MEDICAL BOARD OF CALIFORNIA - 2018 TRACKER LIST
July 24, 2018

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 18	Garcia, E.	Healing Arts: Licensed Physicians and Dentists from Mexico Pilot Program	Sen. Rules		7/2/18
AB 505	Caballero	Medical Board of California: Adjudication: Expert Testimony	Sen. 3rd Reading	Reco: Support	6/28/18
AB 608	Irwin	Medical Assistants	Sen. Rules	Reco: Neutral	7/2/18
AB 710	Wood	Cannabidiol	Chaptered, #62	Neutral	4/2/18
AB 1751	Low	Controlled Substances: CURES Database	Sen. Approps	Support	7/5/18
AB 1752	Low	Controlled Substances: CURES Database	Sen. Approps	Support	6/20/18
AB 1791	Waldron and Gipson	Physicians and Surgeons: Continuing Education	Chaptered, #122	Neutral	4/2/18
AB 1998	Rodriguez	Opioids: Safe Prescribing Policy	Sen. Approps	Reco: Neutral if Amended	7/2/18
AB 2086	Gallagher	Controlled Substances: CURES Database	Senate	Support	4/3/18
AB 2138	Chiu and Low	Licensing Boards: Denial of Application: Criminal Conviction	Sen. Approps	Reco: Oppose Unless Amended	6/20/18
AB 2193	Maienschein	Maternal Mental Health	Sen. Approps	Reco: Neutral	7/2/18
AB 2311	Arambula	Medicine: Trainees: International Medical Graduates	Chaptered, #144	Sponsor/Support	
AB 2461	Flora and Obernolte	Criminal History Information: Subsequent Arrest Notification	Sen. Approps	Support	5/25/18
AB 2487	McCarty	Physicians: Education: Opiate-Dependent Patient Treatment and Management	Sen. Approps	Reco: Neutral	6/18/18

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

MEDICAL BOARD OF CALIFORNIA - 2018 TRACKER LIST
July 24, 2018

AB 2539	Mathis	California Physician Corps Program: Practice Setting	Sen. Approps	Neutral	4/5/18
AB 2760	Wood	Prescription Drugs: Naloxone Hydrochloride and Other FDA-Approved Drugs	Sen. Approps	Support	6/20/18
AB 2789	Wood	Health Care Practitioners: Prescriptions: Electronic Data Transmission	Sen. Approps		7/3/18
AB 2968	Levine	Psychotherapist-Client Relationship: Informational Brochure	Sen. Approps	Support	3/23/18
SB 944	Hertzberg	Community Paramedicine Act of 2018	Asm. Approps		5/25/18
SB 1109	Bates	Controlled Substances: Schedule II Drugs: Opioids	Asm. Approps	Support	6/19/18
SB 1163	Galgiani	Postmortem Examination or Autopsy	Asm. Approps	Support	6/25/18
SB 1238	Roth	Patient Records: Maintenance and Storage	Asm. Approps	Reco: Support if Amended	6/28/18
SB 1448	Hill	Healing Arts Licensees: Probation Status: Disclosure	Asm. Approps		6/11/18
SB 1495	Comm. on Health	Health	Asm. Approps	Neutral	6/14/18

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 18
Author: Garcia, E.
Bill Date: July 2, 2018, Amended
Subject: Healing Arts: Licensed Physicians and Dentists from Mexico Pilot Program
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would amend existing law to strike the six month requirement for the orientation program portion of the Licensed Physicians and Dentists from Mexico Pilot Program.

BACKGROUND

The Licensed Physicians and Dentists from Mexico Pilot Program (Program) was established by AB 1045 (Firebaugh, Chapter 1157, Statutes of 2002). The bill authorized up to 30 licensed physicians specializing in family practice, internal medicine, pediatrics, and obstetrics and gynecology, and up to 30 licensed dentists, from Mexico to practice medicine or dentistry in California for up to three years. It also required the individuals to meet certain requirements related to training and education. Program participants are required to undergo a six month orientation program approved by the Medical Board of California (Board) prior to being approved and coming to California.

The Board's role in this Program is to provide oversight review of the implementation, as specified. However, AB 1045 requires that all of the funding necessary for the implementation of this Program, including the evaluation and oversight functions, be secured from nonprofit philanthropic entities. This law expressly states that implementation of this Program shall not proceed unless appropriate funding is secured from nonprofit philanthropic entities. Only a small amount of funding has never been secured for this Program, so it has not yet been implemented.

ANALYSIS

Existing law authorizes the Program to allow up to 30 licensed physicians from Mexico specializing in family practice, internal medicine, pediatrics, and obstetrics and gynecology to practice medicine in California for a period not to exceed three years. It allows the Board to issue three-year nonrenewable licenses to these physicians.

Among other requirements, these licensed physicians must have satisfactorily completed a six-month orientation program that addresses medical protocol, community clinic history and operations, medical administration, hospital operations and protocol, medical ethics, the California medical delivery system, health maintenance organizations and managed care practices, and pharmacology differences. This orientation program must be approved by the Board to ensure that it contains the requisite subject matter and meets appropriate law and medical standards where applicable.

Existing law requires the Board to provide oversight review of the implementation of this Program and the evaluation required 12 months after the Program has commenced, which must be conducted by one medical school, in consultation with the Board. The Board is required to consult with medical schools applying for funding to implement and evaluate this Program, executive and medical directors of nonprofit community health centers wanting to employ Program participants, and hospital administrators who will have Program participants practicing in their hospital, as the Board conducts its oversight responsibilities of this Program and evaluation. Any funding necessary for the implementation of this Program, including the evaluation and oversight functions, must be secured from nonprofit philanthropic entities. Implementation of this Program cannot proceed unless appropriate funding is secured from nonprofit philanthropic entities. The Board must report to the Legislature every January during which the Program is operational regarding the status of the Program and the ability of the Program to secure the necessary funding.

Board staff has had numerous meetings, starting in 2015, with interested parties and has provided a fiscal estimate of the funding that would be needed to implement the Program from the Board's perspective. However, only a small amount of this funding has been secured. In talking to the interested parties, one area that has been identified to be problematic is the length of the orientation program. The interested parties believe that the orientation program does not need to be six months and can still meet all orientation program requirements in law with a shorter orientation program. As such, this bill proposes to delete the six month requirement for the orientation program and include an urgency clause, which will allow this program to get started sooner. The Board will still need to hire staff to develop this Program before any physicians from Mexico can come to California to participate in this Program.

FISCAL: Any costs for the Program must be secured from nonprofit philanthropic entities.

SUPPORT: None on file

OPPOSITION: None on file

AMENDED IN SENATE JULY 2, 2018

AMENDED IN SENATE AUGUST 30, 2017

AMENDED IN ASSEMBLY FEBRUARY 23, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 18

Introduced by Assembly ~~Members Eduardo Garcia, Chiu, Chu, Eggman, Gonzalez Fletcher, Kalra, Levine, Limón, McCarty, and Thurmond~~ *Member Eduardo Garcia*

December 5, 2016

An act to ~~add Chapter 14 (commencing with Section 5880) to Division 5 of the Public Resources Code, relating to a clean water, climate, coastal protection, and outdoor access for all program, by providing the funds necessary therefor through an election for the issuance and sale of bonds of the State of California and for the handling and disposition of those funds,~~ *amend Section 853 of the Business and Professions Code, relating to healing arts,* and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 18, as amended, Eduardo Garcia. ~~California Clean Water, Climate, Coastal Protection, and Outdoor Access For All Act of 2018.~~ *Healing arts: Licensed Physicians and Dentists from Mexico Pilot Program.*

Existing law, the Licensed Physicians and Dentists from Mexico Pilot Program, allows licensed physicians and dentists from Mexico to practice medicine or dentistry in California for a period not to exceed 3 years and establishes requirements for the participants in the program, including that a physician from Mexico, before leaving Mexico, is

required to satisfactorily complete a 6 months orientation program that addressees specified topics and is approved by the Medical Board of California.

This bill would remove the requirement that the orientation program be 6 months in length.

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

~~Under existing law, programs have been established pursuant to bond acts for, among other things, the development and enhancement of state and local parks and recreational facilities.~~

~~This bill would enact the California Clean Water, Climate, Coastal Protection, and Outdoor Access For All Act of 2018, which, if approved by the voters, would authorize the issuance of bonds in an amount of $3,470,000,000 pursuant to the State General Obligation Bond Law to finance a clean water, climate, coastal protection, and outdoor access for all program.~~

~~The bill would provide for the submission of these provisions to the voters at the June 5, 2018, statewide direct primary election.~~

~~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: no.

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

SECTION 1. Section 853 of the Business and Professions Code is amended to read:

853. (a) The Licensed Physicians and Dentists from Mexico Pilot Program is hereby created. This program shall allow up to 30 licensed physicians specializing in family practice, internal medicine, pediatrics, and obstetrics and gynecology, and up to 30 licensed dentists from Mexico to practice medicine or dentistry in California for a period not to exceed three years. The program shall also maintain an alternate list of program participants.

(b) The Medical Board of California shall issue three-year nonrenewable licenses to practice medicine to licensed Mexican physicians and the Dental Board of California shall issue three-year nonrenewable permits to practice dentistry to licensed Mexican dentists.

(c) Physicians from Mexico eligible to participate in this program shall comply with the following:

(1) Be licensed, certified or recertified, and in good standing in their medical specialty in Mexico. This certification or recertification shall be performed, as appropriate, by the Consejo Mexicano de Ginecología y Obstetricia, A.C., the Consejo Mexicano de Certificación en Medicina Familiar, A.C., the Consejo Mexicano de Medicina Interna, A.C., or the Consejo Mexicano de Certificación en Pediatría, A.C.

(2) Prior to leaving Mexico, each physician shall have completed the following requirements:

(A) Passed the board review course with a score equivalent to that registered by United States applicants when passing a board review course for the United States certification examination in each of his or her specialty areas and passed an interview examination developed by the National Autonomous University of Mexico (UNAM) for each specialty area. Family practitioners who shall include obstetrics and gynecology in their practice shall also be required to have appropriately documented, as specified by United States standards, 50 live births. Mexican obstetricians and gynecologists shall be fellows in good standing of the American College of Obstetricians and Gynecologists.

