens of the labeling and advertising proposed to be used for the drug, medicine, compound, or device.

SEC. 7. Section 109350 of the Health and Safety Code is amended to read:

109350. The department may direct that ~~any~~ *an* individual, person, firm, association, or other entity shall cease and desist any further prescribing, recommending, or use of any drug, medicine, compound, or device for which no application has been approved

under this article and Article 1 (commencing with Section 109250) unless its use is exempt under Section 109325 or 109330 *or authorized under Article 2.5 (commencing with Section 109400).*

SEC. 8. Section 109375 of the Health and Safety Code is amended to read:

109375. The director shall investigate possible violations of this article ~~and~~, Article 1 (commencing with Section 109250), *and Article 2.5 (commencing with Section 109400),* and report violations to the appropriate enforcement authority.

SEC. 9. Article 2.5 (commencing with Section 109400) is added to Chapter 4 of Part 4 of Division 104 of the Health and Safety Code, to read:

Article 2.5. Integrative Cancer Treatment

109400. For purposes of this article:

(a) "Integrative cancer treatment" means the use of a combination of evidence-based substances or therapies for the purpose of reducing the size of a cancer, slowing the progression of a cancer, or improving the quality of life of a patient with cancer, by a physician and surgeon practicing within his or her scope of practice.

(b) "Physician and surgeon" means a physician and surgeon licensed pursuant to Section 2050 of the Business and Professions Code or an osteopathic physician and surgeon licensed pursuant to the Osteopathic Act.

109401. (a) Notwithstanding any other provision of law, a physician and surgeon shall not recommend or prescribe integrative cancer treatment for cancer patients unless the following requirements are met, as applicable:

(1) The treatment is recommended or prescribed after informed consent is given, as provided in Section 109402.

(2) The treatment recommended or prescribed meets the evidence-based medical standard provided in Section 109403.

(3) The physician and surgeon prescribing the treatment complies with the patient reevaluation requirements set forth in Section 109404 after the treatment begins.

(4) The physician and surgeon prescribing the treatment complies with all of the standards of care set forth in Section 109405.

(b) A physician and surgeon shall not provide integrative cancer treatment for cancer patients unless the treatment is prescribed by a physician and surgeon in compliance with subdivision (a).

109402. (a) For purposes of paragraph (1) of subdivision (a) of Section 109401, informed consent has been given if the patient signs a form stating either of the following:

(1) The name and telephone number of the physician and surgeon from whom the patient is receiving conventional cancer care and whether the patient has been informed of the type of cancer from which the patient suffers and his or her prognosis using conventional treatment options.

(2) That the patient has declined to be under the care of an oncologist or other physician and surgeon providing conventional cancer care.

(b) The form described in subdivision (a) shall include all of the following information:

(1) The type of care the patient will be receiving or that is being recommended is not, in whole or in part, the conventional treatment for treating cancer in California.

(2) The conventional treatment for treating cancer in California consists of radiation, chemotherapy, and surgery.

(3) All or part of the treatment that the physician and surgeon will be prescribing or recommending is not approved by the federal Food and Drug Administration for the treatment of cancer.

(4) The care that the patient will be receiving or that is being recommended is not mutually exclusive of the patient receiving conventional cancer treatment.

(5) The following written statements:

THE STATE DEPARTMENT OF PUBLIC HEALTH AND THE PHYSICIAN PRESCRIBING YOUR INTEGRATIVE CANCER CARE RECOGNIZE THE IMPORTANCE OF USING CONVENTIONAL CANCER TREATMENTS, INCLUDING RADIATION, CHEMOTHERAPY, AND SURGERY. IT IS HIGHLY RECOMMENDED THAT YOU SEE AN ONCOLOGIST OR ANOTHER PHYSICIAN TO PROVIDE YOU WITH CONVENTIONAL CANCER CARE.

ANY AND ALL MEDICAL TREATMENTS INVOLVE SOME DEGREE OF RISK OF INJURY UP TO AND INCLUDING DEATH.

109403. For purposes of paragraph (2) of subdivision (a) of Section 109401, a treatment meets the evidence-based medical standard for integrative cancer treatment if one of the following requirements is met:

(a) The treatment is recognized by the Physician's Data Query of the National Cancer Institute.

(b) The treatment has been published in at least three peer-reviewed scientific medical journals.

(c) The treatment has been reported in at least three peer-reviewed articles published in complementary and alternative medicine journals to have the potential of reducing the size of a cancer, slowing the progression of a cancer, or improving the quality of life of a patient with cancer.

109404. For purposes of paragraph (3) of subdivision (a) of Section 109401, a physician and surgeon prescribing integrative cancer treatment complies with the patient reevaluation requirements if all of the following conditions are satisfied:

(a) The patient is informed regarding the measurable results achieved within the timeframe established pursuant to paragraph (2) of subdivision (a) of Section 109405 and at regular and appropriate intervals during the treatment plan.

(b) The physician and surgeon reevaluates treatment when progress stalls or reverses, in the opinion of the physician and surgeon or the patient, or as evidenced by objective evaluations.

(c) The patient is informed about and agrees to any proposed change or changes in treatment, including, but not limited to, the risks and benefits of the proposed change or changes, the costs associated with the proposed change or changes, and the timeframe within which the proposed change or changes will be reevaluated.

109405. For purposes of paragraph (4) of subdivision (a) of Section 109401, a physician and surgeon complies with all of the standards of care in prescribing integrative cancer treatment under this article if all of the following requirements are met:

(a) The physician and surgeon provides the patient with all of the following when prescribing the treatment:

(1) Information regarding the treatment prescribed, including its usefulness in treating cancer.

(2) A timeframe and plan for reevaluating the treatment using standard and conventional means in order to assess treatment efficacy.

(3) A cost estimate for the prescribed treatment.

(b) The physician and surgeon ensures that relevant, generally accepted tests are administered to confirm the effectiveness and progress of the treatment.

(c) The physician and surgeon, prior to prescribing or changing the treatment, makes a good faith effort to obtain from the patient all relevant charts, records, and laboratory results relating to the patient's conventional cancer care.

(d) At the request of the patient, the physician and surgeon makes a good faith effort to coordinate the care of the patient with the physician and surgeon providing conventional cancer care to the patient.

(e) At the request of the patient, the physician and surgeon provides a synopsis of any treatment rendered pursuant to this article to the physician and surgeon providing conventional cancer care to the patient, including subjective and objective assessments of the patient's state of health and response to that treatment.

109406. The failure of a physician and surgeon to comply with this article constitutes unprofessional conduct and cause for discipline by his or her licensing board. That person shall not be subject to Section 109335 or 109370.

All matter omitted in this version of the bill appears in the bill as introduced in the Senate, January 17, 2013. (JR11)

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SB 304

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 304
Author:	Price
Bill Date:	April 16, 2013, Amended
Subject:	Healing Arts: Boards
Sponsor:	Author

STATUS OF BILL:

This bill is in the Senate Business, Professions, and Economic Development Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the bill that would include language on a portion of the new issues from the Board's 2012 Sunset Review Report, and eventually, extend the Board's sunset date. This bill would also remove the sunset date from the provisions in existing law related to vertical enforcement.

ANALYSIS:

The Board included new issues in its 2012 Sunset Review Report to the Legislature and it its 2013 Supplemental Report. This report was submitted to the Legislature and the Legislature prepared a background paper that raised 39 issues, some of them related to the new issues included in the Board's Sunset Review Report. Here are the new issues that were included in the Board's Sunset Review Report that would require legislation:

- Revise existing law, Business and Professions (B&P) Code Section 2177, in order to accommodate the upcoming two parts of the United States Medical Licensing Examination Step 3 examination, and any new evolving examination requirement - **This bill does include language to accommodate two parts of the USMLE Step 3 examination**
- Require all licensees who have an email address to provide the Board with an email address, and specify that the email address shall be confidential - **This bill does include language that would require licensees who have an email address to provide the Board with an email address by July 1, 2014 and would specify that the email address is confidential and not subject to public disclosure.**
- The Board recommended that the requirement in existing law for the Board to post a physician's approved postgraduate training be eliminated - The Committee directed the Board to further discuss this proposal with stakeholders, including those stakeholders representing consumer interests and advise the Committee of the results of those

discussions, and submit language if appropriate.

- The Board recommended that it be clarified in statute that residents in California accredited resident/fellowship programs are exempt from corporate practice laws related to how they are paid – **This bill does include language that clarifies that the corporate practice laws do not apply to physicians enrolled in an approved residency postgraduate training programs or fellowship programs.**
- The Board recommended that a section be added to existing law to require coroners to report all deaths related to prescription drug overdoses to the Board – this language is contained in SB 62 (Price), which the Board currently has a support if amended position on.
- The Board recommended that legislation be introduced to provide an adequate funding source for CURES, so it can be funded and upgraded (e.g. all individuals who prescribe or dispense medications, pharmaceutical companies, and the public). The prescribers/dispensers would include physicians, dentists, pharmacists, veterinarians, nurse practitioners, physician assistants, osteopathic physicians, optometrists, and podiatrists. This funding source would support the necessary enhancements to the computer system and provide for adequate staffing to run the system – The CURES funding and upgrading language is included in SB 809 (DeSaulnier and Steinberg).
- The Board recommended that medical malpractice reports received pursuant to Section 801.01 be excluded from the requirements of in existing law that require review by a medical expert with the expertise necessary to evaluate the specific standard of care issue raised in the complaint – **This bill does include language to exclude 801.01 reports from upfront review.**
- The Board recommended that, in the interest of consumer protection, legislation be written to require that regulations be adopted for physician availability in all clinical settings and for the Board to establish by regulation the knowledge, training, and ability a physician must possess in order to supervise other health care providers – This issue was not addressed in the Committee's background paper and language is not included in this bill.
- The Board recommended that the law be amended to allow a facility only 15 days to provide medical records, upon request, if the facility has electronic health records (EHRs) – **This bill does include language to require health care facilities that have EHRs to provide the authorizing patient's certified medical records to the Board within 15 days of receiving the requires and would subject the health care facility to penalties if the timeline is not adhered to.**
- The Board recommended an amendment to existing law to require the California Department of Public Health (CDPH) and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the Board and to require these entities to notify the Board if a hospital is not performing peer review - The Board was directed to further discuss this proposal with the Committee, and consideration should be given to the Board entering into an arrangement or a MOU with CDPH and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the MBC; and to further require that these entities notify the Board if a hospital is not performing peer review. This bill does not

include language to address this issue.

- The Board recommended elimination of the ten year posting requirement in existing law in order to ensure transparency to the public – In the Committee's background paper, it was recommended that in the interest of transparency and disclosure of information to the public, existing law should be amended to remove the 10 year limit on how long information should be posted on the MBC's Internet Website; however, this bill does not include language that would remove the 10 year limit on posting information.
- The Board recommended amending existing law to require a respondent to provide the full expert witness report and to clarify the timeframes in existing law for providing the reports, such as 90 days from the filing of an accusation – **This bill does include language that would require the complete expert witness report to be provided and that would require the expert testimony information to be provided within 90 days from the filing of a notice of defense.**
- The Board recommended that the provision in existing law that requires the Board to approve non-ABMS specialty boards be deleted. The Board suggested that the law should continue to require physicians to advertise as board certified only if they have been certified by ABMS boards and the four additional boards currently approved by the Board – **This bill does delete provisions in existing law that require the Board to approve non-ABMS specialty boards and only allows physicians to advertise that they have been certified by a non-ABMS board approved by the Board if it was approved prior to January 1, 2014.**
- The Board in suggested that the transfer of the registered dispensing optician (RDO) Program to the Optometry Board or DCA should be examined – The Committee suggested that the Board initiate discussions with all stakeholders and report back to the Committees with findings by July 1, 2014. This bill does not include language to address this issue.
- The Board made suggestions related to the Licensed Midwifery Program, that the issue of physician supervision and obtaining lab accounts and medical supplies should be addressed through legislation – The Committee agreed and AB 1308, which is sponsored by the American Congress of Obstetricians and Gynecologists has been introduced and will be brought to the Board for a position.
- The Board recommended that the issue of midwife students/apprenticeships needs to be clarified in legislation, due to confusion in the midwifery community – **This bill includes language that would define a "bona fide student" as an individual who is enrolled and participating in a midwifery education program or who is enrolled in a program of supervised clinical training as part of the instruction of a three year postsecondary midwifery education program approved by the Board.**
- The Board recommended that the issue of midwife assistants needs to be addressed in legislation, and what duties the assistant may legally perform, as it has been brought to the attention of the Board that licensed midwives use midwife assistants and currently, there is no definition for a midwife assistant or the specific training requirements or the duties that a midwife assistant may perform – The Committee directed the Board to provide more information regarding the proposal to address the issue of midwife

assistants in legislation. This bill does not include language to address this issue.

- The Board suggested that existing law be amended in to include certified nurse midwives (CNM) as being able to supervise midwifery students – **This bill does include language that would allow a CNM to supervise a midwifery student.**
- The Board recommended that language be added to existing law to allow the Board the authority to issue a cease practice order in cases where a licensee fails to comply with an order to compel a physical or mental examination - **This bill does include language that would allow the Board to issue a cease practice order when a licensee fails to comply with an order issued under Section 820 to compel a physical or mental examination.**
- The Board recommended that existing law be amended to include American Osteopathic Association-Healthcare Facilities Accreditation Program as an approved accreditation agency for hospitals offering accredited postgraduate training programs – **This item that was suggested in the Supplemental Report, but was not addressed by the background paper as it was included after the paper was drafted and language was not included in this bill.**
- The Board recommended that the Vertical Enforcement Program be continued and stated that the Board and the Health Quality Enforcement Section (HQES) will continue to work together to establish best practices and identify areas where improvements can be made – **This bill would delete the sunset date in the vertical enforcement statutes, making vertical enforcement permanent. This bill would also require the Board, in consultation with the Department of Justice and the Department of Consumer Affairs to report and make recommendations to the Governor and the Legislature on the Vertical Enforcement Program by March 1, 2015.**

This bill would also extend the timeframe in which an accusation must be filed once an interim suspension order (ISO) is issued. Currently, in order for the Board to stop a physician from practicing while the physician is under investigation, the Board must request an Interim Suspension Order (ISO), which must be granted by an Administrative Law Judge (ALJ). In existing law there is a 15-day time restraint in law to file an accusation after being granted an ISO, and a 30-day time restraint between the accusation being filed and a hearing being set, which means an investigation must be nearly complete in order to file for an ISO. This bill would extend the timeframe to file an accusation from 15 days to 30 days, which would help to further the Board's mission of consumer protection.

This bill would address many of the new issues raised in the Board's 2012 Sunset Review Report and the 2013 Supplemental Report and includes language to make the legislative changes suggested by the Board to accommodate the continuing evolution of medical training and testing, to improve the efficiencies of the Board's Licensing and Enforcement Programs, and most importantly, to enhance consumer protection. There are some issues that the committee background paper didn't address or that recommended that the Board's changes be made, but that the changes aren't included in this bill, i.e., removing the 10-year posting requirement in existing law. More importantly, this bill no longer extends the

Board's sunset date, which must be extended in order for the Board to continue. Board staff is suggesting that the Board support this bill if it is amended to extend the sunset date and possibly include more new issues recommended by the Board.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support if Amended

AMENDED IN SENATE APRIL 16, 2013

SENATE BILL **No. 304**

Introduced by Senator Price
(Principal coauthor: Assembly Member Gordon)

February 15, 2013

An act to amend Sections ~~2001, 2020, 2569, 3010.5, and 3014.6 of~~ *651, 2021, 2177, 2220.08, 2225.5, 2334, 2514, and 2569 of, and to add Sections 2291.5 and 2403 to,* the Business and Professions Code, *and to amend Sections 11529, 12529.6, and 12529.7 of, and to amend and repeal Sections 12529 and 12529.5 of, the Government Code,* relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

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

~~Existing law provides for the licensure and regulation of various healing arts licensees by various boards, as defined, within the Department of Consumer Affairs, including the Medical Board of California. Existing law requires the Governor to appoint members to the board, as provided. Existing law authorizes the board to employ an executive director. Existing law provides that those provisions will be repealed on January 1, 2014. Under existing law, the board is subject to evaluation by the Joint Sunset Review Committee.~~

~~This bill would instead repeal those provisions on January 1, 2018, and subject the board to review by the appropriate policy committees of the Legislature.~~

Existing law makes it unlawful for a healing arts practitioner to disseminate, or cause to be disseminated, any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of, or likely to induce, the

rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. Existing law provides for the licensure of physicians and surgeons by the Medical Board of California. Existing law prohibits a physician and surgeon's advertisements from including a statement that he or she is certified or eligible for certification by a private or public board or parent association, including a multidisciplinary board or association, as defined, unless that board or association meets at least one of several standards, including being a board or association with equivalent requirements approved by that physician and surgeon's licensing board. A violation of these requirements is a crime.

This bill would limit the application of that exception to a board or association with equivalent requirements approved by that physician and surgeon's licensing board prior to January 1, 2014. The bill would establish that the exception continues to apply to a multidisciplinary board or association approved by the Medical Board of California prior to January 1, 2014.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This bill would require that to engage in those practices, the student is to be enrolled and participating in a midwifery education program or enrolled in a program of supervised clinical training, as provided. The bill would add that the student is permitted to engage in those

practices if he or she is under the supervision of a licensed nurse-midwife.

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

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

Existing law authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an interim order related to licenses, as provided. Existing law requires that in all of those cases in which an interim order is issued, and an accusation is not filed and served within 15 days of the date in which the parties to the hearing have submitted the matter, the order be dissolved.

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

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

This bill would extend the operation of those provisions indefinitely.

Existing law establishes a vertical enforcement and prosecution model for cases before the Medical Board of California. Existing law requires that a complaint referred to a district office of the board for investigation also be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health and Quality Enforcement Section, as provided. Existing law provides for the repeal of those

provisions, as provided, on January 1, 2014. Existing law requires the board to report to the Governor and Legislature on the vertical prosecution model by March 1, 2012.

This bill would extend the operation of those provisions indefinitely and would extend the date that report is due to March 1, 2015.

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

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

~~Existing law provides for the licensure and regulation of optometrists by the State Board of Optometry. Existing law requires that the board consist of specified members and authorizes the board to appoint an executive officer. Existing law repeals those provisions on January 1, 2014 and subjects the board to review by the Joint Sunset Review Committee.~~

~~This bill would instead repeal those provisions on January 1, 2018, and require that the board be subject to review by the appropriate policy committees of the Legislature.~~

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

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

~~SECTION 1. Section 2001 of the Business and Professions Code is amended to read:~~

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

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

~~(c) 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. 2. Section 2020 of the Business and Professions Code is amended to read:~~

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

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

~~(c) This section shall remain in effect only until January 1, 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.~~

SECTION 1. Section 651 of the Business and Professions Code is amended to read:

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

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

(1) Contains a misrepresentation of fact.

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

(3) (A) Is intended or is likely to create false or unjustified expectations of favorable results, including the use of any photograph or other image that does not accurately depict the

results of the procedure being advertised or that has been altered in any manner from the image of the actual subject depicted in the photograph or image.

(B) Use of any photograph or other image of a model without clearly stating in a prominent location in easily readable type the fact that the photograph or image is of a model is a violation of subdivision (a). For purposes of this paragraph, a model is anyone other than an actual patient, who has undergone the procedure being advertised, of the licensee who is advertising for his or her services.

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

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

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

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

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

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

(c) Any price advertisement shall be exact, without the use of phrases, including, but not limited to, "as low as," "and up," "lowest prices," or words or phrases of similar import. Any advertisement that refers to services, or costs for services, and that uses words of comparison shall be based on verifiable data

substantiating the comparison. Any person so advertising shall be prepared to provide information sufficient to establish the accuracy of that comparison. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or any statements of a similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

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

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

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

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

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

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

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

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

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

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

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

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

~~For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the Medical Board of California, for certifying medical doctors and other health care professionals that is based on the applicant's education, training, and experience.~~

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

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

~~The Medical Board of California shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this subparagraph. The fee shall not exceed the cost of administering this subparagraph. Notwithstanding Section 2 of Chapter 1660 of the Statutes of 1990, this subparagraph shall become operative July 1, 1993. However, an administrative agency or accrediting organization may take any action contemplated by this subparagraph relating to the establishment or approval of specialist requirements on and after January 1, 1991.~~

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

"board certified" in the statement. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification.

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

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

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

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

(8) A statement of publications authored by the practitioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(d)~~

(e) The board shall annually send an electronic notice to each applicant and licensee ~~who has chosen to receive correspondence via electronic mail~~ that requests confirmation from the applicant or licensee that his or her electronic mail address is current. ~~An applicant or licensee that does not confirm his or her electronic mail address shall receive correspondence at a mailing address provided pursuant to subdivision (b).~~

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

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

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

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

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

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

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

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

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

(A) Relevant patient records.

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

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

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

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

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

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

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

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

records to the board within 15 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. This paragraph shall not require health care facilities to assist the board in obtaining the patient's authorization. The board shall pay the reasonable costs of copying the certified medical records.

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

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

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

filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

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

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

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

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

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

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

SEC. 6: Section 2291.5 is added to the Business and Professions Code, to read:

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

SEC. 7. Section 2334 of the Business and Professions Code is amended to read:

2334. (a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other ~~party, as ordered by the Office of Administrative Hearings:~~ *party within 90 days from the filing of a notice of defense:*

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

(2) ~~A brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis.~~ *A complete expert witness report.*

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

(4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party who retained his or her services.

~~(b) The exchange of the information described in subdivision (a) shall be completed at least 30 calendar days prior to the commencement date of the hearing.~~

~~(c)~~

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

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

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

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

2514. *(a)* Nothing in this chapter shall be construed to prevent a bona fide student ~~who is enrolled or participating in a midwifery education program or who is enrolled in a program of supervised clinical training~~ from engaging in the practice of midwifery in this state, as part of his or her course of study, if both of the following conditions are met:

~~(a)~~

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

~~(b)~~

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

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

~~SEC. 3.~~

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

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

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

11529. (a) The administrative law judge of the Medical Quality Hearing Panel established pursuant to Section 11371 may issue an interim order suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing

each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare.

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

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

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

(1) To be represented by counsel.

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

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

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

(4) To present oral argument.

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

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

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

(f) In all cases where an interim order is issued, and an accusation is not filed and served pursuant to Sections 11503 and 11505 within ~~15~~ *30* days of the date in which the parties to the hearing on the interim order have submitted the matter, the order shall be dissolved.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~or any committee under the jurisdiction of the Medical Board of California, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision (b) of Section 12529.5.~~

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

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

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

~~(e) This section shall become operative January 1, 2014.~~

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

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

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

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

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

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

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

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

~~(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to assist the boards in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.~~

~~A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases.~~

~~(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards or committees in designing and providing initial and in-service training programs for staff of~~

~~the boards or committees, including, but not limited to, information collection and investigation.~~

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

~~(e) This section shall become operative January 1, 2014.~~

SEC. 16. Section 12529.6 of the Government Code is amended to read:

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

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

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

(d) This section does not affect the requirements of Section 12529.5 as applied to the Medical Board of California where

complaints that have not been assigned to a field office for investigation are concerned.

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

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

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

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

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

SEC. 17. Section 12529.7 of the Government Code is amended to read:

12529.7. By March 1,~~2012,~~ *2015,* the Medical Board of California, in consultation with the Department of Justice and the Department of Consumer Affairs, shall report and make recommendations to the Governor and the Legislature on the vertical enforcement and prosecution model created under Section 12529.6.

SEC. 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.

~~SEC. 4. 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.~~

~~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 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. 5. Section 3014.6 of the Business and Professions Code is amended to read:~~

~~3014.6. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.~~

~~(b) 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.~~

O

SB 305

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 305
Author: Price
Bill Date: April 15, 2013, Amended
Subject: Healing Arts: Boards
Sponsor: Author

STATUS OF BILL:

This bill is in the Senate Business, Professions, and Economic Development Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow all boards under the Department of Consumer Affairs (DCA) that require licensees to submit fingerprints, including the Medical Board of California (the Board), to request from a local or state agency, certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation. This bill would specify that a local or state agency may provide these records and that a board may receive these records.

This bill would also extend the sunset date of the Board's registered dispensing optician (RDO) program until January 1, 2018.

ANALYSIS:

Currently, the Medical Board does receive records of arrests and convictions. However, records regarding probation and records from other state and local agencies would be beneficial for the Medical Board to receive and use in applicant and licensee investigations. This bill would clarify that a local or state agency may provide the records and that a board may receive the records.

This bill would also extend the sunset date of the Board's RDO program.

Clarifying in statute that state and local agencies can provide boards under DCA with certified arrest, conviction, and probation records, and other documentation needed to complete an applicant or licensee investigation would be beneficial to the Board's Enforcement Program. There is sometime question on what documents can be shared from agency to agency, and this bill would clarify that information can be shared with specified boards, in order to help with a board's investigation. This will further the Board's mission of consumer protection; Board staff suggests that the Board support this bill.

The Board in its Sunset Review Report suggested the transfer of the RDO Program to the Optometry Board or DCA should be examined. The Senate and Assembly Business and Professions Committees have suggested that the Board initiate discussions with all stakeholders and report back to the Committees with findings by July 1, 2014. The Board will pursue this recommendation.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE APRIL 15, 2013

SENATE BILL No. 305

Introduced by Senator Price
(Principal coauthor: Assembly Member Gordon)

February 15, 2013

An act to amend Sections 2450, 2450.3, *2569, 3010.5, 3014.6,* 3685, 3686, 3710, ~~and~~ 3716, *and 3765*of, *and to add Section 144.5 to,* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 305, as amended, Price. Healing arts: boards.

Existing law requires specified regulatory boards within the Department of Consumer Affairs to require an applicant for licensure to furnish to the board a full set of fingerprints in order to conduct a criminal history record check.

This bill would additionally authorize those boards to request and receive from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation and would authorize a local or state agency to provide those records to the board upon request.

Existing law, the Osteopathic Act, ~~establishes the Osteopathic Medical Board of California, which issues certificates to, and regulates, osteopathic physicians and surgeons.~~ *provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California.*

This bill would require that the powers and duties of the board, as provided, be subject to review by the appropriate policy committees of the Legislature. The bill would require that *the* review be performed as

~~if those~~ *these* provisions were scheduled to be repealed as of January 1, 2018.

Existing law, the Naturopathic Doctors Act, *until January 1, 2014,* provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California. ~~Existing law repeals these provisions on January 1, 2014.~~ Existing law also specifies that the *repeal of the* committee ~~is subject~~ *subjects it* to review by the appropriate policy committees of the Legislature.

This bill would ~~instead repeal those provisions on January 1, 2018,~~ *extend the operation of these provisions until January 1, 2018,* and make conforming changes.

Existing law provides for the regulation of dispensing opticians, as defined, by the Medical Board of California.

This bill would require that the powers and duties of the board, as provided, be subject to review by the appropriate policy committees of the Legislature. The bill would require that the review be performed as if these provisions were scheduled to be repealed as of January 1, 2018.

Existing law, *the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. The Respiratory Care Act* provides for the licensure and regulation of respiratory care practitioners by the Respiratory Care Board of California. ~~Existing law~~ *Each of those acts* authorizes the board to employ an executive officer. Existing law repeals these provisions on January 1, 2014 and subjects the ~~board~~ *boards* to review by the Joint ~~Sunset Review Committee~~ *Committee on Boards, Commissions, and Consumer Protection.*

This bill would ~~instead repeal those provisions on January 1, 2018,~~ *extend the operation of these provisions until January 1, 2018,* and provide that the ~~committee is subject to~~ *repeal of these provisions subjects the boards to* review by the appropriate policy committees of the Legislature.