(B) (i) Satisfactorily completed ~~a six-month~~ *an* orientation program that addressed medical protocol, community clinic history and operations, medical administration, hospital operations and protocol, medical ethics, the California medical delivery system, health maintenance organizations and managed care practices, and pharmacology differences. This orientation program shall be approved by the Medical Board of California to ensure that it contains the requisite subject matter and meets appropriate California law and medical standards where applicable.

(ii) Additionally, Mexican physicians participating in the program shall be required to be enrolled in adult English-as-a-second-language (ESL) classes that focus on both verbal and written subject matter. Each physician participating in the program shall have transcripts sent to the Medical Board of California from the appropriate Mexican university showing enrollment and satisfactory completion of these classes.

(C) Representatives from the UNAM in Mexico and a medical school in good standing or a facility conducting an approved

medical residency training program in California shall confer to develop a mutually agreed upon distant learning program for the ~~six-month~~ orientation program required pursuant to subparagraph (B).

(3) Upon satisfactory completion of the requirements in paragraphs (1) and (2), and after having received their three-year nonrenewable medical license, the Mexican physicians shall be required to obtain continuing education pursuant to Section 2190. Each physician shall obtain an average of 25 continuing education units per year for a total of 75 units for a full three years of program participation.

(4) Upon satisfactory completion of the requirements in paragraphs (1) and (2), the applicant shall receive a three-year nonrenewable license to work in nonprofit community health centers and shall also be required to participate in a six-month externship at his or her place of employment. This externship shall be undertaken after the participant has received a license and is able to practice medicine. The externship shall ensure that the participant is complying with the established standards for quality assurance of nonprofit community health centers and medical practices. The externship shall be affiliated with a medical school in good standing in California. Complaints against program participants shall follow the same procedures contained in the Medical Practice Act (Chapter 5 (commencing with Section 2000)).

(5) After arriving in California, Mexican physicians participating in the program shall be required to be enrolled in adult ESL classes at institutions approved by the Bureau of Private Post Secondary and Vocational Education or accredited by the Western Association of Schools and Colleges. These classes shall focus on verbal and written subject matter to assist a physician in obtaining a level of proficiency in English that is commensurate with the level of English spoken at community clinics where he or she will practice. The community clinic employing a physician shall submit documentation confirming approval of an ESL program to the board for verification. Transcripts of satisfactory completion of the ESL classes shall be submitted to the Medical Board of California as proof of compliance with this provision.

(6) (A) Nonprofit community health centers employing Mexican physicians in the program shall be required to have medical quality assurance protocols and either be accredited by the Joint

Commission on Accreditation of Health Care Organizations or have protocols similar to those required by the Joint Commission on Accreditation of Health Care Organizations. These protocols shall be submitted to the Medical Board of California prior to the hiring of Mexican physicians.

(B) In addition, after the program participant successfully completes the six-month externship program, a free standing health care organization that has authority to provide medical quality certification, including, but not limited to, health plans, hospitals, and the Integrated Physician Association, is responsible for ensuring and overseeing the compliance of nonprofit community health centers medical quality assurance protocols, conducting site visits when necessary, and developing any additional protocols, surveys, or assessment tools to ensure that quality of care standards through quality assurance protocols are being appropriately followed by physicians participating in the program.

(7) Participating hospitals shall have the authority to establish criteria necessary to allow individuals participating in this three-year pilot program to be granted hospital privileges in their facilities.

(8) The Medical Board of California shall provide oversight review of both the implementation of this program and the evaluation required pursuant to subdivision (j). The board shall consult with the medical schools applying for funding to implement and evaluate this program, executive and medical directors of nonprofit community health centers wanting to employ program participants, and hospital administrators who will have these participants practicing in their hospital, as it conducts its oversight responsibilities of this program and evaluation. Any funding necessary for the implementation of this program, including the evaluation and oversight functions, shall be secured from nonprofit philanthropic entities. Implementation of this program may not proceed unless appropriate funding is secured from nonprofit philanthropic entities. The board shall report to the Legislature every January during which the program is operational regarding the status of the program and the ability of the program to secure the funding necessary to carry out its required provisions. Notwithstanding Section 11005 of the Government Code, the board may accept funds from nonprofit philanthropic entities. The board

shall, upon appropriation in the annual Budget Act, expend funds received from nonprofit philanthropic entities for this program.

(d) (1) Dentists from Mexico eligible to participate in this program shall comply with the following requirements or the requirements contained in paragraph (2):

(A) Be graduates from the National Autonomous University of Mexico School of Faculty Dentistry (Facultad de Odontología).

(B) Meet all criteria required for licensure in Mexico that is required and being applied by the National Autonomous University of Mexico School of Faculty Dentistry (Facultad de Odontología), including, but not limited to:

(i) A minimum grade point average.

(ii) A specified English language comprehension and conversational level.

(iii) Passage of a general examination.

(iv) Passage of an oral interview.

(C) Enroll and complete an orientation program that focuses on the following:

(i) Practical issues in pharmacology that shall be taught by an instructor who is affiliated with a California dental school approved by the Dental Board of California.

(ii) Practical issues and diagnosis in oral pathology that shall be taught by an instructor who is affiliated with a California dental school approved by the Dental Board of California.

(iii) Clinical applications that shall be taught by an instructor who is affiliated with a California dental school approved by the Dental Board of California.

(iv) Biomedical sciences that shall be taught by an instructor who is affiliated with a California dental school approved by the Dental Board of California.

(v) Clinical history management that shall be taught by an instructor who is affiliated with a California dental school approved by the Dental Board of California.

(vi) Special patient care that shall be taught by an instructor who is affiliated with a California dental school approved by the Dental Board of California.

(vii) Sedation techniques that shall be taught by an instructor who is affiliated with a California dental school approved by the Dental Board of California.

(viii) Infection control guidelines which shall be taught by an instructor who is affiliated with a California dental school approved by the Dental Board of California.

(ix) Introduction to health care systems in California.

(x) Introduction to community clinic operations.

(2) (A) Graduate within the three-year period prior to enrollment in the program, from a foreign dental school that has received provisional approval or certification by November of 2003 from the Dental Board of California under the Foreign Dental School Approval Program.

(B) Enroll and satisfactorily complete an orientation program that focuses on the health care system and community clinic operations in California.

(C) Enroll and satisfactorily complete a course taught by an approved foreign dental school on infection control approved by the Dental Board of California.

(3) Upon satisfactory completion to a competency level of the requirements in paragraph (1) or (2), dentists participating in the program shall be eligible to obtain employment in a nonprofit community health center pursuant to subdivision (f) within the structure of an extramural dental program for a period not to exceed three years.

(4) Dentists participating in the program shall be required to complete the necessary continuing education units required by the Dental Practice Act (Chapter 4 (commencing with Section 1600)).

(5) The program shall accept 30 participating dentists. The program shall also maintain an alternate list of program applicants. If an active program participant leaves the program for any reason, a participating dentist from the alternate list shall be chosen to fill the vacancy. Only active program participants shall be required to complete the orientation program specified in subparagraph (C) of paragraph (1).

(6) (A) Additionally, an extramural dental facility may be identified, qualified, and approved by the board as an adjunct to, and an extension of, the clinical and laboratory departments of an approved dental school.

(B) As used in this subdivision, “extramural dental facility” includes, but is not limited to, any clinical facility linked to an approved dental school for the purposes of monitoring or overseeing the work of a dentist licensed in Mexico participating

in this program and that is employed by an approved dental school for instruction in dentistry that exists outside or beyond the walls, boundaries, or precincts of the primary campus of the approved dental school, and in which dental services are rendered. These facilities shall include nonprofit community health centers.

(C) Dental services provided to the public in these facilities shall constitute a part of the dental education program.

(D) Approved dental schools shall register extramural dental facilities with the board. This registration shall be accompanied by information supplied by the dental school pertaining to faculty supervision, scope of treatment to be rendered, arrangements for postoperative care, the name and location of the facility, the date operations shall commence at the facility, and a description of the equipment and facilities available. This information shall be supplemented with a copy of the agreement between the approved dental school and the affiliated institution establishing the contractual relationship. Any change in the information initially provided to the board shall be communicated to the board.

(7) The program shall also include issues dealing with program operations, and shall be developed in consultation by representatives of community clinics, approved dental schools, or the National Autonomous University of Mexico School of Faculty Dentistry (Facultad de Odontología).

(8) The Dental Board of California shall provide oversight review of the implementation of this program and the evaluation required pursuant to subdivision (j). The board shall consult with dental schools in California that have applied for funding to implement and evaluate this program and executive and dental directors of nonprofit community health centers wanting to employ program participants, as it conducts its oversight responsibilities of this program and evaluation. Implementation of this program may not proceed unless appropriate funding is secured from nonprofit philanthropic entities. The board shall report to the Legislature every January during which the program is operational regarding the status of the program and the ability of the program to secure the funding necessary to carry out its required provisions. Notwithstanding Section 11005 of the Government Code, the board may accept funds from nonprofit philanthropic entities.

(e) Nonprofit community health centers that employ participants shall be responsible for ensuring that participants are enrolled in

local English-language instruction programs and that the participants attain English-language fluency at a level that would allow the participants to serve the English-speaking patient population when necessary and have the literacy level to communicate with appropriate hospital staff when necessary.

(f) Physicians and dentists from Mexico having met the applicable requirements set forth in subdivisions (c) and (d) shall be placed in a pool of candidates who are eligible to be recruited for employment by nonprofit community health centers in California, including, but not limited to, those located in the Counties of Ventura, Los Angeles, San Bernardino, Imperial, Monterey, San Benito, Sacramento, San Joaquin, Santa Cruz, Yuba, Orange, Colusa, Glenn, Sutter, Kern, Tulare, Fresno, Stanislaus, San Luis Obispo, and San Diego. The Medical Board of California shall ensure that all Mexican physicians participating in this program have satisfactorily met the requirements set forth in subdivision (c) prior to placement at a nonprofit community health center.