The Respiratory Care Act also prohibits a person from engaging in the practice of respiratory care unless he or she is a licensed respiratory care practitioner. However, the act does not prohibit specified acts, including, among others, the performance of respiratory care services in case of an emergency or self-care by a patient.

This bill would additionally authorize the performance of pulmonary function testing by persons who are currently employed by Los Angeles

county hospitals and have performed pulmonary function testing for at least 15 years.

This bill would make legislative findings and declarations as to the necessity of a special statute for the persons described above.

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

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

SECTION 1. Section 144.5 is added to the Business and Professions Code, to read:

144.5. Notwithstanding any other law, a board described in Section 144 may request, and is authorized to receive, from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation. A local or state agency may provide those records to the board upon request.

~~SECTION 1.~~

SEC. 2. Section 2450 of the Business and Professions Code is amended to read:

2450. There is a Board of Osteopathic Examiners of the State of California, established by the Osteopathic Act, which shall be known as the Osteopathic Medical Board of California which enforces this chapter relating to persons holding or applying for physician's and surgeon's certificates issued by the Osteopathic Medical Board of California under the Osteopathic Act.

Persons who elect to practice using the term of suffix "M.D.," as provided in Section 2275, shall not be subject to this article, and the Medical Board of California shall enforce the provisions of this chapter relating to persons who made the election.

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

~~SEC. 2.~~

SEC. 3. Section 2450.3 of the Business and Professions Code is amended to read:

2450.3. There is within the jurisdiction of the Osteopathic Medical Board of California a Naturopathic Medicine Committee authorized under the Naturopathic Doctors Act (Chapter 8.2 (commencing with Section 3610)). This section shall become inoperative on 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 provision of law, the repeal of this section renders the Naturopathic Medicine Committee subject to review by the appropriate policy committees of the Legislature.

SEC. 4. Section 2569 of the Business and Professions Code is amended to read:

2569. ~~The~~ *Notwithstanding any other law, the* powers and duties of the board, as set forth in this chapter, shall be subject to ~~the~~ review ~~required by Division 1.2 (commencing with Section 473).~~ *by the appropriate policy committees of the Legislature.* The review shall be performed as if this chapter were scheduled to be repealed as of January 1, ~~2014, as described in Section 473.1.~~ *2018.*

SEC. 5. 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.

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 Section 3010. The board may enforce any disciplinary actions undertaken by that board.

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

SEC. 6. Section 3014.6 of the Business and Professions Code is amended to read:

3014.6. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

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

~~SEC. 3.~~

SEC. 7. Section 3685 of the Business and Professions Code is amended to read:

3685. Notwithstanding any other law, the repeal of this chapter renders the committee subject to review by the appropriate policy committees of the Legislature.

~~SEC. 4.~~

SEC. 8. Section 3686 of the Business and Professions Code is amended to read:

3686. This chapter 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.

~~SEC. 5.~~

SEC. 9. Section 3710 of the Business and Professions Code is amended to read:

3710. (a) The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter.

(b) 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. 6.~~

SEC. 10. Section 3716 of the Business and Professions Code is amended to read:

3716. The board may employ an executive officer exempt from civil service and, subject to the provisions of law relating to civil service, clerical assistants and, except as provided in Section 159.5, other employees as it may deem necessary to carry out its powers and duties.

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.

SEC. 11. Section 3765 of the Business and Professions Code is amended to read:

3765. This act does not prohibit any of the following activities:

(a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.

(b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold himself or herself out to be a respiratory care practitioner licensed under the provisions of this chapter.

(c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.

(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their speciality.

(e) Respiratory care services in case of an emergency. "Emergency," as used in this subdivision, includes an epidemic or public disaster.

(f) Persons from engaging in cardiopulmonary research.

(g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.

(h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department of Health Services of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the board.

(i) The performance of pulmonary function testing by persons who are currently employed by Los Angeles county hospitals and have performed pulmonary function testing for at least 15 years.

SEC. 12. The Legislature finds and declares that a special law, as set forth in Section 11 of this act, is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances relating to persons who are currently employed by

Los Angeles county hospitals and have performed pulmonary function testing for at least 15 years.

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SB 352

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 352
Author:	Pavley
Bill Date:	April 10, 2013, Introduced
Subject:	Medical Assistants: Supervision
Sponsor:	California Academy of Physician Assistants (CAPA)

STATUS OF BILL:

This bill is on the Senate Third Reading File.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physician assistants (PAs), nurse practitioner (NPs) and certified nurse-midwives (CNMs) to supervise medical assistants (MAs)

ANALYSIS

MAs are unlicensed personnel trained to perform basic administrative, clerical, and technical support services in a medical office or clinical setting. These services include, but are not limited to, taking blood pressure, charting height and weight, administering medication, performing skin tests, and withdrawing blood by venipuncture. The Bureau of Labor and Statistics (2011) reports nearly 82,000 MAs are employed in California.

Currently, a physician must be present in the practice site to supervise an MA in most settings. PAs, NPs, and CNMs can currently supervise MAs in licensed community and free clinics. If a physician is not present, MAs are limited to performing administrative and clerical duties and cannot perform or assist with simple technical supportive services if the physician is not on the premises, except in community and free clinics. This means that in many settings, MAs cannot perform many of the tasks that they are qualified for and are needed to perform. This bill would allow PAs, NPs, and CNMs to supervise MAs in all settings.

According to the sponsors, physicians have been delegating the task of supervising MAs when the physician is not in the office for over a decade in community clinics and the Physician Assistant Board and the Department of Consumer Affairs have not reported any patient safety issues or disciplinary action related to PA supervision of MAs. The sponsors believe that this bill will eliminate legal restrictions and barriers to efficient coordinated care. The sponsors believe this change is necessary if California hopes to accommodate the dramatic increase in patients expected to result from health care reform.

With the health care reform being implemented in 2014, this bill may help to accommodate the expected increase in patients, as well as help to ensure that MAs are being supervised while a physician is not physically present in the office. Given that PAs, NPs, and NMs are currently allowed to supervise MAs in some settings now, and that this authority would have to be delegated by the physician, it makes sense for this to be allowed in all settings. However, existing law (BPC 2264) prohibits physicians from aiding and abetting unlicensed individuals from engaging in the practice of medicine. Board staff suggested that the Board take a Neutral position on this bill if it is amended to include language to ensure that if a PA, NP, or NM were to allow the MA to perform tasks that are not in the approved scope of responsibility, that the PA, NP, or NM would be held responsible and subject to discipline by their licensing board. The Executive Committee voted to support this bill if it is amended per staff recommendations.

FISCAL: None

SUPPORT: CAPA (sponsor)

OPPOSITION: None on file

POSITION: Executive Committee Recommendation: Support if Amended

AMENDED IN SENATE APRIL 10, 2013

SENATE BILL No. 352

Introduced by Senator Pavley
(Principal coauthor: Senator Hernandez)

February 20, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

SB 352, as amended, Pavley. Medical assistants: supervision.

Existing law authorizes a medical assistant to perform specified services relating to the administration of medication and performance of skin tests and simple routine medical tasks and procedures upon specific authorization from and under the supervision of a licensed physician and surgeon or podiatrist, or in a specified clinic upon specific authorization of a physician assistant, nurse practitioner, or nurse-midwife. *Existing law requires the Board of Registered Nursing to issue a certificate to practice nurse-midwifery to a qualifying applicant who is licensed pursuant to the Nursing Practice Act.*

This bill would delete the requirement that the services performed by the medical assistant be in a specified clinic when under the specific authorization of a physician assistant, nurse practitioner, or *certified* nurse-midwife. The bill would also delete several obsolete references and make other *conforming,* technical, *and* nonsubstantive changes.

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

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

SECTION 1. Section 2069 of the Business and Professions Code is amended to read:

2069. (a) (1) Notwithstanding any other ~~provision of~~ law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services ~~in a clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code~~ upon the specific authorization of a physician assistant, a nurse practitioner, or a *certified* nurse-midwife.

(2) The supervising physician and surgeon ~~at a clinic described in paragraph (1)~~ may, at his or her discretion, in consultation with the nurse practitioner, *certified* nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, *certified* nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the supervising physician and surgeon is not onsite, ~~so long as~~ *if either of* the following apply:

(A) The nurse practitioner or *certified* nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725, or protocol. The standardized procedures or protocol shall be developed and approved by the supervising physician and ~~surgeon,~~ *surgeon and* the nurse practitioner or *certified* nurse-midwife~~, and the facility administrator or his or her designee~~.

(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502 and is approved to do so by the supervising physician ~~or~~ *and* surgeon.

(b) As used in this section and Sections 2070 and 2071, the following definitions ~~shall~~ apply:

(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist,

or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a *certified* nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the ~~Division of Licensing~~ *board*. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

(2) "Specific authorization" means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the *certified* nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the *certified* nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

(3) "Supervision" means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

(C) A physician assistant, nurse practitioner, or *certified* nurse-midwife as provided in subdivision (a).

(4) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a *certified* nurse-midwife as provided in subdivision (a).

(c) Nothing in this section shall be construed as authorizing ~~the~~ *any of the following:*

(1) The licensure of medical assistants. ~~Nothing in this section shall be construed as authorizing the~~

(2) The administration of local anesthetic agents by a medical assistant. ~~Nothing in this section shall be construed as authorizing the division to~~

(3) The board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.

(4) A medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1200).

(5) A nurse practitioner, certified nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.

(d) Notwithstanding any other ~~provision of~~ law, a medical assistant ~~may~~ *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.

~~(e) Nothing in this section shall be construed as authorizing a medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1206.5). Nothing in this section shall be construed as authorizing a nurse practitioner, nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.~~

~~SECTION 1. Section 2069 of the Business and Professions Code is amended to read:~~

~~2069. (a) (1) Notwithstanding any other law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a nurse-midwife.~~

~~(2) The supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, nurse-midwife, or physician assistant, provide written instructions~~

~~to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the supervising physician and surgeon is not onsite, if either of the following apply:~~

~~(A) The nurse practitioner or nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725, or protocol. The standardized procedures or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner or nurse-midwife, and the facility administrator or his or her designee.~~

~~(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502 and is approved to do so by the supervising physician and surgeon.~~

~~(b) As used in this section and Sections 2070 and 2071, the following definitions apply:~~

~~(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.~~

~~(2) "Specific authorization" means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the~~

~~supervising podiatrist, or the physician assistant, the nurse practitioner, or the nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.~~

~~(3) "Supervision" means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:~~

~~(A) A licensed physician and surgeon.~~

~~(B) A licensed podiatrist.~~

~~(C) A physician assistant, nurse practitioner, or nurse-midwife as provided in subdivision (a).~~

~~(4) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a nurse-midwife as provided in subdivision (a).~~

~~(c) Nothing in this section shall be construed as authorizing any of the following:~~

~~(1) The licensure of medical assistants.~~

~~(2) The administration of local anesthetic agents by a medical assistant.~~

~~(3) The board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.~~

~~(e) Nothing in this section shall be construed as authorizing a medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1206.5). Nothing in this section shall be construed as authorizing a nurse practitioner, nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.~~

~~(d) Notwithstanding any other law, a medical assistant shall not be employed for inpatient care in a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code.~~

~~(4) A medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1200).~~

~~(5) A nurse practitioner, nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.~~

O

SB 491

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 491
Author:	Hernandez
Bill Date:	April 16, 2013, amended
Subject:	Nurse Practitioners
Sponsor:	Author

STATUS OF BILL:

This bill is in the Senate Business, Professions and Economic Development Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would make findings and declarations related to the role and importance of nurse practitioners (NPs). This bill would establish independent practice for NPs by removing provisions in existing law that require physician supervision through standardized procedures, collaboration or consultation with a physician. This bill would also expand the scope of practice for a NP and would allow a NP to order, furnish or prescribe drugs.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, NPs operate under standardized procedures, that are overseen by a supervising physician. NPs are advanced practice registered nurses (RNs) who have pursued higher education and certification as a NP. There are approximately 17,000 NPs licensed by the Board of Registered Nursing in California.

This bill would make findings and declarations regarding the role and importance of NPs. This bill would establish independent practice for NPs by removing provisions in existing law that require physician supervision through standardized procedures, collaboration or consultation with a physician. This bill would require a NP to maintain malpractice insurance. This bill would expand the scope of a NP and would allow a NP to do the following:

- Assess patients, synthesize and analyze data, and apply principles of health care.
- Manage the physical and psychosocial health status of patients.
- Analyze multiple sources of data, identify alternative possibilities as to the nature of a health care problem, and select, implement, and evaluate appropriate treatment.
- Examine patients and establish a medical diagnosis by client history, physical examination, and other criteria.
- Order, furnish, or prescribe drugs or devices, as specified.
- Refer patients to other health care providers, as specified.

- Delegate to a medical assistant.
- Perform additional acts that require education and training that are recognized by the nursing profession as proper to be performed by a NP.
- Order hospice care as appropriate.
- Perform procedures that are necessary and consistent with the NPs training and education.

As stated in the bullets above, this bill will allow NPs to refer a patient to a physician or other licensed health care provider if the referral will protect the health and welfare of the patient, and must consult with a physician or other licensed health care provider if a situation or condition occurs in a patient that is beyond the NPs knowledge and experience.

As stated in the bullets above, this bill would allow a NP to furnish order or prescribe drugs or devices if they are consistent with the practitioners education preparation or for which clinical competency has been established and maintained and the BRN has certified that the NP has satisfactorily completed a course in pharmacology covering the drugs or devices. An NP would not be allowed to furnish, order or prescribe a dangerous drug without an appropriate prior examination and a medical indication, unless one of the following applies:

- The NP was a designated practitioner serving in the absence of the patient's physician, podiatrist, or NP and the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but no longer than 72 hours.
- The NP transmitted the order for drugs to a RN or licensed vocational nurse (LVN) in an inpatient facility and the NP consulted with the RN or LVN who reviewed the patients records and the NP was designated as the practitioner to serve in the absence of the patient's physician, podiatrist or NP.
- The NP was a designated practitioner serving in the absence of the patient's physician, podiatrist, or NP and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount for more than one renewal.