(g) Nonprofit community health centers in the counties listed in subdivision (f) shall apply to the Medical Board of California and the Dental Board of California to hire eligible applicants who shall then be required to complete a six-month externship that includes working in the nonprofit community health center and a corresponding hospital. Once enrolled in this externship, and upon payment of the required fees, the Medical Board of California shall issue a three-year nonrenewable license to practice medicine and the Dental Board of California shall issue a three-year nonrenewable dental special permit to practice dentistry. For purposes of this program, the fee for a three-year nonrenewable license to practice medicine shall be nine hundred dollars ($900) and the fee for a three-year nonrenewable dental permit shall be five hundred forty-eight dollars ($548). A licensee or permitholder shall practice only in the nonprofit community health center that offered him or her employment and the corresponding hospital. This three-year nonrenewable license or permit shall be deemed to be a license or permit in good standing pursuant to the provisions of this chapter for the purpose of participation and reimbursement in all federal, state, and local health programs, including managed care organizations and health maintenance organizations.

(h) The three-year nonrenewable license or permit shall terminate upon notice by certified mail, return receipt requested, to the licensee's or permitholder's address of record, if, in the Medical Board of California or Dental Board of California's sole discretion, it has determined that either:

(1) The license or permit was issued by mistake.

(2) A complaint has been received by either board against the licensee or permitholder that warrants terminating the license or permit pending an investigation and resolution of the complaint.

(i) All applicable employment benefits, salary, and policies provided by nonprofit community health centers to their current employees shall be provided to medical and dental practitioners from Mexico participating in this pilot program. This shall include nonprofit community health centers providing malpractice insurance coverage.

(j) Beginning 12 months after this pilot program has commenced, an evaluation of the program shall be undertaken with funds provided from philanthropic foundations. The evaluation shall be conducted jointly by one medical school and one dental school in California and either UNAM or a foreign dental school approved by the Dental Board of California, in consultation with the Medical Board of California. If the evaluation required pursuant to this section does not begin within 15 months after the pilot project has commenced, the evaluation may be performed by an independent consultant selected by the Director of the Department of Consumer Affairs. This evaluation shall include, but not be limited to, the following issues and concerns:

(1) Quality of care provided by doctors and dentists licensed under this pilot program.

(2) Adaptability of these licensed practitioners to California medical and dental standards.

(3) Impact on working and administrative environment in nonprofit community health centers and impact on interpersonal relations with medical licensed counterparts in health centers.

(4) Response and approval by patients.

(5) Impact on cultural and linguistic services.

(6) Increases in medical encounters provided by participating practitioners to limited-English-speaking patient populations and increases in the number of limited-English-speaking patients

seeking health care services from nonprofit community health centers.

(7) Recommendations on whether the program should be continued, expanded, altered, or terminated.

(8) Progress reports on available data listed shall be provided to the Legislature on achievable time intervals beginning the second year of implementation of this pilot program. An interim final report shall be issued three months before termination of this pilot program. A final report shall be submitted to the Legislature at the time of termination of this pilot program on all of the above data. The final report shall reflect and include how other initiatives concerning the development of culturally and linguistically competent medical and dental providers within California and the United States are impacting communities in need of these health care providers.

(k) Costs for administering this pilot program shall be secured from philanthropic entities.

(*l*) Program applicants shall be responsible for working with the governments of Mexico and the United States in order to obtain the necessary three-year visa required for program participation.

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 California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to address the urgent shortage of doctors in rural and farmworker communities in California and the consequences to the public health, it is necessary that this act take effect immediately.

All matter omitted in this version of the bill appears in the bill as amended in the Senate August 30, 2017. (JR11)

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 505
Author: Caballero
Bill Date: June 28, 2018, Amended
Subject: Medical Board of California: Adjudication: Expert Testimony
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow an administrative law judge (ALJ) to extend the deadline for the exchange of expert witness reports, upon a motion and based upon a showing of good cause. This bill would specify that the ALJ may extend the timeline for a period not to exceed 100 calendar days cumulatively, but in no case would this bill allow the exchange to take place less than 30 calendar days before the hearing date, whichever comes first.

ANALYSIS

The Medical Board of California (Board) raised the issue of requiring expert reviewer reports to be provided in a more timely fashion and for both parties to include more information in its 2012 and 2016 Sunset Review Reports. Prior to the Board's sunset bill being signed into law, Business and Professions Code Section 2334 only required a brief narrative statement that the expert is expected to give to the other party, although the Board turns over its whole expert reviewer report to the other side. In addition, the Board included this issue in its sunset report to ensure that the expert reviewer reports are exchanged in a timely manner, and tied the deadline to the originally scheduled hearing date, to avoid the exchange getting delayed due to the hearing being delayed. Language was included in the Board's sunset bill SB 798 (Hill) to require the complete expert witness report be exchanged by both parties 30 calendar days prior to the originally scheduled commencement date of the hearing, or as determined by an administrative law judge in the case of interim orders under Government Code Section 11529.

In the Governor's signing message for the Board's sunset bill, he stated that two issues needed further review; one being the exchange of expert witness reports regarding a doctor under investigation by the Board. The Governor directed his staff to work with the Legislature to determine what changes are needed. Board staff met with the Governor's staff and interested parties and provided technical assistance, as concerns were brought up that ALJs should be given more discretion to extend the timeline of the exchange of reports for good cause. The language included in this bill is a result of those meetings and will allow ALJs some flexibility to extend the deadline

for the exchange of expert reviewer reports for good cause, with limits on the extension.

This bill is in response to the Governor's signing message on SB 798, the Board's sunset bill. Board staff believes this bill will provide ALJs with some flexibility to extend the deadline for the exchange of expert witness reports, but still place reasonable limits on the extension. Board staff provided technical assistance on this language and is suggesting that the Board take a support position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: California Medical Association

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE JUNE 28, 2018

AMENDED IN SENATE JUNE 20, 2018

AMENDED IN ASSEMBLY MARCH 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 505

Introduced by Assembly Member Caballero

February 13, 2017

An act to amend Section 2334 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 505, as amended, Caballero. Medical Board of California: adjudication: expert testimony.

Existing law prohibits the use of expert testimony in matters brought by the Medical Board of California unless specified information is exchanged with counsel for the other party, and requires the exchange of the information to be completed 30 calendar days prior to the commencement date of the hearing or as specified.

This bill would authorize the administrative law judge to extend the time for ~~disclosure,~~ *the exchange of information,* upon a motion based on a showing of good cause, for a period not to exceed 100 calendar days, as specified.

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

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

SECTION 1. 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:

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

(2) A complete expert witness report, which must include the following:

(A) A complete statement of all opinions the expert will express and the bases and reasons for each opinion.

(B) The facts or data considered by the expert in forming the opinions.

(C) Any exhibits that will be used to summarize or support the opinions.

(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 30 calendar days prior to the originally scheduled commencement date of the hearing, or as determined by an administrative law judge when Section 11529 of the Government Code applies. Upon motion to extend the deadline based on a showing of good cause, the administrative law judge may extend the time for the ~~disclosure~~ *exchange* of information for a period not to exceed 100 calendar days cumulatively, but in no case shall the ~~disclosure~~ *exchange* take place less than 30 calendar days before the hearing date, whichever comes first.

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 608
Author: Irwin
Bill Date: July 2, 2018, Amended
Subject: Medical Assistants
Sponsor: California Society of Dermatology and Dermatologic Surgery

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow medical assistants to draw up a local anesthetic, if specified conditions are met.

BACKGROUND

Medical assistants are unlicensed individuals who perform non-invasive, routine technical support services under the supervision of a licensed physician and surgeon, podiatrist, physician assistant (PA), nurse practitioner (NP), or certified nurse-midwife (CNM) in a medical office or clinic setting without the need of receiving a certification. The supervisor must be on the premises in order for the medical assistant to perform non-invasive technical support services. Existing law does not allow medical assistants to administer anesthetic agents.

ANALYSIS

This bill would specify a medical assistant's technical supportive services includes drawing up a local anesthetic, such as lidocaine, in a syringe if all of the following conditions are met:

- A supervising licensed physician, podiatrist, PA, NP, CNM is present while the medical assistant is drawing up the anesthetic.
- A supervising licensed physician, podiatrist, PA, NP, or CNM verifies that each syringe label is accurate.
- The anesthetic is a local anesthetic and is reconstituted by someone with a license to do so or comes reconstituted from the manufacturer.

This bill includes an urgency clause and would take effect immediately upon signature.

Existing law does not specify if a medical assistant can draw up a local anesthetic; however it does prohibit a medical assistant from administering a local anesthetic. This bill would make it clear that drawing up an anesthetic is permissible to be included in a medical assistant's technical supportive services, and specifies under what conditions. This has been a gray area that Board staff agrees needs clarification;

as such, Board staff suggests that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: California Society of Dermatology and Dermatologic Surgery (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN SENATE JULY 2, 2018

AMENDED IN SENATE FEBRUARY 13, 2018

AMENDED IN ASSEMBLY JANUARY 3, 2018

AMENDED IN ASSEMBLY MAY 3, 2017

AMENDED IN ASSEMBLY MARCH 1, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 608

Introduced by Assembly Member Irwin
~~(Coauthors: Assembly Members Cervantes, Muratsuchi, and Quirk-Silva)~~
~~(Coauthors: Senators Hill and Newman)~~

February 14, 2017

~~An act to amend Section 1785.11.11 of the Civil Code, relating to consumer credit, and declaring the urgency thereof, to take effect immediately.~~ *An act to amend Section 2069 of the Business and Professions Code, relating to healing arts, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

AB 608, as amended, Irwin. ~~Consumer credit reports: security freezes: protected consumers.~~ *Medical assistants.*

Existing law, the Medical Practice Act, provides for the licensure and regulation of the practice of medicine by the Medical Board of California. The act authorizes a medical assistant to administer medication only by intradermal, subcutaneous, or intramuscular injections and to perform skin tests and additional technical supportive

services upon the specific authorization and supervision of a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife. Existing law defines the term "technical supportive services" to mean simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife.

This bill would define "technical supportive services" to also include drawing up a local aesthetic provided specified conditions are met.

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

~~The Consumer Credit Reporting Agencies Act permits a consumer to place a security freeze on his or her credit report to prohibit the release of the consumer's credit reporting information, subject to certain exceptions, by making a request in writing by mail to a consumer credit reporting agency.~~

~~The act also requires a consumer credit reporting agency, in certain circumstances, to place a security freeze on behalf of a "protected consumer," defined to include an individual under 16 years of age at the time a request for the placement of a security freeze is made, an incapacitated person, an individual for whom a guardian or conservator has been appointed, or a person in foster care under county jurisdiction who meets certain conditions. With respect to placing a security freeze for a protected consumer, a consumer credit reporting agency is required to do so if it receives a request from the protected consumer's representative, along with certain identifying information and proof of authority to act on behalf of the protected consumer, and if that representative pays to the consumer credit reporting agency a fee, not to exceed $10 for each placement or removal of a security freeze, subject to specified exceptions.~~

~~This bill would prohibit a consumer credit reporting agency from charging fees for these services.~~

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

Vote: $^2/_3$. 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 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 certified nurse-midwife.