Beginning on and after July 1, 2016, this bill would require an applicant for initial qualification or certification as a NP to hold a national certification as a NP from a national certifying body recognized by the BRN

According to the author, this bill will establish independent practice for NPs and enable them to perform all tasks and functions consistent with their education and training and would allow NPs to choose to see Medi-Cal patients. According to the author, the Institutes of Medicine and the National Council of State Boards of Nursing have recommended full practice for NPs. The author believe this package of bills will allow for better utilization of the existing infrastructure of trained medical providers to bridge the provider gap through expanded practice.

This bill significantly expands the scope of practice of a NP by establishing independent practice and deleting all provisions in existing law that currently require physician supervision, oversight, collaboration or consultation. NPs are well qualified to provide medical care when practicing under standardized procedures and physician supervision; however, the standardized procedures and physician supervision, collaboration, and consultation are in existing law to ensure that the patient care provided by a NP includes physician involvement and oversight, as physicians should be participating in the patient's care in order to ensure consumer protection. It is also unknown how this bill would affect corporate practice, as the bill does not address this issue. The Board's primary mission is consumer protection and by significantly expanding the scope of practice for a NP, patient care and consumer protection could be compromised. Board staff suggests that the Board oppose this bill, or oppose this bill unless it is amended to require collaboration with physicians.

FISCAL: None

SUPPORT: United Nurses Associations of California
Bay Area Council

OPPOSITION: California Medical Association
Various Individuals

POSITION: Recommendation: Oppose

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 491

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 2835.5, 2835.7, 2836.1, 2836.2, and 2836.3 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 491, as amended, Hernandez. Nurse practitioners.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing. Existing law requires an applicant for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including, among others, ordering durable medical equipment, and, in consultation with a physician and surgeon, ~~approve, sign, modify, or add~~ *approving, signing, modifying, or adding* to a plan of treatment or plan for an individual receiving home health services or personal care services.

This bill would revise these provisions by deleting the requirement that those acts be performed pursuant to a standardized procedure or in consultation with a physician and surgeon. The bill would also authorize a nurse practitioner to perform specified additional acts, including,

among others, ~~diagnosing patients, performing therapeutic procedures,~~ *examining patients and establishing a medical diagnosis* and prescribing drugs and devices. The bill would require that, on and after July 1, 2016, an applicant for initial qualification or certification as a nurse practitioner hold a national certification as a nurse practitioner from a national certifying body recognized by the board.

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

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

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

(a) Nurse practitioners are a longstanding, vital, safe, effective, and important part of the state's health care delivery system. They are especially important given California's shortage of physicians, with just 16 of 58 counties having the federally recommended ratio of physicians to residents.

(b) Nurse practitioners will play an especially important part in the implementation of the federal Patient Protection and Affordable Care Act, which will bring an estimated five million more Californians into the health care delivery system, because they will provide for greater access to primary care services in all areas of the state. This is particularly true for patients in medically underserved urban and rural communities.

(c) Due to the excellent safety and efficacy record that nurse practitioners have earned, the Institute of Medicine of the National Academy of Sciences has recommended full independent practice for nurse practitioners. Currently, 17 states allow nurse practitioners to practice to the full extent of their training and education with independent practice.

(d) Furthermore, nurse practitioners will assist in addressing the primary care provider shortage by removing delays in the provision of care that are created when dated regulations require a physician's signature or protocol before a patient can initiate treatment or obtain diagnostic tests that are ordered by a nurse practitioner.

SEC. 2. Section 2835.5 of the Business and Professions Code is amended to read:

2835.5. (a) A registered nurse who is holding himself or herself out as a nurse practitioner or who desires to hold himself or herself out as a nurse practitioner shall, within the time prescribed by the board and prior to his or her next license renewal or the issuance of an initial license, submit educational, experience, and other credentials and information as the board may require for it to determine that the person qualifies to use the title "nurse practitioner," pursuant to the standards and qualifications established by the board.

(b) Upon finding that a person is qualified to hold himself or herself out as a nurse practitioner, the board shall appropriately indicate on the license issued or renewed, that the person is qualified to use the title "nurse practitioner." The board shall also issue to each qualified person a certificate evidencing that the person is qualified to use the title "nurse practitioner."

(c) A person who has been found to be qualified by the board to use the title "nurse practitioner" prior to January 1, 2005, shall not be required to submit any further qualifications or information to the board and shall be deemed to have met the requirements of this section.

(d) 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:

(1) Hold a valid and active registered nursing license issued under this chapter.

(2) Possess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing.

(3) Satisfactorily complete a nurse practitioner program approved by the board.

(e) On and after July 1, 2016, an applicant for initial qualification or certification as a nurse practitioner shall, in addition, hold a national certification as a nurse practitioner from a national certifying body recognized by the board.

SEC. 3. Section 2835.7 of the Business and Professions Code is amended to read:

2835.7. (a) Notwithstanding any other law, in addition to any other practices authorized in statute or regulation, a nurse practitioner may do any of the following:

(1) Order durable medical equipment. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) After performance of a physical examination by the nurse practitioner, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(3) For individuals receiving home health services or personal care services, approve, sign, modify, or add to a plan of treatment or plan of care.

(4) Assess patients, synthesize and analyze data, and apply principles of health care ~~at an advanced level~~.

(5) Manage the physical and psychosocial health status of patients.

(6) Analyze multiple sources of data, identify alternative possibilities as to the nature of a health care problem, and select, implement, and evaluate appropriate treatment.

~~(7) Make independent decisions in treating health conditions.~~

~~(8) Diagnose patients and perform diagnostic and therapeutic procedures.~~

(7) Examine patients and establish a medical diagnosis by client history, physical examination, and other criteria.

~~(9)~~

(8) Order, furnish, or prescribe drugs or devices pursuant to Section 2836.1.

~~(10)~~

(9) Refer patients to other health care providers ~~when appropriate due to the limits of the nurse practitioner's knowledge, experience, or educational preparation.~~ *as provided in subdivision (b).*

~~(11)~~

(10) Delegate to a medical assistant.

~~(12)~~

(11) Perform additional acts that require education and training and that are recognized by the nursing profession as proper to be performed by a nurse practitioner.

~~(13)~~

(12) Order hospice care as appropriate.

~~(14)~~

(13) Perform procedures that are necessary and consistent with the nurse practitioner's training and education.

(b) A nurse practitioner shall refer a patient to a physician or another licensed health care provider if the referral will protect the health and welfare of the patient, and shall consult with a physician or other licensed health care provider if a situation or condition occurs in a patient that is beyond the nurse practitioner's knowledge and experience.

~~(b)~~

(c) A nurse practitioner shall maintain medical malpractice insurance.

SEC. 4. Section 2836.1 of the Business and Professions Code is amended to read:

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

~~(a)~~

(1) The drugs or devices that are furnished, ordered, or prescribed are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

~~(b) (1)~~

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

~~(2)~~

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

~~(c)~~

(b) A nurse practitioner shall not furnish, order, or prescribe a dangerous drug, as defined in Section 4022, without an appropriate prior examination and a medical indication, unless one of the following applies:

(1) The nurse practitioner was a designated practitioner serving in the absence of the patient's physician and surgeon, podiatrist,

or nurse practitioner, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

(2) The nurse practitioner transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The nurse practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The nurse practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon, podiatrist, or nurse practitioner, as the case may be.

(3) The nurse practitioner was a designated practitioner serving in the absence of the patient's physician and surgeon, podiatrist, or nurse practitioner, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with subdivision (b) of Section 120582 of the Health and Safety Code.

~~(d)~~

(c) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include the ordering of a drug or device.

~~(e)~~

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

SEC. 5. Section 2836.2 of the Business and Professions Code is amended to read:

2836.2. All nurse practitioners who are authorized pursuant to Section 2836.1 to prescribe, furnish, or issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.

SEC. 6. Section 2836.3 of the Business and Professions Code is amended to read:

2836.3. (a) The furnishing of drugs or devices by nurse practitioners is conditional on issuance by the board of a number to the nurse applicant who has successfully completed the requirements of *paragraph (2) of* subdivision (b) of Section 2836.1. The number shall be included on all transmittals of orders for drugs or devices by the nurse practitioner. The board shall make the list of numbers issued available to the Board of Pharmacy. The board may charge the applicant a fee to cover all necessary costs to implement this section.

(b) The number shall be renewable at the time of the applicant's registered nurse license renewal.

(c) The board may revoke, suspend, or deny issuance of the numbers for incompetence or gross negligence in the performance of functions specified in Sections 2836.1 and 2836.2.

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SB 492

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 492
Author:	Hernandez
Bill Date:	April 16, 2013 amended
Subject:	Optometrist Practice: Licensure
Sponsor:	Author

STATUS OF BILL:

This bill is in the Senate Business, Professions and Economic Development Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would delete the definition of the practice of optometry in existing law and would expand the scope of an optometrist by allowing an optometrist: to examine, prevent, diagnose, and treat any disease, condition, or disorder of the visual system, the human eye, and adjacent and related structures of the visual system; to perform minor surgical and nonsurgical primary care procedures; and to prescribe drugs, including narcotics, among other allowances.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, optometrists measure and correct vision and prescribe fit lenses, as well as provide some basic primary care services.

This bill would delete the definition of the practice of optometry in existing law and would expand the scope of an optometrist by allowing an optometrist to do the following:

- Examine, prevent, diagnose, and treat any disease, condition, or disorder of the visual system, the human eye, and adjacent and related structures of the visual system.
- Use or prescribe appropriate drugs, including narcotic substances other than those listed in Schedule I.
- Perform minor surgical and nonsurgical primary care procedures requiring no more than topical or local anesthetic, or both, consistent with an optometrist's education and training.
- Use or prescribe visual therapy, ocular exercises or vision habilitation, and rehabilitation services.
- Perform or order appropriate laboratory and diagnostic imaging tests.
- Administer immunizations.
- Diagnose other common primary care conditions that have ocular manifestations.

This bill would also allow an optometrist who is operating under a protocol with a physician, a health care facility, or participating in a medical home, accountable care organization, or other system of care in which the patient is being treated, to initiate treatment and manage medications for diagnosed conditions of the visual system and other common primary care conditions that have ocular manifestations.

This bill would require the State Board of Optometry (SBO) to establish, by regulation, educational and examination requirements for licensure to ensure the competence of optometrists. This bill would require applicants to successfully complete Part 1, Part II, and Part III examinations of the National Board of Examiners in Optometry in order to be licensed as an optometrist. This bill would also require applicants to successfully complete an examination in California law and ethics to be developed and administered by SBO. This bill would also allow SBO to require applicants to pass additional examinations to ensure the competency of optometrists to utilize diagnostic and therapeutic pharmaceutical agents, if not otherwise covered by the required examinations.

This bill significantly expands the scope of practice of an optometrist by allowing optometrists to examine, prevent, diagnose, and treat any disease, condition, or disorder of the visual system, human eye and "adjacent related structures of the visual system". This bill would allow an optometrist to prescribe controlled substances, as well as perform minor surgical and nonsurgical primary care procedures. This is a significant expansion of the scope of practice of an optometrist, that requires no physician supervision or consultation. Optometrists do not currently have the appropriate education, training, or experience to provide the types of services this bill would allow them to provide; this could put patients at serious risk of harm and significantly impact consumer protection. The Board's primary mission is consumer protection and by significantly expanding the scope of practice for an optometrist, patient care and consumer protection would be compromised. Board staff suggests that the Board oppose this bill.

FISCAL: None

SUPPORT: None known (at this time)

OPPOSITION: California Medical Association
Various Individuals

POSITION: Recommendation: Oppose

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL **No. 492**

Introduced by Senator Hernandez

February 21, 2013

An act to repeal and add Sections 3041 and 3041.2 of the Business and Professions Code, relating to optometry.

LEGISLATIVE COUNSEL'S DIGEST

SB 492, as amended, Hernandez. Optometrist: practice: licensure.

The Optometry Practice Act creates the State Board of Optometry, which licenses optometrists and regulates their practice. Existing law defines the practice of optometry to include, among other things, the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and doing certain things, including, but not limited to, the examination of the human eyes, the determination of the powers or range of human vision, and the prescribing of contact and spectacle lenses. Existing law provides that the State Board of Optometry is required, by regulation, to establish educational and examination requirements for licensure to ensure the competence of optometrists to practice. Any violation of the act is a crime.

This bill would delete the definition of the practice of optometry and would instead provide that a licensed optometrist would be authorized to perform certain health-related services, including, but not limited to, examining, preventing, diagnosing, and treating any disease, condition, or disorder of the visual system, the human eye, and adjacent and related structures *of the visual system*, prescribing appropriate drugs, including

narcotics, and administering immunizations *and to diagnose other common primary care conditions that have ocular manifestations. The bill would also authorize an optometrist, who is operating under a protocol with a physician and surgeon or a health care facility, or participating in a specified system of care in which the patient is being otherwise treated, to initiate treatment and manage medications for those diagnosed conditions.* The bill would require the board to require applicants for licensure to successfully complete specified examinations, and would authorize the board to require the passage of additional examinations with regard to competency to utilize diagnostic and therapeutic pharmaceutical agents, if not covered by the required examinations.

Because this bill would change the definition of a crime, it would create a state-mandated local program.

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

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

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

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

SECTION 1. Section 3041 of the Business and Professions Code is repealed.

SEC. 2. Section 3041 is added to the Business and Professions Code, to read:

3041. (a) An optometrist license authorizes the holder to do all of the following:

(1) Examine, prevent, diagnose, and treat any disease, condition, or disorder of the visual system, the human eye, and adjacent and related structures *of the visual system.*

(2) The use or prescription of appropriate drugs, including narcotic substances other than those listed in Schedule 1.