(2) The supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, certified nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, certified nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the supervising physician and surgeon is not onsite, if either of the following apply:

(A) The nurse practitioner or certified nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725, or protocol. The standardized procedures or protocol, including instructions for specific authorizations, shall be developed and approved by the supervising physician and surgeon and the nurse practitioner or certified nurse-midwife.

(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502, including instructions for specific authorizations, and is approved to do so by the supervising physician and surgeon.

(b) As used in this section and Sections 2070 and 2071, the following definitions apply:

(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist,

or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a certified nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

(2) "Specific authorization" means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

(3) "Supervision" means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

(C) A physician assistant, nurse practitioner, or certified nurse-midwife as provided in subdivision (a).

(4) (A) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a certified nurse-midwife as provided in subdivision (a).

(B) Notwithstanding any other law, in a facility licensed by the California State Board of Pharmacy under Section 4180 or 4190,

other than a facility operated by the state, "technical supportive services" also includes handing to a patient a prepackaged prescription drug, excluding a controlled substance, that is labeled in compliance with Section 4170 and all other applicable state and federal laws and ordered by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife in accordance with subdivision (a). In every instance, prior to handing the medication to a patient pursuant to this subparagraph, the properly labeled and prepackaged prescription drug shall have the patient's name affixed to the package and a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife shall verify that it is the correct medication and dosage for that specific patient and shall provide the appropriate patient consultation regarding use of the drug.

(C) Notwithstanding any other law, "technical supportive services" also includes drawing up a local anesthetic, such as lidocaine in a syringe, provided all of the following conditions are met:

(i) A supervising licensed physician and surgeon, licensed podiatrist, licensed physician assistant, licensed nurse practitioner, or certified nurse-midwife is present while the medical assistant is drawing up the anesthetic.

(ii) A supervising licensed physician and surgeon, licensed podiatrist, licensed physician assistant, licensed nurse practitioner, or certified nurse-midwife verifies that each syringe label is accurate.

(iii) The anesthetic is a local anesthetic and is reconstituted by someone with a license to do so or comes reconstituted from the manufacturer.

(c) Nothing in this section shall be construed as authorizing any of the following:

(1) The licensure of medical assistants.

(2) The administration of local anesthetic agents by a medical assistant.

(3) The board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.

(4) A medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1200).

(5) A nurse practitioner, certified nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.

(d) A nurse practitioner, certified nurse-midwife, or physician assistant shall not authorize a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized by Chapter 3 (commencing with Section 1200). A violation of this subdivision constitutes unprofessional conduct.

(e) Notwithstanding any other law, a medical assistant shall not be employed for inpatient care in a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

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 California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to assist physicians and surgeons with the treatment of their patients by utilizing medical assistants to draw up a local anesthetic under certain circumstances to protect the public health and safety, it is necessary that this act take effect immediately.

~~SECTION 1. Section 1785.11.11 of the Civil Code is amended to read:~~

~~1785.11.11. (a) A consumer credit reporting agency shall place a security freeze for a protected consumer if both of the following occur:~~

~~(1) The consumer credit reporting agency receives a request from the protected consumer's representative for the placement of the security freeze pursuant to this section.~~

~~(2) The protected consumer's representative does all of the following:~~

~~(A) Submits the request to the consumer credit reporting agency at the address or other point of contact and in the manner specified by the consumer credit reporting agency.~~

~~(B) Provides to the consumer credit reporting agency sufficient proof of identification of the protected consumer and the representative.~~

~~(C) Provides to the consumer credit reporting agency sufficient proof of authority to act on behalf of the protected consumer.~~

~~(b) If a consumer credit reporting agency does not have a file pertaining to a protected consumer when the consumer credit reporting agency receives a request pursuant to paragraph (1) of subdivision (a), the consumer credit reporting agency shall create a record for the protected consumer.~~

~~(c) If a protected consumer's representative requests a security freeze, the consumer credit reporting agency shall disclose the process for placing and removing a security freeze.~~

~~(d) Within 30 days after receiving a request that meets the requirements of subdivision (a), a consumer credit reporting agency shall place a security freeze for the protected consumer. The consumer credit reporting agency shall send written confirmation of the security freeze to the address on file within 10 days of the placement of the security freeze.~~

~~(e) Unless a security freeze for a protected consumer is removed pursuant to subdivision (h) or (j), a consumer credit reporting agency shall not release the protected consumer's consumer credit report, any information derived from the protected consumer's consumer credit report, or any record created for the protected consumer.~~

~~(f) A security freeze for a protected consumer placed pursuant to this section shall remain in effect until either of the following occurs:~~

~~(1) The protected consumer or the protected consumer's representative requests that the consumer credit reporting agency remove the security freeze in accordance with subdivision (h).~~

~~(2) The security freeze is removed in accordance with subdivision (j).~~

~~(g) To remove a security freeze, a protected consumer or a protected consumer's representative shall do both of the following:~~

~~(1) Submit a request for removal of the security freeze to the consumer credit reporting agency at the address or other point of contact and in the manner specified by the consumer credit reporting agency.~~

~~(2) Provide to the consumer credit reporting agency:~~

~~(A) If the request is made by the protected consumer:~~

~~(i) Proof that the sufficient proof of authority for the protected consumer's representative to act on behalf of the protected consumer is no longer valid, he or she has been emancipated, or he or she is 16 years of age or older.~~

~~(ii) Sufficient proof of identification of the protected consumer.~~

~~(B) If the request is made by the representative of a protected consumer:~~

~~(i) Sufficient proof of identification of the protected consumer and the representative.~~

~~(ii) Sufficient proof of authority to act on behalf of the protected consumer.~~

~~(h) Within 30 days after receiving a request that meets the requirements of subdivision (g), a consumer credit reporting agency shall remove a security freeze for a protected consumer.~~

~~(i) A consumer credit reporting agency may not charge a fee for any service performed pursuant to this section.~~

~~(j) A consumer credit reporting agency is authorized to remove a security freeze for a protected consumer or to delete a record of a protected consumer if the security freeze was placed or the record was created based upon a material misrepresentation of fact by the protected consumer or the protected consumer's representative.~~

~~(k) A consumer credit reporting agency may develop procedures involving the use of telephone, mail, fax, the Internet, or other electronic media to receive and process a request for a protected consumer's security freeze to be placed or removed.~~

~~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 California Constitution and shall go into immediate effect. The facts constituting the necessity are:~~

~~To remove barriers for the representatives of protected consumers, who may be the victims of data breaches, to freeze the credit reports, and to protect the identity of protected consumers as soon as possible, it is necessary that this bill take effect immediately.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1751
Author: Low
Bill Date: July 5, 2018, Amended
Subject: Controlled Substances: CURES Database
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow for information sharing between California's prescription drug monitoring program (PDMP), the Controlled Substances Utilization Review and Evaluation System (CURES), and other states' PDMPs. This bill would require the Department of Justice (DOJ) to adopt regulations, by July 1, 2020, regarding the access and use of information within CURES. This bill would allow DOJ to enter into an interstate data sharing agreement, as specified.

BACKGROUND:

The CURES Program is currently housed in DOJ and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, to access patient controlled substance history information through a secure website. SB 809 (DeSaulnier, Chapter 400) was signed into law in 2013 and included a provision to collect funds from boards that license individuals who prescribe and dispense, for purposes of funding and upgrading the CURES system. This bill also required all prescribers to register with CURES by January 1, 2016, but the law was amended to extend the registration deadline to July 1, 2016. The new CURES 2.0 system, which is a modernized system that has been updated to more efficiently serve prescribers, pharmacists and other entities, is now operational and available online, as long as the prescriber uses a compliant browser.

According to the Centers for Disease Control and Prevention, drug overdose deaths continue to increase in the United States. From 1999 to 2016, more than 630,000 people have died from a drug overdose. Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid. In 2016, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 5 times higher than in 1999. On average, 115 Americans die every day from an opioid overdose.

According to the author's office, 48 other states have their own PDMPs like CURES. Use of PDMPs is recognized as one of the most effective ways to combat the growing opioid abuse crisis.

ANALYSIS

This bill would allow DOJ to enter into an agreement with an entity operating an interstate data share hub for purposes of participating in inter-jurisdictional information sharing between PDMPs across state lines. This bill would require any agreement entered into by DOJ to ensure that all access of data within CURES complies with California law and meets the same patient privacy and data security standards employed and required for direct access of CURES.

This bill would specify that DOJ cannot disclose any personal information in a manner that would identify the individual to whom it pertains, unless the information is disclosed for the sole purpose of participation in interstate data sharing of PDMP information, if disclosure is limited to PDMP information.

This bill would require DOJ to adopt regulations, by July 1, 2020, regarding the access and use of information within CURES. This bill would require DOJ to consult with stakeholders representing law enforcement agencies, licensed prescriber and dispenser communities, and any other stakeholders identified by DOJ during the rulemaking process. This bill would require the regulations, at a minimum, to address all of the following:

- The process for approving, denying, and disapproving individuals or entities seeking access to information in CURES.
- The purposes for which a health care practitioner may access information in CURES.
- The conditions under which a warrant, subpoena, or court order is required for a law enforcement agency to obtain information from CURES as part of a criminal investigation of a patient or health care practitioner, respectively.
- The process by which information in CURES may be provided for educational, peer review, statistical, or research purposes.

This bill would allow a health care practitioner who is eligible for access to CURES, or a pharmacist who is employed by a health insurer or health care services plan, and is involved in accepting, denying, or adjusting a claim for health insurance policy benefits or heath care service plan contract benefits related to controlled substances, to access CURES for purposes of reviewing a claim.