(3) The performance of *minor* surgical and nonsurgical primary *eye* care procedures requiring no more than topical or local anesthetic, or both, *consistent with an optometrist's education and training.*

(4) The use or prescription of visual therapy, ocular exercises or vision habilitation, and rehabilitation services.

(5) The performance or ordering of appropriate laboratory and diagnostic imaging tests.

(b) An optometrist may administer immunizations.

(c) In addition to diagnosing and treating conditions of the visual system pursuant to subdivision (a), an optometrist may diagnose other *common primary care* conditions that have ocular manifestations~~, initiate treatment, and, in consultation with a physician, manage medications for these conditions~~.

(d) In addition to the authority provided in subdivisions (a) to (c), inclusive, an optometrist who is operating under a protocol with a physician and surgeon or a health care facility, or participating in a medical home, accountable care organization, or other system of care in which the patient is being otherwise treated, may initiate treatment and manage medications for conditions diagnosed pursuant to subdivision (c).

SEC. 3. Section 3041.2 of the Business and Professions Code is repealed.

SEC. 4. Section 3041.2 is added to the Business and Professions Code, to read:

3041.2. (a) The State Board of Optometry shall establish, by regulation, educational and examination requirements for licensure to ensure the competence of optometrists to practice.

(b) On and after January 1, 2014, the board shall require each applicant for licensure to successfully complete the Part I, Part II, and Part III examinations of the National Board of Examiners in Optometry.

(c) On and after January 1, 2014, the board shall require each applicant for licensure to successfully complete an examination in California law and ethics developed and administered by the board.

(d) On and after January 1, 2014, the board may require passage of additional examinations to ensure the competency of licentiates to utilize diagnostic and therapeutic pharmaceutical agents, if not otherwise covered by the examinations required pursuant to subdivisions (a) and (b).

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school

district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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SB 493

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 493
Author:	Hernandez
Bill Date:	April 1, 2013 amended
Subject:	Pharmacy Practice
Sponsor:	Author

STATUS OF BILL:

This bill is in the Senate Business, Professions and Economic Development Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a pharmacists to furnish medication, order and interpret tests, and furnish self-administered hormonal contraceptives, initiate and administer vaccines, and furnish prescription smoking cessation drugs and devices. This bill would establish an Advanced Practice Pharmacist (APP) recognition. This bill would allow an APP to perform physical assessments and if operating under a protocol, it would allow an APP to initiate, adjust, or discontinue drug therapy and participate in the evaluation and management of disease and health conditions.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, pharmacists provide patient care that optimized medication therapy.

This bill expands the scope of a pharmacist by allowing a pharmacist to do the following:

- Provide training and education to patients about drug therapy, disease management, and disease prevention.
- Participate in multidisciplinary review of patient progress, including access to medical records.
- Furnish emergency contraception drug therapy and self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by the Board of Pharmacy (BOP) and the Medical Board of California (Board).
- Furnish prescription smoking cessation drugs and devices - The pharmacist must maintain records of drugs and devices furnished for three years, notify the patient's primary care provider, be certified in smoking cessation therapy, and complete one

hour of continuing education focused on smoking cessation therapy biennially.

- Furnish Prescription medications not requiring a diagnosis that are recommended by the federal Centers for Disease Control and Prevention for individuals traveling outside of the United States.
- Independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices - A pharmacist must complete an immunization training program, be certified in basic life support, and comply with all state and federal recordkeeping reporting requirements, in order to initiate and administer an immunization.

This bill would require the BOP and the Board to develop standardized procedures or protocols for emergency contraception drug therapy and self-administered hormonal contraceptives. This bill would authorize both the BOP and the Board to ensure compliance with procedures or protocols, with respect to the appropriate licensees.

This bill would establish an APP, which means a pharmacist who as been recognized as APP by BOP. An APP may perform physical assessments; order and interpret drug therapy-related tests; and refer patients to other health care providers. An APP who is acting in collaboration with the patient's health care providers, operating under a protocol with a physician, health care facility, or health plan or disability insurer, or participating in a medical home, accountable care organization, or other system of care, may do the following:

- Initiate, adjust, or discontinue drug therapy. Adjust means changing the dosage, duration, frequency, or potency of a drug. An APP must transmit written notification to the patient's diagnosing provider or enter the appropriate information in a patient record system shared with the prescriber. This bill would also require a pharmacist to register with the federal Drug Enforcement Administration.
- Participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers.

This bill would require a pharmacist who seeks recognition as an APP to meet the following requirements:

- Hold an active license to practice pharmacy that is in good standing.
- Either earn certification in a relevant area of practice from an organization approved by a BOP-recognized accrediting agency or another entity recognized by BOP; or complete a one-year postgraduate residency where at least 50 percent of the experience includes the provision of direct patient care services with interdisciplinary teams; or have actively managed patients for at least one year under a collaborative practice agreement or protocol with a physician, APP, pharmacist practicing collaborative drug therapy management, or a health system.
- File an application with BOP for recognition as an APP and pay the applicable fee to BOP.
- An APP must complete 10 hours of continuing education each renewal cycle in one or more areas of practice relevant to the pharmacists clinical practice.

This bill would expand the scope of a pharmacist and create a new APP recognition category. Currently, pharmacists do provide education to patients regarding drug therapy, and allowing this to be expanded would help in the implementation of the Affordable Care Act. Allowing pharmacists to furnish self-administered hormonal contraceptives in accordance with standardized procedures developed by BOP, the Board, and stakeholders and allowing pharmacists to furnish some smoking cessation drugs and devices also makes sense and is in line with their scope (some drugs that are known to have side effects could be exempted from this provision). Allowing pharmacists to initiate and administer routine vaccines also seems to reasonable.

However, allowing for an APP recognition and allowing an APP to initiate, adjust, or discontinue drug therapy is a significant expansion of the scope of practice. The APP would only be required to notify the prescribing physician if the drug therapy was discontinued or adjusted. The criteria for APP recognition is very broad, and could be as little as working with another APP for a year. This would allow the APP to make treatment decisions without having the benefit of knowing of the patient's medical history or the reason behind the physician's decision for the particular drug therapy choice. This is a significant expansion of the scope of practice of pharmacist, and allowing an APP to discontinue or adjust the drug therapy could put patients at serious risk of harm and significantly impact consumer protection. The Board's primary mission is consumer protection and by significantly expanding the scope of practice for a pharmacist, patient care and consumer protection could be compromised. Board staff suggests that the Board oppose this bill unless it is amended to remove the APP recognition and related expanded scope expansion from the bill, or is significantly amended to require physician supervision or collaboration so it would not allow totally independent practice regarding the drug therapy and prescribing authority.

FISCAL: Minimal and absorbable workload to help develop standardized procedures.

SUPPORT: None known (at this time)

OPPOSITION: California Medical Association
Various Individuals

POSITION: Recommendation: Oppose Unless Amended

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL **No. 493**

Introduced by Senator Hernandez

February 21, 2013

An act to amend ~~Section 4050 of~~ *Sections 733, 4050, 4051, 4052, 4052.3, and 4060 of, and to add Sections 4016.5, 4052.6, 4052.8, 4052.9, 4210, and 4233 to,* the Business and Professions Code, relating to ~~pharmacies~~ *pharmacy*.

LEGISLATIVE COUNSEL'S DIGEST

SB 493, as amended, Hernandez. Pharmacy practice.

The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy in the Department of Consumer Affairs~~, and states that pharmacy practice is a dynamic, patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use and drug-related therapy~~. *The law specifies the functions pharmacists are authorized to perform, including to administer, orally or topically, drugs and biologicals pursuant to a prescriber's order, and to administer immunizations pursuant to a protocol with a prescriber. Pharmacists may also furnish emergency contraception drug therapy pursuant to standardized procedures if they have completed a training program. A violation of the Pharmacy Law is a crime.*

~~This bill would make a technical, nonsubstantive change to that provision.~~

This bill, instead, would authorize a pharmacist to administer drugs and biological products that have been ordered by a prescriber. The bill would expand other functions pharmacists are authorized to

perform, including, among other things, to furnish self-administered hormonal contraceptives, prescription smoking-cessation drugs, and prescription medications not requiring a diagnosis that are recommended for international travelers, as specified. Additionally, the bill would authorize pharmacists to order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies, and to independently initiate and administer routine vaccinations, as specified. This bill also would establish board recognition for an advanced practice pharmacist, as defined, would specify the criteria for that recognition, and would specify additional functions that may be performed by an advanced practice pharmacist, including, among other things, performing physical assessments, and certain other functions, as specified. Because a violation of these provisions would be a crime, the bill would impose a state-mandated local program.

The bill would make other conforming and technical changes.

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

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

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

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

SECTION 1. Section 733 of the Business and Professions Code is amended to read:

733. (a) ~~No~~ *A* licentiate shall *not* obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. A violation of this section constitutes unprofessional conduct by the licentiate and shall subject the licentiate to disciplinary or administrative action by his or her licensing agency.

(b) Notwithstanding any other ~~provision of~~ law, a licentiate shall dispense drugs and devices, as described in subdivision (a) of Section 4024, pursuant to a lawful order or prescription unless one of the following circumstances exists:

(1) Based solely on the licentiate's professional training and judgment, dispensing pursuant to the order or the prescription is contrary to law, or the licentiate determines that the prescribed drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

(2) The prescription drug or device is not in stock. If an order, other than an order described in Section 4019, or prescription cannot be dispensed because the drug or device is not in stock, the licentiate shall take one of the following actions:

(A) Immediately notify the patient and arrange for the drug or device to be delivered to the site or directly to the patient in a timely manner.

(B) Promptly transfer the prescription to another pharmacy known to stock the prescription drug or device that is near enough to the site from which the prescription or order is transferred, to ensure the patient has timely access to the drug or device.

(C) Return the prescription to the patient and refer the patient. The licentiate shall make a reasonable effort to refer the patient to a pharmacy that stocks the prescription drug or device that is near enough to the referring site to ensure that the patient has timely access to the drug or device.

(3) The licentiate refuses on ethical, moral, or religious grounds to dispense a drug or device pursuant to an order or prescription. A licentiate may decline to dispense a prescription drug or device on this basis only if the licentiate has previously notified his or her employer, in writing, of the drug or class of drugs to which he or she objects, and the licentiate's employer can, without creating undue hardship, provide a reasonable accommodation of the licentiate's objection. The licentiate's employer shall establish protocols that ensure that the patient has timely access to the prescribed drug or device despite the licentiate's refusal to dispense the prescription or order. For purposes of this section, "reasonable accommodation" and "undue hardship" shall have the same meaning as applied to those terms pursuant to subdivision (*l*) of Section 12940 of the Government Code.

(c) For the purposes of this section, "prescription drug or device" has the same meaning as the definition in Section 4022.

(d) ~~The provisions of this section shall apply to the~~ *This section applies to emergency contraception* drug therapy *and*

self-administered hormonal contraceptives described in Section 4052.3.

(e) This section imposes no duty on a licentiate to dispense a drug or device pursuant to a prescription or order without payment for the drug or device, including payment directly by the patient or through a third-party payer accepted by the licentiate or payment of any required copayment by the patient.

(f) The notice to consumers required by Section 4122 shall include a statement that describes patients' rights relative to the requirements of this section.

SEC. 2. Section 4016.5 is added to the Business and Professions Code, to read:

4016.5. "Advanced practice pharmacist" means a licensed pharmacist who has been recognized as an advanced practice pharmacist by the board, pursuant to Section 4210. A board-recognized advanced practice pharmacist is entitled to practice advanced practice pharmacy as described in Section 4052.6, within or outside of a licensed pharmacy as authorized by this chapter.

~~SECTION 1.~~

SEC. 3. Section 4050 of the Business and Professions Code is amended to read:

4050. (a) In recognition of and consistent with the decisions of the appellate courts of this state, the Legislature hereby declares the practice of pharmacy to be a profession.

(b) Pharmacy practice is a dynamic, patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use, drug-related therapy, and communication for clinical and consultative purposes. Pharmacy practice is continually evolving to include more sophisticated and comprehensive patient care activities.

(c) The Legislature further declares that pharmacists are health care providers who have the authority to provide health care services.

SEC. 4. Section 4051 of the Business and Professions Code is amended to read:

4051. (a) Except as otherwise provided in this chapter, it is unlawful for any person to manufacture, compound, furnish, sell, or dispense ~~any~~ *a* dangerous drug or dangerous device, or to

dispense or compound ~~any~~ *a* prescription pursuant to Section 4040 of a prescriber unless he or she is a pharmacist under this chapter.

(b) Notwithstanding any other law, a pharmacist may authorize the initiation of a prescription, pursuant to Section 4052.1, 4052.2, ~~or~~ 4052.3, *or 4052.6,* and otherwise provide clinical advice ~~or~~, *services,* information, or patient consultation, *as set forth in this chapter,* if all of the following conditions are met:

(1) The clinical advice ~~or~~, *services,* information, or patient consultation is provided to a health care professional or to a patient.

(2) The pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice.

(3) Access to the information described in paragraph (2) is secure from unauthorized access and use.

SEC. 5. Section 4052 of the Business and Professions Code is amended to read:

4052. (a) Notwithstanding any other ~~provision of~~ law, a pharmacist may:

(1) Furnish a reasonable quantity of compounded drug product to a prescriber for office use by the prescriber.

(2) Transmit a valid prescription to another pharmacist.

(3) Administer~~, orally or topically, drugs and biologicals pursuant to a prescriber's order~~ *drugs and biological products that have been ordered by a prescriber.*

(4) Perform procedures or functions in a licensed health care facility as authorized by Section 4052.1.

(5) Perform procedures or functions as part of the care provided by a health care facility, a licensed home health agency, a licensed clinic in which there is a physician oversight, a provider who contracts with a licensed health care service plan with regard to the care or services provided to the enrollees of that health care service plan, or a physician, as authorized by Section 4052.2.

(6) Perform procedures or functions as authorized by Section 4052.6.

~~(6)~~

(7) Manufacture, measure, fit to the patient, or sell and repair dangerous devices, or furnish instructions to the patient or the patient's representative concerning the use of those devices.

~~(7)~~

(8) Provide consultation, *training, and education* to patients ~~and~~ *about drug therapy, disease management, and disease prevention.*

(9) Provide professional information, including clinical or pharmacological information, advice, or consultation to other health care professionals, *and participate in multidisciplinary review of patient progress, including appropriate access to medical records.*

~~(8) Furnish emergency~~

(10) Furnish the following medications:

(A) Emergency contraception drug therapy *and self-administered hormonal contraceptives,* as authorized by Section 4052.3.

(B) Prescription smoking-cessation drugs and devices, as authorized by Section 4052.9.

(C) Prescription medications not requiring a diagnosis that are recommended by the federal Centers for Disease Control and Prevention for individuals traveling outside of the United States.

~~(9)~~

(11) Administer immunizations pursuant to a protocol with a prescriber.

(12) Order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies.

(b) A pharmacist who is authorized to issue an order to initiate or adjust a controlled substance therapy pursuant to this section shall personally register with the federal Drug Enforcement Administration.

~~(c) Nothing in this section shall affect the requirements of existing law relating to maintaining the confidentiality of medical records.~~

~~(d) Nothing in this section shall affect the requirements of existing law relating to the licensing of a health care facility.~~

(c) This section does not affect the applicable requirements of law relating to either of the following:

(1) Maintaining the confidentiality of medical records.

(2) The licensing of a health care facility.

SEC. 6. Section 4052.3 of the Business and Professions Code is amended to read:

4052.3. (a) *(1) Notwithstanding any other law, a pharmacist may furnish self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed*

and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. The standardized procedure or protocol shall require that the patient use a self-screening tool, based on the United States Medical Eligibility Criteria (USMEC) for Contraceptive Use developed by the federal Centers for Disease Control and Prevention, and that the pharmacist refer the patient to the patient's primary care provider or, if the patient does not have a primary care provider, to nearby clinics.

(2) The board and the Medical Board of California are both authorized to ensure compliance with this subdivision, and each board is specifically charged with the enforcement of this subdivision with respect to its respective licensees. This subdivision does not expand the authority of a pharmacist to prescribe any prescription medication.

(b) (1) Notwithstanding any other ~~provision of~~ law, a pharmacist may furnish emergency contraception drug therapy in accordance with either of the following:

~~(1)~~

(A) Standardized procedures or protocols developed by the pharmacist and an authorized prescriber who is acting within his or her scope of practice.

~~(2)~~

(B) Standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American ~~College~~ *Congress* of Obstetricians and Gynecologists, the California ~~Pharmacist~~ *Pharmacists* Association, and other appropriate entities. ~~Both the~~ *The* board and the Medical Board of California ~~shall have authority~~ *are both authorized* to ensure compliance with this clause, and ~~both boards are~~ *each board is* specifically charged with the enforcement of this provision with respect to ~~their~~ *its* respective licensees. ~~Nothing in this clause shall be construed to~~ *This subdivision does not* expand the authority of a pharmacist to prescribe any prescription medication.

~~(b)~~

(2) Prior to performing a procedure authorized under this ~~paragraph~~ *subdivision*, a pharmacist shall complete a training

program on emergency contraception that consists of at least one hour of approved continuing education on emergency contraception drug therapy.

~~(c)~~

(3) A pharmacist, pharmacist's employer, or pharmacist's agent ~~may~~ *shall* not directly charge a patient a separate consultation fee for emergency contraception drug therapy services initiated pursuant to this ~~paragraph~~ *subdivision*, but may charge an administrative fee not to exceed ten dollars ($10) above the retail cost of the drug. Upon an oral, telephonic, electronic, or written request from a patient or customer, a pharmacist or pharmacist's employee shall disclose the total retail price that a consumer would pay for emergency contraception drug therapy. As used in this ~~subparagraph~~ *paragraph*, total retail price includes providing the consumer with specific information regarding the price of the emergency contraception drugs and the price of the administrative fee charged. This limitation is not intended to interfere with other contractually agreed-upon terms between a pharmacist, a pharmacist's employer, or a pharmacist's agent, and a health care service plan or insurer. Patients who are insured or covered and receive a pharmacy benefit that covers the cost of emergency contraception shall not be required to pay an administrative fee. These patients shall be required to pay copayments pursuant to the terms and conditions of their coverage. ~~The provisions of this subparagraph shall cease to be operative~~ *This paragraph shall become inoperative* for dedicated emergency contraception drugs ~~when~~ *if* these drugs are reclassified as over-the-counter products by the federal Food and Drug Administration.

~~(d)~~

(4) A pharmacist ~~may~~ *shall* not require a patient to provide individually identifiable medical information that is not specified in Section 1707.1 of Title 16 of the California Code of Regulations before initiating emergency contraception drug therapy pursuant to this ~~section~~ *subdivision*.

~~(e)~~

(c) For each emergency contraception drug therapy *or self-administered hormonal contraception* initiated pursuant to this section, the pharmacist shall provide the recipient of the ~~emergency contraception drugs~~ *drug* with a standardized factsheet that includes, but is not limited to, the indications *and*

contraindications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. The board shall develop this form in consultation with the State Department of Public Health, the American ~~College~~ *Congress* of Obstetricians and Gynecologists, the California Pharmacists Association, and other health care organizations. ~~The provisions of this section do~~ *This section does* not preclude the use of existing publications developed by nationally recognized medical organizations.

SEC. 7. Section 4052.6 is added to the Business and Professions Code, to read:

4052.6. (a) A pharmacist recognized by the board as an advanced practice pharmacist may do all of the following:

(1) Perform physical assessments.

(2) Order and interpret drug therapy-related tests.

(3) Refer patients to other health care providers.

(b) In addition to the authority provided in subdivision (a), a pharmacist recognized as an advanced practice pharmacist who is acting in collaboration with a patient's health care providers, operating under a protocol with a physician, health care facility, or health plan or disability insurer, or participating in a medical home, accountable care organization, or other system of care, may do both of the following:

(1) Initiate, adjust, or discontinue drug therapy. As used in this section, "adjust" means changing the dosage, duration, frequency, or potency of a drug.

(2) Participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers.

(c) A pharmacist who adjusts or discontinues drug therapy shall promptly transmit written notification to the patient's diagnosing prescriber or enter the appropriate information in a patient record system shared with the prescriber. A pharmacist who initiates drug therapy shall promptly transmit written notification to, or enter the appropriate information into, a patient record system shared with the patient's primary care provider or diagnosing provider, as appropriate.

(d) This section shall not interfere with a physician's order to dispense a prescription drug as written, or other order of similar meaning.

(e) Prior to initiating or adjusting a controlled substance therapy pursuant to this section, a pharmacist shall personally register with the federal Drug Enforcement Administration.

SEC. 8. Section 4052.8 is added to the Business and Professions Code, to read:

4052.8. (a) In addition to the authority provided in paragraph (9) of subdivision (a) of Section 4052, a pharmacist may independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC) for persons three years of age and older.

(b) In order to initiate and administer an immunization described in subdivision (a), a pharmacist shall do all of the following:

(1) Complete an immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and shall maintain that training.

(2) Be certified in basic life support.

(3) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.

(c) A pharmacist administering immunizations pursuant to this section, or paragraph (9) of subdivision (a) of Section 4052, may also initiate and administer epinephrine or diphenhydramine by injection for the treatment of a severe allergic reaction.

SEC. 9. Section 4052.9 is added to the Business and Professions Code, to read:

4052.9. A pharmacist may furnish prescription smoking-cessation drugs and devices, and provide smoking-cessation services if all of the following conditions are met:

(a) The pharmacist maintains records of all prescription drugs and devices furnished for a period of at least three years for

purposes of notifying other health care providers and monitoring the patient.

(b) The pharmacist notifies the patient's primary care provider of any drugs or devices furnished to the patient. If the patient does not have a primary care provider, the pharmacist provides the patient with a written record of the drugs or devices furnished and advises the patient to consult a physician of the patient's choice.

(c) The pharmacist is certified in smoking-cessation therapy by an organization recognized by the board.

(d) The pharmacist completes one hour of continuing education focused on smoking-cessation therapy biennially.

SEC. 10. Section 4060 of the Business and Professions Code is amended to read:

4060. ~~No~~ *A* person shall *not* possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to ~~either~~ Section 4052.1 ~~or~~, 4052.2, *or 4052.6*. This section ~~shall~~ *does* not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, ~~when~~ *if* in stock in containers correctly labeled with the name and address of the supplier or producer.

~~Nothing in this section authorizes~~

This section does not authorize a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

SEC. 11. Section 4210 is added to the Business and Professions Code, to read:

4210. (a) A person who seeks recognition as an advanced practice pharmacist shall meet all of the following requirements:

(1) Hold an active license to practice pharmacy issued pursuant to this chapter that is in good standing.

(2) Satisfy any one of the following criteria:

(A) Earn certification in a relevant area of practice from an organization approved by a board-recognized accrediting agency or another entity recognized by the board.

(B) Complete a one-year postgraduate residency where at least 50 percent of the experience includes the provision of direct patient care services with interdisciplinary teams.

(C) Have actively managed patients for at least one year under a collaborative practice agreement or protocol with a physician, advanced practice pharmacist, pharmacist practicing collaborative drug therapy management, or health system.

(3) File an application with the board for recognition as an advanced practice pharmacist.

(4) Pay the applicable fee to the board.

(b) An advanced practice pharmacist recognition issued pursuant to this section shall be valid for two years, coterminous with the certificate holder's license to practice pharmacy.

SEC. 12. Section 4233 is added to the Business and Professions Code, to read:

4233. A pharmacist who is recognized as an advanced practice pharmacist shall complete 10 hours of continuing education each renewal cycle in addition to the requirements of Section 4231. The subject matter shall be in one or more areas of practice relevant to the pharmacist's clinical practice.

SEC. 13. 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.

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SB 670

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 670
Author:	Steinberg
Bill Date:	April 8, 2013, Amended
Subject:	Physicians: Drug Prescribing Privileges: Investigation
Sponsor:	Author

STATUS OF BILL:

This bill is in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize the Medical Board of California (the Board) to inspect the medical records of a patient who dies of a prescription drug overdose without the consent of the patient's next of kin or a court order. This bill would make it unprofessional conduct, for a licensee who is under investigation, if the licensee fails to attend and participate in an interview of the Board within 30 days of notification from the Board. Lastly, this bill would allow the Board to impose limitations on the authority of a physician to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is a reasonable suspicion that the physician is overprescribing drugs or whose prescribing has resulted in the death of a patient.

ANALYSIS:

Currently, if the Board is investigating a physician whose patient has died, the Board must receive written authorization by the patient's next of kin in order to obtain the patient's medical records. The Board needs the medical records in order to determine if a physician is prescribing appropriately. If the Board cannot obtain the medical records, it has to go to court to get those records through a subpoena and it must be proven that there is a compelling state need in order to obtain those records through a subpoena. In the past, prescription drug monitoring data (from CURES) has not been successful in compelling the state to release those records.

The Board has reason to believe that numerous deaths have occurred in California that are related to prescription drug overdoses. However, complaints regarding drug-related offenses are often hard for the Board to obtain. In most instances, patients who are receiving prescription drugs in a manner that is not within the standard of practice, are unlikely to make a complaint to the Board. Some complaints regarding overprescribing come from anonymous tips, which usually do not have enough information to allow forwarding to the Board's district office for investigation, as there is no patient to obtain records for or not enough information to

open an investigation. Family members of patients may make a complaint to the Board; however, the Board must have a patient release in order to obtain medical records or seek a subpoena. Sometimes it is difficult to obtain evidence to warrant a subpoena, or the family is not responsive.

This bill would allow the Board to obtain medical records without a written release by the patient's next of kin or a court order if the board receives a report from a coroner or a peer review report that involves the death of a patient from a prescription drug overdose. This will allow the Board to move forward with its investigation in a more expedient manner, and help to ensure consumer protection.

In the Board's 2012 Sunset Review Report, information was included related to existing law regarding unprofessional conduct and physician interviews. Existing law provides that it only constitutes unprofessional conduct if a physician repeatedly fails to come to the interview that has been scheduled by "mutual agreement" of the physician and the Board. Although the existing statute was well intended, it has been infective in reducing the time it takes to complete an interview with a licensee and in fact may have resulted in physicians failing to agree to any interview with the Board. The report recommended that no more than thirty days should elapse between the time the interview is requested and completed.

This bill would require a physician to attend and participate in an interview within 30 days of notification from the Board.

Requiring the interview to be conducted within 30 days will significantly reduce the timeline for the physician interview and will force the physician to agree to an interview time.

Currently, in order for the Board to stop a physician from practicing while the physician is under investigation, the Board must request an Interim Suspension Order (ISO), which must be granted by an Administrative Law Judge (ALJ). An ISO is considered extraordinary relief and the Board must prove that a physician's continued practice presents an immediate danger to public health, safety, or welfare. In addition, there is a 15-day time restraint in law to file an accusation after being granted an ISO, and a 30-day time restraint between the accusation being filed and a hearing being set, which means an investigation must be nearly complete in order to file for an ISO. The Board can currently only restrict a physician from prescribing if the physician is under probation and limits on prescribing are part of the terms and conditions of that probation that has been adopted or stipulated to by the Board.

This bill would require the Board to impose limitations on the authority of physician to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is a reasonable suspicion that the physician has overprescribed drugs or engaged in prescribing behavior that has resulted in the death of a patient.

This would give the Board authority to stop physicians from prescribing drugs if the Board is investigating the physician and believes the physician is overprescribing or their prescribing has resulted in the death of the patient. However, the process for when and in what circumstances that Board could put this type of a restriction on the physicians would need to be spelled out in this bill or in regulations. Also, it is not clear in the bill if there would be due process given to the physician if the Board were to impose limitations on a physician's prescribing privileges.