This bill would allow DOJ to enter into an agreement with any entity operating an interstate data sharing hub, or any agency operating a PDMP in another state, for purposes of interstate data sharing of PDMP information. This bill would allow data obtained from CURES to be provided to authorized users of another state's PDMP, as determined by DOJ, if the entity operating the interstate data sharing hub, and the PDMP of that state have entered into an agreement with

DOJ for interstate data sharing of PDMP information. This bill would require any agreement entered into by DOJ to ensure that all access to data obtained from CURES complies with California law, including regulations, and meets the same patient privacy, audit, and data security standards employed and required for direct access to CURES. This bill would specify that an authorized user for another state's PDMP would not be required to register with CURES if he or she is registered and in good standing with that state's PDMP. This bill would not allow DOJ to enter into an agreement until it has issued the final regulations regarding the access and use of information within CURES, as required by this bill.

According to the author, several entities offer interstate data share hubs to allow doctors to review prescriptions dispensed in other states, and many state PDMPs are already participating. The author believes this bill will provide health professionals in California with state-of-the-art tools to combat the opioid abuse crisis.

The Medical Board of California (Board) believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent doctor shopping. This bill will give physicians access to prescription drug information from other states, which will help to further the Board's mission of consumer protection; as such, the Board took a support position on this bill.

FISCAL: None to the Board

SUPPORT: America's Physician Groups; Biocom; California Association of Underwriters; California Chiropractic Association; California Dental Association; California District Attorneys Association; CaliforniaHealth+ Advocates; California Life Sciences Association; California Pharmacists Association; California Police Chiefs Association; California State Board of Pharmacy; California State Sheriffs' Association; Consumer Attorneys of California; County Health Executives Association; Kaiser Permanente; Medical Board of California; OCHIN; San Diego County District Attorney Summer Stephan; and Troy and Alana Pack Foundation

OPPOSITION: American Civil Liberties Union
California Medical Association

AMENDED IN SENATE JULY 5, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1751

Introduced by Assembly Member Low

January 3, 2018

An act to amend ~~Section 11165~~ *Section 1798.24 of the Civil Code, and to amend Sections 11165 and 11165.1* of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

AB 1751, as amended, Low. Controlled substances: CURES database.

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

This *bill would require the department, no later than July 1, 2020, to adopt regulations regarding the access and use of the information within CURES by consulting with specified stakeholders, and addressing certain processes, purposes, and conditions in the regulations. The* bill would authorize the ~~Department of Justice~~ *department, once those regulations have been adopted,* to enter into an agreement with ~~an~~ *any* entity operating an interstate data ~~share hub for the purposes of participating in interjurisdictional information sharing between prescription drug monitoring programs across state lines.~~ *sharing hub, or any agency operating a prescription drug monitoring program in*

another state, for purposes of interstate data sharing of prescription drug monitoring program information, as specified. The bill would require any agreement entered into by the ~~Department of Justice~~ *department* for those purposes to ensure that all access to data ~~within~~ *obtained from* CURES complies with California law and meets the same patient ~~privacy~~ *privacy, audit,* and data security standards employed and required for direct access ~~of~~ *to* CURES.

The bill would authorize a health care practitioner otherwise eligible for access to CURES, or a pharmacist who is employed by a health insurer or health care service plan and is involved in accepting, denying, or adjusting a claim for health insurance policy benefits or health care service plan contract benefits related to controlled substances, to access CURES for purposes of reviewing a claim. The bill would make conforming changes to related provisions concerning the department's release of the electronic history of controlled substances corresponding to an individual, and to provisions concerning exceptions to the prohibition on a state agency from disclosing personal information.

Existing law requires specified health care practitioners and pharmacists to submit an application to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the department. Existing law authorizes the denial of an application, or the suspension of a subscriber, for specified reasons, including, among others, accessing information for a reason other than to diagnose or treat the patient, or to document compliance with the law.

This bill would additionally authorize the denial of an application, or the suspension of a subscriber, in that circumstance if the information is accessed for a reason other than to assess or ensure patient safety, or to make a determination regarding accepting, denying, or adjusting a benefits claim, as specified.

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

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

SECTION 1. Section 1798.24 of the Civil Code is amended to read:

1798.24. An agency shall not disclose any personal information in a manner that would ~~link the information disclosed to~~ *identify*

the individual to whom it pertains unless the information is disclosed, as follows:

(a) To the individual to whom the information pertains.

(b) With the prior written voluntary consent of the individual to whom the ~~record~~ *information* pertains, but only if that consent has been obtained not more than 30 days before the disclosure, or in the time limit agreed to by the individual in the written consent.

(c) To the duly appointed guardian or conservator of the individual or a person representing the individual if it can be proven with reasonable certainty through the possession of agency forms, ~~documents~~ *documents,* or correspondence that this person is the authorized representative of the individual to whom the information pertains.

(d) To those officers, employees, attorneys, agents, or volunteers of the agency that has custody of the information if the disclosure is relevant and necessary in the ordinary course of the performance of their official duties and is related to the purpose for which the information was acquired.

(e) To a person, or to another agency ~~where~~ *if* the transfer is necessary for the transferee agency to perform its constitutional or statutory duties, and the use is compatible with a purpose for which the information was collected and the use or transfer is ~~accounted for~~ in accordance with Section 1798.25. With respect to information transferred from a law enforcement or regulatory agency, or information transferred to another law enforcement or regulatory agency, a use is compatible if the use of the information requested is needed in an investigation of unlawful activity under the jurisdiction of the requesting agency or for licensing, certification, or regulatory purposes by that agency.

(f) To a governmental entity ~~when~~ *if* required by state or federal law.

(g) Pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(h) To a person who has provided the agency with advance, adequate written assurance that the information will be used solely for statistical research or reporting purposes, but only if the information to be disclosed is in a form that will not identify any individual.

(i) Pursuant to a determination by the agency that maintains information that compelling circumstances exist that affect the health or safety of an individual, if upon the disclosure notification is transmitted to the individual to whom the information pertains at his or her last known address. Disclosure shall not be made if it is in conflict with other state or federal laws.

(j) To the State Archives as a record that has sufficient historical or other value to warrant its continued preservation by the California state government, or for evaluation by the Director of General Services or his or her designee to determine whether the record has further administrative, legal, or fiscal value.

(k) To any person pursuant to a subpoena, court order, or other compulsory legal process if, before the disclosure, the agency reasonably attempts to notify the individual to whom the record pertains, and if the notification is not prohibited by law.

(*l*) To any person pursuant to a search warrant.

(m) Pursuant to Article 3 (commencing with Section 1800) of Chapter 1 of Division 2 of the Vehicle Code.

(n) For the sole purpose of verifying and paying government health care service claims made pursuant to Division 9 (commencing with Section 10000) of the Welfare and Institutions Code.

(o) To a law enforcement or regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes, unless the disclosure is otherwise prohibited by law.

(p) To another person or governmental organization to the extent necessary to obtain information from the person or governmental organization ~~as necessary~~ for an investigation by the agency of a failure to comply with a specific state law that the agency is responsible for enforcing.

(q) To an adopted person and is limited to general background information pertaining to the adopted person's ~~natural~~ *biological* parents, ~~provided that~~ *if* the information does not include or reveal the identity of the ~~natural~~ *biological* parents.

(r) To a child or a grandchild of an adopted person and disclosure is limited to medically necessary information pertaining to the adopted person's ~~natural~~ *biological* parents. However, the information, or the process for obtaining the information, shall not include or reveal the identity of the ~~natural~~ *biological* parents. The

State Department of Social Services shall adopt regulations governing the release of information pursuant to this ~~subdivision by July 1, 1985.~~ *subdivision.* The regulations shall require licensed adoption agencies to provide the same services provided by the department as established by this subdivision.

(s) To a committee of the Legislature or to a Member of the Legislature, or his or her staff ~~when~~ *if* authorized in writing by the member, ~~where~~ *if* the member has permission to obtain the information from the individual to whom it pertains or ~~where~~ *if* the member provides reasonable assurance that he or she is acting on behalf of the individual.

(t) (1) To the University of California, a nonprofit educational institution, or, in the case of education-related data, another nonprofit entity, conducting scientific research, ~~provided~~ *if* the request for information is approved by the Committee for the Protection of Human Subjects (CPHS) for the California Health and Human Services Agency (CHHSA) or an institutional review board, as authorized in paragraphs (4) and (5). The approval ~~required under this subdivision~~ shall include a review and determination that all the following criteria have been satisfied:

(A) The researcher has provided a plan sufficient to protect personal information from improper use and disclosures, including sufficient administrative, physical, and technical safeguards to protect personal information from reasonable anticipated threats to the security or confidentiality of the information.

(B) The researcher has provided a sufficient plan to destroy or return all personal information as soon as it is no longer needed for the research project, unless the researcher has demonstrated an ongoing need for the personal information for the research project and has provided a long-term plan sufficient to protect the confidentiality of that information.

(C) The researcher has provided sufficient written assurances that the personal information will not be reused or disclosed to any other person or entity, or used in any manner, not approved in the research protocol, except as required by law or for authorized oversight of the research project.

(2) The CPHS or institutional review board shall, at a minimum, accomplish all of the following as part of its review and approval of the research project for the purpose of protecting personal information held in agency databases:

(A) Determine whether the requested personal information is needed to conduct the research.

(B) Permit access to personal information only if it is needed for the research project.

(C) Permit access only to the minimum necessary personal information needed for the research project.

(D) Require the assignment of unique subject codes that are not derived from personal information in lieu of social security numbers if the research can still be conducted without social security numbers.

(E) If feasible, and if cost, time, and technical expertise permit, require the agency to conduct a portion of the data processing for the researcher to minimize the release of personal information.

(3) Reasonable costs to the agency associated with the agency's process of protecting personal information under the conditions of CPHS approval may be billed to the researcher, including, but not limited to, the agency's costs for conducting a portion of the data processing for the researcher, removing personal information, encrypting or otherwise securing personal information, or assigning subject codes.

(4) The CPHS may enter into written agreements to enable other institutional review boards to provide the data security approvals required by this subdivision, ~~provided~~ *if* the data security requirements set forth in this subdivision are satisfied.

(5) Pursuant to paragraph (4), the CPHS shall enter into a written agreement with the institutional review board established pursuant to *former* Section ~~49079.5~~ *49079.6* of the Education Code. The agreement shall authorize, commencing July 1, 2010, or the date upon which the written agreement is executed, whichever is later, that board to provide the data security approvals required by this subdivision, ~~provided~~ *if* the data security requirements set forth in this subdivision and the act specified in ~~paragraph (1) of~~ subdivision (a) of Section 49079.5 *of the Education Code* are satisfied.