The author introduced this bill due to the Los Angeles Times investigation that uncovered significant issues with physicians, overprescribing and patient deaths. This bill will help to speed up investigations in cases where patients have died as a result of prescription drug overdose. This bill will also make improvements to the Board's enforcement process, which will result in timelier investigations. Board staff suggests that the Board support this bill if it is amended to make it clear when and how the Board can impose limitations on a physician's prescribing privileges and the due process afforded to the physician.

FISCAL: Minimal and absorbable

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support if Amended

AMENDED IN SENATE APRIL 8, 2013

SENATE BILL **No. 670**

Introduced by Senator Steinberg

February 22, 2013

An act *to amend Sections 2225 and 2234 of, and to add Section 2221.5 to, the Business and Professions Code, and* to amend Section 11529 of the Government Code, relating to ~~administrative adjudication~~ *healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

SB 670, as amended, Steinberg. ~~Medical Quality Hearing Panel: limitation on licensee authority: controlled substances.~~ *Physicians and surgeons: drug prescribing privileges: investigation.*

(1) Existing law authorizes investigators and representatives of the Medical Board of California, among others, to inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, and to inspect documents relevant to those investigations, including the inspection and copying of any document relevant to an investigation where patient consent is given.

Existing law requires specified persons, including the administrator of a peer review body, to file a report with the board within 15 days after the effective date of any specified action taken against a licensee for a medical disciplinary cause or reason. Existing law also requires a coroner to make a report to the board, among other specified entities, when he or she receives information that indicates that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence.

This bill would authorize the board, if it receives a report pursuant to either of the provisions described above that involves the death of a patient from a prescription drug overdose, to inspect and copy the medical records of the deceased patient without the consent of the patient's next of kin or a court order in order to determine the extent to which the death was the result of a prescriber's inappropriate conduct.

(2) Existing law requires the board to take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct is defined for this purpose to include, among other things, the repeated failure by a licensee who is the subject of a board investigation, in the absence of good cause, to attend and participate in an interview scheduled by the mutual agreement of the licensee and the board.

This bill would revise that definition of unprofessional conduct to include the failure by a licensee who is the subject of a board investigation, in the absence of good cause, to attend and participate in an interview scheduled within 30 days of notification from the board.

(3) Existing law, the Administrative Procedure Act, authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an interim order suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other licensee restrictions.

This bill would further authorize the administrative law judge to issue an interim order limiting the authority to prescribe, furnish, administer, or dispense controlled substances. The bill would also ~~declare the intent of the Legislature to enact legislation that would significantly reduce the time in which a disciplinary proceeding against a physician is adjudicated, if the proceeding involves a patient who has died as a result of the overprescribing of controlled substances~~ *require the board, notwithstanding the authority of an administrative law judge to issue an interim order, to impose limitations on the authority of a physician and surgeon to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is a reasonable suspicion that the physician and surgeon has engaged in overprescribing drugs or other behavior related to his or her drug prescribing privileges that has resulted in the death of a patient.*

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

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

~~SECTION 1. It is the intent of the Legislature to enact legislation that would significantly reduce the time in which a disciplinary proceeding against a physician is adjudicated, if the proceeding involves a patient who has died as a result of the overprescribing of controlled substances.~~

SECTION 1. Section 2221.5 is added to the Business and Professions Code, to read:

2221.5. Notwithstanding Section 11529 of the Government Code, the board shall impose limitations on the authority of a physician and surgeon to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is a reasonable suspicion that the physician and surgeon has engaged in either of the following:

(a) Overprescribing drugs.

(b) Other behavior related to his or her drug prescribing privileges that has resulted in the death of a patient.

SEC. 2. Section 2225 of the Business and Professions Code is amended to read:

2225. (a) Notwithstanding Section 2263 and any other ~~provision of~~ law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any patients whose records are reviewed and ~~may~~ *shall* not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

(b) Notwithstanding any other ~~provision of~~ law, the Attorney General and his or her investigative agents, and investigators and

representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied ~~where~~ *if* relevant to an investigation of a licensee.

(c) Notwithstanding subdivision (b) or any other law, if the board receives a report pursuant to Section 802.5 or 805 that involves the death of a patient from a prescription drug overdose, the board may inspect and copy the medical records of the deceased patient without the consent of the patient's next of kin or a court order in order to determine the extent to which the death was the result of a prescriber's inappropriate conduct.

~~(c)~~

(d) In all cases ~~where~~ *in which* documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

~~(d) Where~~

(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, ~~they~~ *the documents* shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

~~(e)~~

(f) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

SEC. 3. Section 2234 of the Business and Professions Code is amended to read:

2234. The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption ~~which~~ *that* is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct ~~which~~ *that* would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

(h) The ~~repeated~~ failure by a certificate holder, in the absence of good cause, to attend and participate in an interview scheduled ~~by the mutual agreement of the certificate holder and~~ *within 30 days of notification from* the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

~~SEC. 2.~~

SEC. 4. Section 11529 of the Government Code is amended to read:

11529. (a) The administrative law judge of the Medical Quality Hearing Panel established pursuant to Section 11371 may issue an interim order suspending a license, imposing drug testing, continuing education, supervision of procedures, limitations on the authority to prescribe, furnish, administer, or dispense controlled substances, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare.

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

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

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

(1) To be represented by counsel.

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

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

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

(4) To present oral argument.

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

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

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

(f) In all cases ~~where~~ *in which* an interim order is issued, and an accusation is not filed and served pursuant to Sections 11503 and 11505 within 15 days of the date ~~in~~ *on* which the parties to the hearing on the interim order have submitted the matter, the order shall be dissolved.

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

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

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

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

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

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

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SB 809

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 809
Author: DeSaulnier and Steinberg
Bill Date: February 22, 2013, introduced
Subject: Controlled Substances: Reporting
Sponsor: California Attorney General Kamala Harris

STATUS OF BILL:

This bill is in the Senate Governance and Finance Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Controlled Substance Utilization Review and Evaluation System (CURES) Fund that would be administered by the Department of Justice (DOJ), and would consist of funds collected from boards that license prescribers and dispensers, manufacturers, and health insurers, for purposes of funding the CURES program and upgrading the CURES system. Once the CURES program is funded and the system is upgraded, all prescribers and pharmacists would be required to consult CURES before prescribing or dispensing Schedule II, III, or IV controlled substances.

ANALYSIS:

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

According to a DOJ, there is currently no permanent funding to support the CURES/ PDMP program. The California Budget Act of 2011 eliminated all General Fund support of CURES/PDMP, which included funding for system support, staff support and related operating expenses. To perform the minimum critical functions and to avoid shutting down the program, DOJ opted to assign five staff to perform temporary dual job assignments on a part-time basis. Although some tasks are being performed, the program is faced with a constant backlog (e.g., four-week backlog on processing new user applications, six-week response time on emails, twelve week backlog on voicemails, etc.).

The only funding currently available to DOJ for CURES is through renewable contracts with five separate regulatory boards (including the Medical Board of California (Board)) and one grant. While DOJ has been able to successfully renew contracts with the boards and receive grant funding this year, these sources of funding are not permanent and may not be available in future years and cannot be used to fund staff positions. In addition, these funding sources are insufficient to operate and maintain the PDMP system, make necessary enhancements or fully fund a PDMP modernization effort.

This bill would make findings and declarations related to the importance of CURES. This bill would establish the CURES Fund that would be funded by an annual 1.16% licensing, certification and renewal fee increase for licensees of the following boards that are authorized to prescribe or dispense Schedule II, III, or IV controlled substances: Medical Board of California; Dental Board of California; Board of Pharmacy (including wholesalers non-resident wholesalers, and veterinary food-animal drug retailers); Veterinary Medical Board; Board of Registered Nursing; Physician Assistant Board; Osteopathic Medical Board of California; State Board of Optometry; and the California Board of Podiatric Medicine. This bill would make the money in the CURES Fund available for allocation to DOJ, upon appropriation by the Legislature, for the purposes of funding the CURES Program. This bill would specify that the fee increase shall not exceed the reasonable costs associated with maintaining CURES.

> The 1.16% annual fee would result in an increase of $18 for physician renewal fees ($9 each year of the two-year renewal cycle), and a $9 initial licensing fee increase. Staff suggests that the word "annual" be taken out, which would instead result in a $9 renewal fee increase and a $9 initial licensing fee increase.

This bill would impose an unspecified one-time tax on health insurers for the purposes of upgrading the CURES system. This bill would impose an unspecified on-going tax on manufacturers of controlled substances for the purposes of creating and maintaining a new enforcement team in DOJ, which would focus on prescription diversion and abuse and criminal activity associated with bringing large quantities of illegal prescription drugs into California. The team would coordinate with state, federal and local law enforcement entities, and work with the various health care boards and departments to conduct investigations based on CURES data and intelligence.

Once CURES is funded, upgraded, and able to handle inquiries from all eligible prescribers and dispensers in California, this bill would require DOJ to notify all prescribers and dispensers who have submitted applications to CURES that they are capable of accommodating this workload. DOJ would also be required to notify the Legislature and post the notification on DOJ's Web site. Once DOJ issues this notification, all prescribers and dispensers eligible to prescribe and dispense Schedule II, III, and IV controlled substances would be required to access and consult the electronic history of controlled substances dispensed to a patient under his or her care, prior to prescribing or dispensing a Schedule II, III, or IV controlled substance.

This bill contains an urgency clause, which means it would take effect immediately once signed into law by the Governor.

This is a concern in relation to the collection of the renewal fee. There needs to be an implementation schedule included, as the Board sends out renewal notices 90 days in advance and would need to give licensees appropriate notice of the renewal fee increase.

Board staff is suggesting the fee increase not be an annual fee increase, but be a 1.16% increase on licensing and renewals or a flat fee of $9. Although this bill requires physicians to utilize CURES prior to prescribing Schedule II, III, and IV controlled substances once DOJ has provided notice that the system is capable, there is no penalty associated if a physician does not comply. In addition, requiring a physician to utilize CURES each time they prescribe a Schedule II, III, or IV controlled substance and also requiring the pharmacist to utilize CURES before they dispense that same prescription, may be overly excessive. In addition, placing a tax on manufacturers to support a new enforcement team in DOJ may be premature, as CURES will not be upgraded for some time.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent "doctor shopping". Although the Board currently helps to fund CURES at a cost of $150,000 this year, these funds cannot be used for staffing. The Board is aware of the issues DOJ is facing related to insufficient staffing and funding for CURES/PDMP, and due to the importance of this program, is suggesting that the Board support any effort to get CURES more fully funded in order for the PDMP to be at optimum operating capacity.

The Executive Committee voted to recommend that the Board take a Support in Concept position, as this bill is still a work in progress. Board staff will continue to participate in work group meetings and will work with the authors' offices on any amendments needed.

FISCAL: This bill would result in an annual 1.16% licensing fee increase for physicians, which equates to a $18 increase for renewals and a $9 increase for initial licensing fees.

SUPPORT:
California Attorney General Kamala Harris (Sponsor)
California Medical Association (if amended)
California Narcotics Officers Association
California Pharmacists Association
California Police Chiefs Association
California State Sheriffs' Association
Center for Public Interest Law (CPIL)
City and County of San Francisco
Healthcare Distribution Management Association
Troy and Alanna Pack Foundation
University of California

OPPOSITION: Pharmaceutical Research and Manufacturers of America

POSITION: Executive Committee Recommendation: Support in Concept with noted concerns:

- Fee increase should be biennial versus annual and should be a flat fee.
- An implementation schedule for the fee increase should be addressed, as it is impossible to implement on the day the bill is signed.
- DOJ enforcement team should not be funded until CURES system is fully operational and upgraded.

SENATE BILL No. 809

Introduced by Senators DeSaulnier and Steinberg
(Coauthors: Senators Hancock, Lieu, Pavley, and Price)
(Coauthor: Assembly Member Blumenfield)

February 22, 2013

An act to add Section 805.8 to the Business and Professions Code, to amend Sections 11165 and 11165.1 of the Health and Safety Code, and to add Part 21 (commencing with Section 42001) to Division 2 of the Revenue and Taxation Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 809, as introduced, DeSaulnier. Controlled substances: reporting.

(1) Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

Existing law requires dispensing pharmacies and clinics to report, on a weekly basis, specified information for each prescription of Schedule II, Schedule III, or Schedule IV controlled substances, to the department, as specified.

This bill would establish the CURES Fund within the State Treasury to receive funds to be allocated, upon appropriation by the Legislature, to the Department of Justice for the purposes of funding CURES, and would make related findings and declarations.

This bill would require the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the

Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine to increase the licensure, certification, and renewal fees charged to practitioners under their supervision who are authorized to prescribe or dispense controlled substances, by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified. This bill would also require the California State Board of Pharmacy to increase the licensure, certification, and renewal fees charged to wholesalers, nonresident wholesalers, and veterinary food-animal drug retailers under their supervision by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified.

(2) Existing law permits a licensed health care practitioner, as specified, or a pharmacist to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care. Existing law also authorizes the Department of Justice to provide the history of controlled substances dispensed to an individual to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

This bill would require licensed health care practitioners, as specified, and pharmacists to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care, and, upon the happening of specified events, to access and consult that information prior to prescribing or dispensing Schedule II, Schedule III, or Schedule IV controlled substances.

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

This bill would impose a tax upon qualified manufacturers, as defined, for the privilege of doing business in this state, as specified. This bill would also impose a tax upon specified insurers, as defined, for the privilege of doing business in this state, as specified. The tax would be administered by the State Board of Equalization and would be collected pursuant to the procedures set forth in the Fee Collection Procedures Law. The bill would require the board to deposit all taxes, penalties, and interest collected pursuant to these provisions in the CURES Fund,

as provided. Because this bill would expand application of the Fee Collection Procedures Law, the violation of which is a crime, it would impose a state-mandated local program.