(u) To an insurer if authorized by Chapter 5 (commencing with Section 10900) of Division 4 of the Vehicle Code.

(v) Pursuant to Section 450, 452, 8009, or 18396 of the Financial Code.

(w) For the sole purpose of participation in interstate data sharing of prescription drug monitoring program information

pursuant to the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code), if disclosure is limited to prescription drug monitoring program information.

This article ~~shall~~ *does* not ~~be construed to~~ require the disclosure of personal information to the individual to whom the information pertains ~~when~~ *if* that information may otherwise be withheld as set forth in Section 1798.40.

~~SECTION 1.~~

SEC. 2. Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data

may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, ~~provided that~~ *if* patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party, unless authorized by, or pursuant to, state and federal privacy and security laws and regulations. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(B) Notwithstanding subparagraph (A), a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

(3) The Department of Justice shall, no later than July 1, 2020, adopt regulations regarding the access and use of the information within CURES. The Department of Justice shall consult with stakeholders representing law enforcement agencies, the licensed prescriber and dispenser communities, and any other stakeholders identified by the department during the rulemaking process. The regulations shall, at a minimum, address all of the following in a manner consistent with this chapter:

(A) The process for approving, denying, and disapproving individuals or entities seeking access to information in CURES.

(B) The purposes for which a health care practitioner may access information in CURES.

(C) The conditions under which a warrant, subpoena, or court order is required for a law enforcement agency to obtain information from CURES as part of a criminal investigation of a patient or health care practitioner, respectively.

(D) The process by which information in CURES may be provided for educational, peer review, statistical, or research purposes.

(4) Consistent with this subdivision, a health care practitioner otherwise eligible for access to CURES, or a pharmacist who is employed by a health insurer or health care service plan and is involved in accepting, denying, or adjusting a claim for health insurance policy benefits or health care service plan contract

benefits related to controlled substances, may access CURES for purposes of reviewing a claim.

~~(3)~~

(5) In accordance with federal and state privacy laws and regulations, a health care practitioner may provide a patient with a copy of the patient's CURES patient activity report as long as no additional CURES data ~~is~~ *are* provided and keep a copy of the report in the patient's medical record in compliance with subdivision (d) of Section 11165.1.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(e) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber and dispenser invitees shall be licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

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

(g) The Department of Justice may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

(h) (1) The Department of Justice may enter into an agreement with ~~an~~ *any* entity operating an interstate data ~~share hub for purposes of participating in interjurisdictional information sharing between prescription drug monitoring programs across state lines.~~ *sharing hub, or any agency operating a prescription drug monitoring program in another state, for purposes of interstate data sharing of prescription drug monitoring program information.*

(2) Data obtained from CURES may be provided to authorized users of another state's prescription drug monitoring program, as determined by the Department of Justice pursuant to subdivision (c), if the entity operating the interstate data sharing hub, and the prescription drug monitoring program of that state, as applicable, have entered into an agreement with the Department of Justice for interstate data sharing of prescription drug monitoring program information.

~~(2)~~

(3) Any agreement entered into by the Department of Justice for purposes of interstate data sharing *of prescription drug monitoring program information* shall ensure that all access to data ~~within~~ *obtained from* CURES complies with California ~~law~~

law, including regulations, and meets the same patient ~~privacy~~ *privacy, audit,* and data security standards employed and required for direct access ~~of~~ *to* CURES.

(4) For purposes of interstate data sharing of CURES information pursuant to this subdivision, an authorized user of another state's prescription drug monitoring program shall not be required to register with CURES, if he or she is registered and in good standing with that state's prescription drug monitoring program.

(5) The Department of Justice shall not enter into an agreement pursuant to this subdivision until the department has issued final regulations regarding the access and use of the information within CURES as required by paragraph (3) of subdivision (c).

SEC. 3. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the department to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the department. Upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under his or her ~~care~~ *care, or for whom the practitioner is involved in accepting, denying, or adjusting a claim for health insurance policy benefits or health care service plan contract benefits related to controlled substances,* based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the department to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the department. Upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under his or her ~~care~~ *care, or for whom the pharmacist is involved in accepting, denying, or adjusting a claim for health insurance policy benefits or health*

care service plan contract benefits related to controlled substances, based on data contained in the CURES PDMP.

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

(i) Materially falsifying an application to access information contained in the CURES database.

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

(iii) Having his or her federal DEA registration suspended or revoked.

(iv) Violating a 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) Accessing information for a reason other than to diagnose or treat his or her patients, *or to assess or ensure patient safety, or to make a determination regarding accepting, denying, or adjusting a claim for health insurance policy benefits or health care service plan contract benefits,* or to document compliance with the law.

(C) An authorized subscriber shall notify the department within 30 days of any changes to the subscriber account.

(D) Commencing no later than October 1, 2018, an approved health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist pursuant to subdivision (b) of Section 209 of the Business and Professions Code may use the department's online portal or a health information technology system that meets the criteria required in subparagraph (E) to access information in the CURES database pursuant to this section. A subscriber who uses a health information technology system that meets the criteria required in subparagraph (E) to access the CURES database may submit automated queries to the CURES database that are triggered by predetermined criteria.

(E) Commencing no later than October 1, 2018, an approved health care practitioner or pharmacist may submit queries to the CURES database through a health information technology system if the entity that operates the health information technology system can certify all of the following:

(i) The entity will not use or disclose data received from the CURES database for any purpose other than delivering the data

to an approved health care practitioner or pharmacist or performing data processing activities that may be necessary to enable the delivery unless authorized by, and pursuant to, state and federal privacy and security laws and regulations.

(ii) The health information technology system will authenticate the identity of an authorized health care practitioner or pharmacist initiating queries to the CURES database and, at the time of the query to the CURES database, the health information technology system submits the following data regarding the query to CURES:

(I) The date of the query.

(II) The time of the query.

(III) The first and last name of the patient queried.

(IV) The date of birth of the patient queried.

(V) The identification of the CURES user for whom the system is making the query.

(iii) The health information technology system meets applicable patient privacy and information security requirements of state and federal law.

(iv) The entity has entered into a memorandum of understanding with the department that solely addresses the technical specifications of the health information technology system to ensure the security of the data in the CURES database and the secure transfer of data from the CURES database. The technical specifications shall be universal for all health information technology systems that establish a method of system integration to retrieve information from the CURES database. The memorandum of understanding shall not govern, or in any way impact or restrict, the use of data received from the CURES database or impose any additional burdens on covered entities in compliance with the regulations promulgated pursuant to the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations.

(F) No later than October 1, 2018, the department shall develop a programming interface or other method of system integration to allow health information technology systems that meet the requirements in subparagraph (E) to retrieve information in the CURES database on behalf of an authorized health care practitioner or pharmacist.

(G) The department shall not access patient-identifiable information in an entity's health information technology system.

(H) An entity that operates a health information technology system that is requesting to establish an integration with the CURES database shall pay a reasonable fee to cover the cost of establishing and maintaining integration with the CURES database.

(I) The department may prohibit integration or terminate a health information technology system's ability to retrieve information in the CURES database if the health information technology system fails to meet the requirements of subparagraph (E), or the entity operating the health information technology system does not fulfill its obligation under subparagraph (H).

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

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

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the department 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.~~ *individual, including services provided by a practitioner or pharmacist employed by a health insurer or health care service plan who reviews claims related to that individual.*

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the department pursuant to this section is 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 practitioner 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.

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

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

(1) "Automated basis" means using predefined criteria to trigger an automated query to the CURES database, which can be attributed to a specific health care practitioner or pharmacist.

(2) "Department" means the Department of Justice.

(3) "Entity" means an organization that operates, or provides or makes available, a health information technology system to a health care practitioner or pharmacist.

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

(5) "User-initiated basis" means an authorized health care practitioner or pharmacist has taken an action to initiate the query to the CURES database, such as clicking a button, issuing a voice command, or taking some other action that can be attributed to a specific health care practitioner or pharmacist.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1752
Author: Low
Bill Date: June 20, 2018, Amended
Subject: Controlled Substances: CURES Database
Sponsor: California State Board of Pharmacy
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would add Schedule V drugs to the Controlled Substances Utilization Review and Evaluation System (CURES) database and would shorten the timeline for pharmacists to report dispensed prescriptions.

BACKGROUND:

The CURES Program is currently housed in the Department of Justice (DOJ) and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, to access patient controlled substance history information through a secure website. SB 809 (DeSaulnier, Chapter 400) was signed into law in 2013 and included a provision to collect funds from boards that license individuals who prescribe and dispense, for purposes of funding and upgrading the CURES system. This bill also required all prescribers to register with CURES by January 1, 2016, but the law was amended to extend the registration deadline to July 1, 2016. The new CURES 2.0 system, which is a modernized system that has been updated to more efficiently serve prescribers, pharmacists and other entities, is now operational and available online, as long as the prescriber uses a compliant browser.

According to the Centers for Disease Control and Prevention, drug overdose deaths and opioid-involved deaths continue to increase in the United States. Since 1999, the number of overdose deaths involving opioids quadrupled. From 2000 to 2015, more than half a million people died from drug overdoses. Opioids killed more than 42,000 people in 2016, more than any year on record.

ANALYSIS

This bill would add Schedule V drugs to CURES and would shorten the timeframe for pharmacists to report dispensed controlled substances to CURES, from the current seven days, to one working day after the date a controlled

substance is dispensed. This bill would also require pharmacies to report to DOJ the date of the sale of the prescription, if applicable.

According to the author, the recent rise in street use of cough syrups containing the opioid codeine has led to a spike in theft and abuse of Schedule V drugs. Adding Schedule V drugs to CURES will help to curb the abuse and diversion of all controlled substances. Changing the 7-day reporting timeline to one-day will allow for more real-time access to data used to prevent prescription drug abuse.

This bill will not add Schedule V drugs to the section of law that requires physicians to check the CURES database. Therefore, adding Schedule V drugs to CURES will have a significant impact on dispensers, not prescribers. In addition, changing the reporting deadline for dispensers will result in up-to-date information in CURES and will make it even more of an effective aid for physicians to use to prevent doctor shopping. This bill would also expand the controlled substances information included in CURES. The Board is supportive of these provisions. For these reasons the Board is supportive of this bill.