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

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

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

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

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

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

(a) The Controlled Substance Utilization Review and Evaluation System (CURES) is a valuable investigative, preventive, and educational tool for law enforcement, regulatory boards, educational researchers, and the health care community. Recent budget cuts to the Attorney General's Division of Law Enforcement have resulted in insufficient funding to support the CURES Prescription Drug Monitoring Program (PDMP). The PDMP is necessary to ensure health care professionals have the necessary data to make informed treatment decisions and to allow law enforcement to investigate diversion of prescription drugs. Without a dedicated funding source, the CURES PDMP is not sustainable.

(b) Each year CURES responds to more than 60,000 requests from practitioners and pharmacists regarding all of the following:

(1) Helping identify and deter drug abuse and diversion of prescription drugs through accurate and rapid tracking of Schedule II, Schedule III, and Schedule IV controlled substances.

(2) Helping practitioners make better prescribing decisions.

(3) Helping reduce misuse, abuse, and trafficking of those drugs.

(c) Schedule II, Schedule III, and Schedule IV controlled substances have had deleterious effects on private and public interests, including the misuse, abuse, and trafficking in dangerous prescription medications resulting in injury and death. It is the intent of the Legislature to work with stakeholders to fully fund

the operation of CURES which seeks to mitigate those deleterious effects, and which has proven to be a cost-effective tool to help reduce the misuse, abuse, and trafficking of those drugs.

SEC. 2. Section 805.8 is added to the Business and Professions Code, to read:

805.8. (a) (1) The Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine shall increase the licensure, certification, and renewal fees charged to practitioners under their supervision who are authorized pursuant to Section 11150 of the Health and Safety Code to prescribe or dispense Schedule II, Schedule III, or Schedule IV controlled substances by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating prescribers and dispensers of controlled substances licensed or certificated by these boards.

(2) The California State Board of Pharmacy shall increase the licensure, certification, and renewal fees charged to wholesalers and nonresident wholesalers of dangerous drugs, licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9, by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating wholesalers and nonresident wholesalers of dangerous drugs licensed or certificated by that board.

(3) The California State Board of Pharmacy shall increase the licensure, certification, and renewal fees charged to veterinary food-animal drug retailers, licensed pursuant to Article 15 (commencing with Section 4196) of Chapter 9, by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating veterinary food-animal drug retailers licensed or certificated by that board.

(b) The funds collected pursuant to subdivision (a) shall be deposited in the CURES accounts, which are hereby created, within the Contingent Fund of the Medical Board of California, the State

Dentistry Fund, the Pharmacy Board Contingent Fund, the Veterinary Medical Board Contingent Fund, the Board of Registered Nursing Fund, the Osteopathic Medical Board of California Contingent Fund, the Optometry Fund, and the Board of Podiatric Medicine Fund. Moneys in the CURES accounts of each of those funds shall, upon appropriation by the Legislature, be available to the Department of Justice solely for maintaining CURES for the purposes of regulating prescribers and dispensers of controlled substances. All moneys received by the Department of Justice pursuant to this section shall be deposited in the CURES Fund described in Section 11165 of the Health and Safety Code.

SEC. 3. Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds ~~from~~ *in the CURES accounts within* the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, ~~and~~ the Osteopathic Medical Board of California Contingent Fund, *the Veterinary Medical Board Contingent Fund, the Optometry Fund, the Board of Podiatric Medicine Fund, and the CURES Fund,* maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

(b) The reporting of Schedule III and Schedule IV controlled substance prescriptions to CURES shall be contingent upon the availability of adequate funds ~~from~~ *for* the Department of Justice *for the purpose of finding CURES*. The department may seek and use grant funds to pay the costs incurred from the reporting of controlled substance prescriptions to CURES. ~~Funds~~ *The department shall make information about the amount and the source of all private grant funds it receives for support of CURES available to the public. Grant funds* shall not be appropriated from the Contingent Fund of the Medical Board of California, the

Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, the Naturopathic Doctor's Fund, or the Osteopathic Medical Board of California Contingent Fund to pay the costs of reporting Schedule III and Schedule IV controlled substance prescriptions to CURES.

(c) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal persons or public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or ~~agency~~ *agency,* as described in this ~~subdivision~~ *subdivision,* shall not be disclosed, sold, or transferred to any third party.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy or clinic shall provide the following information to the Department of Justice on a weekly basis and in a format specified by the Department of Justice:

(1) Full name, address, and ~~the~~ telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure and license ~~number;~~ *number, the* federal controlled substance registration ~~number;~~ *number,* and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, and federal controlled substance registration number.

(4) ~~NDC (National Drug Code)~~ *National Drug Code (NDC)* number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) ~~ICD-9 (diagnosis code),~~ *International Statistical Classification of Diseases, 9th revision (ICD-9) Code,* if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(e) ~~This section shall become operative on January 1, 2005.~~ *The CURES Fund is hereby established within the State Treasury. The CURES Fund shall consist of all funds made available to the Department of Justice for the purpose of funding CURES. Money in the CURES Fund shall, upon appropriation by the Legislature, be available for allocation to the Department of Justice for the purpose of funding CURES.*

SEC. 4. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) A licensed health care practitioner eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances or a pharmacist ~~may~~ *shall* provide a notarized application developed by the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient maintained within the Department of Justice, ~~and~~ *and, upon approval,* the department ~~may~~ *shall* release to that practitioner or pharmacist, the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

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

(i) Materially falsifying an application for a subscriber.

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

(iii) Suspended or revoked federal Drug Enforcement Administration (DEA) registration.

(iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the

possession or use of a controlled substance is an element of the crime.

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

(B) Any authorized subscriber shall notify the Department of Justice within 10 days of any changes to the subscriber account.

(2) To allow sufficient time for licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and a pharmacist to apply and receive access to PDMP, a written request may be made, until July 1, 2012, and the Department of Justice may release to that practitioner or pharmacist the history of controlled substances dispensed to an individual under his or her care based on data contained in CURES.

(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~~ *(1) Until the Department of Justice has issued the notification described in paragraph (3), in* order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(2) Upon the Department of Justice issuing the notification described in paragraph (3) and approval of the application required pursuant to subdivision (a), licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and pharmacists shall access and consult the electronic history of controlled substances dispensed to an individual under his or her care prior to prescribing or dispensing a Schedule II, Schedule III, or Schedule IV controlled substance.

(3) The Department of Justice shall notify licensed health care practitioners and pharmacists who have submitted the application required pursuant to subdivision (a) when the department determines that CURES is capable of accommodating the mandate contained in paragraph (2). The department shall provide a copy of the notification to the Secretary of the State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative

Counsel, and shall post the notification on the department's Internet Web site.

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

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

SEC. 5. Part 21 (commencing with Section 42001) is added to Division 2 of the Revenue and Taxation Code, to read:

PART 21. CONTROLLED SUBSTANCE UTILIZATION REVIEW AND EVALUATION SYSTEM (CURES) TAX LAW

42001. For purposes of this part, the following definitions apply:

(a) "Controlled substance " means a drug, substance, or immediate precursor listed in any schedule in Section 11055, 11056, or 11057 of the Health and Safety Code.

(b) "Insurer" means a health insurer licensed pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code, 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), and a workers' compensation insurer licensed pursuant to Part 3 (commencing with Section 11550) of Division 2 of the Insurance Code.

(c) "Qualified manufacturer" means a manufacturer of a controlled substance doing business in this state, as defined in Section 23101, but does not mean a wholesaler or nonresident wholesaler of dangerous drugs, regulated pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2 of the Business and Professions Code, a veterinary food-animal drug retailer, regulated pursuant to Article 15 (commencing with Section

4196) of Chapter 9 of Division 2 of the Business and Professions Code, or an individual regulated by the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, or the California Board of Podiatric Medicine.

42003. (a) For the privilege of doing business in this state, an annual tax is hereby imposed on all qualified manufacturers in an amount of ____ dollars ($____), for the purpose of establishing and maintaining enforcement of the Controlled Substance Utilization Review and Evaluation System (CURES), established pursuant to Section 11165 of the Health and Safety Code.

(b) For the privilege of doing business in this state, a tax is hereby imposed on a one time basis on all insurers in an amount of ____ dollars ($____), for the purpose of upgrading CURES.

42005. Each qualified manufacturer and insurer shall prepare and file with the board a return, in the form prescribed by the board, containing information as the board deems necessary or appropriate for the proper administration of this part. The return shall be filed on or before the last day of the calendar month following the calendar quarter to which it relates, together with a remittance payable to the board for the amount of tax due for that period.

42007. The board shall administer and collect the tax imposed by this part pursuant to the Fee Collection Procedures Law (Part 30 (commencing with Section 55001)). For purposes of this part, the references in the Fee Collection Procedures Law (Part 30 (commencing with Section 55001)) to "fee" shall include the tax imposed by this part and references to "feepayer" shall include a person required to pay the tax imposed by this part.

42009. All taxes, interest, penalties, and other amounts collected pursuant to this part, less refunds and costs of administration, shall be deposited into the CURES Fund.

42011. The board shall prescribe, adopt, and enforce rules and regulations relating to the administration and enforcement of this part.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school

district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 7. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the public from the continuing threat of prescription drug abuse at the earliest possible time, it is necessary this act take effect immediately.

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SCR 8

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SCR 8
Author:	DeSaulnier
Bill Date:	April 15, 2013, Amended
Subject:	Prescription Drug Abuse Awareness Month
Sponsor:	Author
Position:	Support

STATUS OF BILL:

This resolution has been resolved and concurred to by the Senate and the Assembly.

DESCRIPTION OF CURRENT LEGISLATION:

This concurrent resolution proclaims the month of March, each year, as Prescription Drug Abuse Awareness Month and encourages all citizens to participate in prevention programs and activities and to pledge to "Spread the Word....One Pill Can Kill."

ANALYSIS:

This resolution makes declarations regarding prescription drugs. In 2008, 20,044 deaths were from prescription drug overdoses; in 2009, 1.2 million emergency department visits were related to misuse or abuse of pharmaceuticals; in 2010, 2 million people reported using prescription painkillers non-medically for the first time within the last year; and as many as 70 percent of people who abuse prescription drugs get them from a relative or friend instead of a doctor. This resolution also states that the National Coalition Against Prescription Drug Abuse, in cooperation with local law enforcement agencies and other community organizations, coordinate Prescription Drug Abuse Awareness Month activities. Lastly, this resolution states that community organizations, local government, practitioners, pharmacists, and the general public will demonstrate their commitment to the prevention of prescription medication abuse by participating in activities to highlight local efforts in March.

This bill proclaims the month of March, each year, to be Prescription Drug Abuse Awareness Month and encourages all citizens to participate in prevention programs and activities and to pledge to "Spread the Word....One Pill Can Kill."

The epidemic of prescription drug abuse and overdoses is plaguing the nation, as well as California. This bill would help to increase awareness of the prescription drug abuse problem in California and would encourage participation in prescription medication abuse prevention programs. The Board has taken a support position on this resolution, which has been resolved by the Senate and the Assembly.

FISCAL: None to the Board.

SUPPORT: National Coalition Against Prescription Drug Abuse
The Board

OPPOSITION: None on file

AMENDED IN ASSEMBLY APRIL 15, 2013

Senate Concurrent Resolution No. 8

Introduced by Senator DeSaulnier
(Coauthors: Senators *Block, Cannella, Correa,* Hancock, *Hill,* Lieu, ~~and Price~~ *Monning, Pavley, Price, Walters, and Wolk*)
(Coauthors: Assembly Members Ammiano, Bloom, Blumenfield, Brown, Fox, Nestande, V. Manuel Pérez, Quirk-Silva, Salas, Ting, Wagner, Waldron, and Wilk)

January 14, 2013

Senate Concurrent Resolution No. 8—Relative to Prescription Drug Abuse Awareness Month.

LEGISLATIVE COUNSEL'S DIGEST

SCR 8, as amended, DeSaulnier. Prescription Drug Abuse Awareness Month.

This measure would proclaim the month of March, each year, as Prescription Drug Abuse Awareness Month and encourage all citizens to participate in prevention programs and activities and to pledge to "Spread the Word ... One Pill Can Kill."

Fiscal committee: no.

WHEREAS, In 2008, drug overdoses in the United States caused 36,450 deaths and 20,044 of these were from prescription drug overdoses; and

WHEREAS, Overdose deaths involving opioid pain relievers (OPR) have increased and now exceed deaths involving heroin and cocaine combined; and

WHEREAS, In 2009, 1.2 million emergency department visits were related to misuse or abuse of pharmaceuticals (an increase of 98.4 percent since 2004); and

WHEREAS, Nonmedical use of OPR costs insurance companies up to $72.5 billion annually in health care costs; and

WHEREAS, By 2010, enough prescription painkillers were sold to medicate every American adult with a typical dose of five milligrams of hydrocodone every four hours for one month; and

WHEREAS, In 2010, 2 million people reported using prescription painkillers nonmedically for the first time within the last year—nearly 5,500 a day; and

WHEREAS, As many as 70 percent of people who abuse prescription drugs get them from a relative or friend instead of a doctor; and

WHEREAS, The National Coalition Against Prescription Drug Abuse, in cooperation with law enforcement agencies, community-based organizations, alcohol and other drug service providers, and civic and business leaders, coordinates Prescription Drug Abuse Awareness Month activities to offer our citizens the opportunity to demonstrate their commitment to campaigns and education aimed at raising awareness about the abuse and misuse of prescription drugs, promoting safe storage and disposal of prescription drugs, and using medications only as prescribed; and

WHEREAS, Families, schools, businesses, faith-based communities, law enforcement, medical professionals, county and local governments, health care practitioners, pharmacists, and the general public throughout the state will demonstrate their commitment to the prevention of prescription medication abuse by participating in activities intended to highlight local efforts during the month of March; now, therefore, be it

Resolved by the Senate of the State of California, the Assembly thereof concurring, That the month of March, each year, is hereby ~~be~~ proclaimed to be Prescription Drug Abuse Awareness Month and that all citizens are encouraged to participate in prevention programs and activities and to pledge to "Spread the Word ... One Pill Can Kill"; and be it further

Resolved, That the Secretary of the Senate transmit copies of this resolution to the author for appropriate distribution.

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