FISCAL: None to the Board

SUPPORT: California State Board of Pharmacy (Sponsor); California Association of Health Underwriters; California Chiropractic Association; California Dental Association; California District Attorneys Association; California Medical Association; California Police Chiefs Association; California Society of Anesthesiologists; California State Sheriffs' Association; Consumer Attorneys of California; County Behavioral Health Directors Association; Medical Board of California; and Troy and Alana Pack Foundation

OPPOSITION: American Civil Liberties Union
Electronic Frontier Foundation

AMENDED IN SENATE JUNE 20, 2018

AMENDED IN ASSEMBLY APRIL 5, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1752

Introduced by Assembly Member Low

January 3, 2018

An act to amend Sections 11165 and 11165.1 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

AB 1752, as amended, Low. Controlled substances: CURES database.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by a health care practitioner authorized to prescribe, order, administer, furnish, or dispense a Schedule II, Schedule III, or Schedule IV controlled substance. Existing law requires a dispensing pharmacy, clinic, or other dispenser to report specified information to the Department of Justice as soon as reasonably possible, but not more than 7 days after the date a controlled substance is dispensed.

This bill would add Schedule V controlled substances to the CURES database. The bill would require a dispensing pharmacy, clinic, or other dispenser to report the information required by the CURES database no more than one working day after a controlled substance is dispensed. The bill would ~~change what information is required to be reported by deleting references to classification codes and adding the date of sale~~

~~of the prescription.~~ *additionally require the date of sale of the prescription, if applicable, to be reported.*

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 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, Schedule IV, and Schedule V controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, Schedule IV, and Schedule V controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or

research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party, unless authorized by, or pursuant to, state and federal privacy and security laws and regulations. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(B) Notwithstanding subparagraph (A), a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

(3) In accordance with federal and state privacy laws and regulations, a health care practitioner may provide a patient with a copy of the patient's CURES patient activity report as long as no additional CURES data is provided and keep a copy of the report in the patient's medical record in compliance with subdivision (d) of Section 11165.1.

(d) For each prescription for a Schedule II, Schedule III, Schedule IV, or Schedule V controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, 1308.14, and 1308.15, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than one working day after the date a controlled substance is dispensed, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

~~(6)~~

(7) Number of refills ordered.

~~(7)~~

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

~~(8)~~

(9) Date of origin of the prescription.

~~(9)~~

(10) Date of dispensing of the prescription.

~~(10)~~

(11) Date of sale of the ~~prescription.~~ *prescription, if applicable.*

(e) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber and dispenser invitees shall be licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

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

(g) The Department of Justice may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

SEC. 2. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, Schedule IV, or Schedule V controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the department to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the department. Upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

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

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

(i) Materially falsifying an application to access information contained in the CURES database.

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

(iii) Having his or her federal DEA registration suspended or revoked.

(iv) Violating a 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) Accessing information for a reason other than to diagnose or treat his or her patients, or to document compliance with the law.

(C) An authorized subscriber shall notify the department within 30 days of any changes to the subscriber account.

(D) Commencing no later than October 1, 2018, an approved health care practitioner, pharmacist, and any person acting on

behalf of a health care practitioner or pharmacist pursuant to subdivision (b) of Section 209 of the Business and Professions Code may use the department's online portal or a health information technology system that meets the criteria required in subparagraph (E) to access information in the CURES database pursuant to this section. A subscriber who uses a health information technology system that meets the criteria required in subparagraph (E) to access the CURES database may submit automated queries to the CURES database that are triggered by predetermined criteria.

(E) Commencing no later than October 1, 2018, an approved health care practitioner or pharmacist may submit queries to the CURES database through a health information technology system if the entity that operates the health information technology system can certify all of the following:

(i) The entity will not use or disclose data received from the CURES database for any purpose other than delivering the data to an approved health care practitioner or pharmacist or performing data processing activities that may be necessary to enable the delivery unless authorized by, and pursuant to, state and federal privacy and security laws and regulations.

(ii) The health information technology system will authenticate the identity of an authorized health care practitioner or pharmacist initiating queries to the CURES database and, at the time of the query to the CURES database, the health information technology system submits the following data regarding the query to CURES:

(I) The date of the query.

(II) The time of the query.

(III) The first and last name of the patient queried.

(IV) The date of birth of the patient queried.

(V) The identification of the CURES user for whom the system is making the query.

(iii) The health information technology system meets applicable patient privacy and information security requirements of state and federal law.

(iv) The entity has entered into a memorandum of understanding with the department that solely addresses the technical specifications of the health information technology system to ensure the security of the data in the CURES database and the secure transfer of data from the CURES database. The technical specifications shall be universal for all health information

technology systems that establish a method of system integration to retrieve information from the CURES database. The memorandum of understanding shall not govern, or in any way impact or restrict, the use of data received from the CURES database or impose any additional burdens on covered entities in compliance with the regulations promulgated pursuant to the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations.

(F) No later than October 1, 2018, the department shall develop a programming interface or other method of system integration to allow health information technology systems that meet the requirements in subparagraph (E) to retrieve information in the CURES database on behalf of an authorized health care practitioner or pharmacist.

(G) The department shall not access patient-identifiable information in an entity's health information technology system.

(H) An entity that operates a health information technology system that is requesting to establish an integration with the CURES database shall pay a reasonable fee to cover the cost of establishing and maintaining integration with the CURES database.

(I) The department may prohibit integration or terminate a health information technology system's ability to retrieve information in the CURES database if the health information technology system fails to meet the requirements of subparagraph (E), or the entity operating the health information technology system does not fulfill its obligation under subparagraph (H).

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

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

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, Schedule IV, or Schedule V

controlled substances, the department may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

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

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

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

(1) "Automated basis" means using predefined criteria to trigger an automated query to the CURES database, which can be attributed to a specific health care practitioner or pharmacist.

(2) "Department" means the Department of Justice.

(3) "Entity" means an organization that operates, or provides or makes available, a health information technology system to a health care practitioner or pharmacist.

(4) "Health information technology system" means an information processing application using hardware and software for the storage, retrieval, sharing of or use of patient data for communication, decisionmaking, coordination of care, or the quality, safety, or efficiency of the practice of medicine or delivery of health care services, including, but not limited to, electronic

medical record applications, health information exchange systems, or other interoperable clinical or health care information system.

(5) "User-initiated basis" means an authorized health care practitioner or pharmacist has taken an action to initiate the query to the CURES database, such as clicking a button, issuing a voice command, or taking some other action that can be attributed to a specific health care practitioner or pharmacist.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1998
Author: Rodriguez
Bill Date: July 2, 2018, Amended
Subject: Opioids: Safe Prescribing Policy
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require, by July 1, 2019, every health care practitioner who prescribes, administers or furnishes opioids to establish or adopt a safe opioid prescribing policy (policy), as specified. This bill would specify that it does not apply to veterinarians.

BACKGROUND:

According to the Centers for Disease Control and Prevention, drug overdose deaths continue to increase in the United States. From 1999 to 2016, more than 630,000 people have died from a drug overdose. Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid. In 2016, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 5 times higher than in 1999. On average, 115 Americans die every day from an opioid overdose.

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

In 2014, the Director of the California Department of Public Health (CDPH) launched a state agency Prescription Opioid Misuse and Overdose Prevention

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

ANALYSIS

This bill would state the intent of the Legislature from July 1, 2019, to July 1, 2023, is to continue in a year-over-year downward trend for opioid prescriptions in California, consistent with the average trend established between 2014 and 2017. This bill would require, by July 1, 2019, every health care practitioner who prescribes, orders, administers or furnishes opioids classified as Schedule II and Schedule III to establish or adopt a safe opioid prescribing policy. This bill would specify that a health care practitioner or group of practitioners, including a hospital pharmacy and therapeutics committee, is deemed to have satisfied the requirements of this bill by adopting a nationally or professionally recognized guideline, or a guideline established by the state licensing board or commission that was updated after January 1, 2015, for the use of opioids for managing pain if the guideline meets the criteria specified in this bill.

This bill would require the policy to be a written document promoting the appropriate dosage and duration of opioid prescriptions for a health care provider's patients, with the goal of reducing the overall prescription, administration, or furnishing of opioids to the lowest effective dose and the shortest duration necessary to treat the patient. This bill would require the policy to include, but not be limited to, all of the following:

- The appropriate dose and duration of prescriptions for adult patients, as applicable, experiencing acute pain.
- The appropriate dose and duration of prescriptions for pediatric patients, as applicable, experiencing acute pain.
- Alternatives to opioid treatment, including non-pharmacological treatment options and referral to specialty care, as appropriate.
- Recommendations for assessing patients' continued use of opioids for pain management.
- Recommendations for counseling patients on overdose and addiction risk and response.

In addition to the above-mentioned requirements, this bill would require every policy to include a requirement that the prescriber offer a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression to a patient when one or more of the following conditions are present:

- The prescription dosage for the patient is 90 morphine milligram equivalents or more of an opioid medication per day.
- An opioid medication is prescribed concurrently with a prescription for a benzodiazepine.
- The patient presents an increased risk for overdose, including a patient with a history of overdose, a patient with a history of substance use disorder, or a patient at risk of returning to a high dose of opioid medication to which the patient is no longer tolerant.

This bill would require the development of the policy to include review and consideration of evidence-based science, literature, research, and guidelines, including relevant recommendations and research from academia and consideration of existing guidelines and recommendations from groups including, but not limited to, the federal Centers for Disease Control and Prevention, the federal Centers for Medicare and Medicaid Services, the Board, and the American Society of Addiction Medicine.

This bill would require the policy to be reviewed periodically and updated according to applicable scientific studies and available data.

This bill would specify that when a prescriber determines, based on his or her professional judgment, that the policy is not appropriate for a specific patient's treatment, the health care practitioner must provide adequate documentation in the patient's record to support the treatment decision.

This bill would specify that the policy shall not place limitations on the prescription, ordering, administration, or furnishing of opioids to patients undergoing treatment for chronic pain, cancer, substance use disorder, sickle cell disease with acute intermittent porphyria, hospice, or end-of-life care.

This bill would state a health care practitioner who fails to establish or adopt a policy must be referred to the appropriate state licensing board solely for administrative sanctions, as deemed appropriate by that board. This bill would specify that this bill does not create a private right of action against a health care practitioner or limit a practitioner's liability for the negligent failure to diagnose or treat a patient.

This bill would require CDPH, by July 1, 2024, to submit a report to the Legislature and publish the report to the public, using data from the CURES database, detailing progress toward the end goal of continuing in a year-over-year downward trend for opioid prescriptions in California. This bill would allow and encourage CDPH to contract with an independent academic entity,

including the University of California, to prepare the report. This bill would require the report to address, but not be limited to, the following:

- The overall number of opioid prescriptions, rates of opioid prescription per 1,000 persons, and morphine milligram equivalents per year in the years 2019 to 2023, inclusive. The information must be provided in total, and by prescriber's license.
- The overall year-by-year change in opioid prescriptions, rates of opioid prescription per 1,000 persons, and morphine milligram equivalents from the years 2019 to 2023, inclusive.
- The progress made toward reducing the over-prescription of opioids.
- Recommendations for whether further reduction of opioid prescription is needed.
- Information, if available, on opioid prescriptions by geographic location.

This bill would require CDPH to provide an opportunity for feedback on the draft report by relevant stakeholders before publishing the final report. This bill would sunset the reporting requirement on July 1, 2028.

The growing opioid abuse epidemic remains a matter of concern for the Board. This bill does not mandate the standard of care in law, but it does require physicians to have a policy for prescribing opioids, which may help to promote appropriate prescribing. This bill would require individual physicians and/or physician groups to develop policies for safe prescribing. However, instead of each individual physician and group developing a new policy, this bill would allow them to adopt a nationally or professionally recognized guideline, or a guideline established by the state licensing board or commission that was updated after January 1, 2015, for the use of opioids for managing pain if the guideline meets the criteria specified in this bill. The intent of putting the 2015 date in this bill is to incentivize the Board to update its Guidelines, which were adopted in November 2014. The Board already plans on updating its guidelines if it receives feedback from interested parties that updates are needed. Not allowing physicians and groups to use the Board's current Guidelines is problematic. Board staff suggests that the Board now take a neutral if amended position and request that the date be changed to 2014, to allow the Board's guidelines to be used by physicians to meet the requirements of this bill.

FISCAL: Minimal and absorbable

SUPPORT: America's Physician Groups; California Access Coalition; California Association of Code Enforcement Officers; California College and University Police Chiefs Association; California Council of Community Behavioral Health Agencies; California Narcotic Officers Association; Depression and Bipolar Support Alliance; Los Angeles County Professional Peace Officers Association; and Osteopathic Physicians and Surgeons of California

OPPOSITION: California Academy of Family Physicians

California Chapter of the American College of Emergency Physicians

POSITION: Recommendation: Neutral if Amended

AMENDED IN SENATE JULY 2, 2018

AMENDED IN SENATE JUNE 19, 2018

AMENDED IN ASSEMBLY MAY 25, 2018

AMENDED IN ASSEMBLY APRIL 11, 2018

AMENDED IN ASSEMBLY MARCH 12, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1998

Introduced by Assembly Member Rodriguez

February 1, 2018

An act to add Section 11153.1 to the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

AB 1998, as amended, Rodriguez. Opioids: safe prescribing policy.

Existing law, the Uniform Controlled Substances Act, classifies opioids as Schedule II controlled substances and places restrictions on the prescription of those drugs, including prohibiting refills and specifying the requirements of a prescription for these drugs. Violation of these provisions and the Uniform Controlled Substances Act is a misdemeanor.

This bill would require, by July 1, 2019, every health care ~~practitioner~~ *practitioner, with the exception of veterinarians,* who prescribes, ~~orders,~~ administers, or furnishes opioids classified as Schedule II and Schedule III to adopt, review, and periodically update a safe opioid prescribing policy, as specified. The bill would prohibit the safe opioid prescribing policy from placing a limitation on the prescription, ordering,

administration, or furnishing of opioids to patients with prescribed conditions. The bill would require a health care practitioner who determines, based on his or her professional judgment, that the safe prescribing policy is not appropriate for a specific patient's treatment, to provide adequate documentation in the patient's record to support the treatment decision. The bill would make the failure to establish or adopt a safe opioid prescribing policy to be referred to the appropriate state professional licensing board for administrative sanctions. Because violation of these provisions is also a crime, the bill would create a new crime, thereby imposing a state-mandated local program.

The bill would require the State Department of Public Health, utilizing data from the CURES database, to submit a report detailing progress toward the stated goals of declining opioid prescriptions, as specified.

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

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

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

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

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

(a) The opioid epidemic is a public health crisis affecting not only the State of California, but the entire country.

(b) According to the federal Centers for Disease Control and Prevention, 66 percent of the drug overdose deaths in the United States involve an opioid.

(c) In 2016, there were almost 2,000 overdose deaths due to opioids alone, and nearly 4,000 emergency room visits due to opioid overdoses.

(d) According to a 2018 University of Southern California study, about 83.45 percent of opioid prescriptions originated from physician offices.

(e) In 2016, there were 23 million opioid prescriptions in California, a state that has nearly 40 million residents.

(f) According to data from the State Department of Public Health, opioid prescriptions declined by an average of three percent between 2014 and 2017.

SEC. 2. Section 11153.1 is added to the Health and Safety Code, to read:

11153.1. (a) It is the intent of the Legislature that, from July 1, 2019, to July 1, 2023, inclusive, opioid prescriptions in California for Schedule II and Schedule III, as defined in Sections 11055 and 11056 respectively, continue in a year-over-year downward trend consistent with the average trend established between 2014 and 2017.

(b) By July 1, 2019, every health care practitioner who prescribes, ~~orders,~~ administers, or furnishes opioids classified as Schedule II and Schedule III pursuant to Sections 11055 and 11056, respectively, shall establish or adopt a safe opioid prescribing policy, as described in subdivision (d). A group of practitioners, including a hospital pharmacy and therapeutics committee, may adopt a safe opioid prescribing policy that applies to all parties as part of a business affiliation or contract with an organized provider group.

(c) A health care practitioner or group of practitioners, including a hospital pharmacy and therapeutics committee, is deemed to have satisfied this section by adopting a nationally or professionally recognized guideline, or a guideline established by the state licensing board or commission that was updated after January 1, 2015, for the use of opioids for managing pain if the guideline meets the criteria specified in subdivision (d).

(d) The safe opioid prescribing policy shall be a written document promoting the appropriate dosage and duration of opioid prescriptions for *a health care provider's* patients, with the goal of reducing the overall prescription, ~~ordering,~~ administration, or furnishing of opioids to the lowest effective dose and the shortest duration necessary to treat the patient. The policy shall address, but not be limited to, all of the following:

(1) The appropriate dose and duration of prescriptions for adult patients, as applicable, experiencing acute pain.

(2) The appropriate dose and duration of prescriptions for pediatric patients, as applicable, experiencing acute pain.

(3) Alternatives to opioid treatment, including nonpharmacological treatment options and referral to specialty care, as appropriate.

(4) Recommendations for assessing patients' continued use of opioids for pain management.

(5) Recommendations for counseling patients on overdose and addiction risk and response.

(e) In addition to the requirements in subdivision (d), every policy shall include a requirement that the prescriber offer a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression to a patient when one or more of the following conditions are present:

(1) The prescription dosage for the patient is 90 morphine ~~milligrams~~ *milligram equivalents* or more of an opioid medication per day.

(2) An opioid medication is prescribed concurrently with a prescription for benzodiazepine.

(3) The patient presents an increased risk for overdose, including a patient with a history of overdose, a patient with a history of substance use disorder, or a patient at risk of returning to a high dose of opioid medication to which the patient is no longer tolerant.

(f) The development of a safe opioid prescribing policy shall include review and consideration of evidence-based science, literature, research, and guidelines, including relevant recommendations and research from academia and consideration of existing guidelines and recommendations from groups including, but not limited to, the federal Centers for Disease Control and Prevention, the federal Centers for Medicare and Medicaid Services, the Medical Board of California, and the American Society of Addiction Medicine.

(g) The safe opioid prescribing policy shall be reviewed periodically and updated according to applicable scientific studies and available data.

(h) When a prescriber determines, based on his or her professional judgment, that the safe prescribing policy is not appropriate for a specific patient's treatment, the health care practitioner shall provide adequate documentation in the patient's record to support the treatment decision.

~~(i) A health care practitioner who prescribes, orders, administers, or furnishes opioids classified as Schedule II or Schedule III pursuant to Sections 11055 and 11056, respectively, to a hospital patient shall follow the guideline or policy of that hospital's pharmacy and therapeutics committee adopted pursuant to subdivision (b).~~

~~(j)~~

(i) The safe opioid prescribing policy shall not place limitations on the prescription, ordering, administration, or furnishing of opioids to patients undergoing treatment for chronic pain, cancer, substance use disorder, sickle cell disease with acute intermittent porphyria, hospice, *palliative care,* or end-of-life care.

~~(k)~~

(j) (1) A health care practitioner who fails to establish or adopt a safe opioid prescribing policy, as required by subdivision (b), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private right of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

~~(l)~~

(k) (1) By July 1, 2024, the State Department of Public Health shall submit a report to the Legislature and publish to the public, using data from the CURES database, detailing progress toward the goal stated in subdivision (a). The department may, and is encouraged to, contract with an independent academic entity, including the University of California, to prepare the report. The report shall address, but not be limited to, all of the following:

(A) The overall number of opioid prescriptions, rates of opioid prescription per 1,000 persons, and morphine milligram equivalents per year in the years 2019 to 2023, inclusive. This information shall be provided in total, and by prescribing license.

(B) The overall year-by-year change in opioid prescriptions, rates of opioid prescription per 1,000 persons, and morphine milligram equivalents from the years 2019 to 2023, inclusive.

(C) The progress made toward reducing the over-prescription of opioids.

(D) Recommendations for whether further reduction of opioid prescription is needed.

(E) Information, if available, on opioid prescriptions by geographic location.

(2) Before publishing the final report, the department shall provide an opportunity for feedback on the draft report by relevant stakeholders.

(3) The report submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(4) The requirement for submitting a report imposed under this subdivision is inoperative on July 1, 2028, pursuant to Section 10231.5 of the Government Code.

(l) This section does not apply to a veterinarian licensed pursuant to Chapter 11 (commencing with Section 4800) of Division 2 of the Business and Professions Code.

SEC. 3. 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.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 2138
Author:	Chiu and Low
Bill Date:	June 20, 2018, Amended
Subject:	Licensing boards: denial of application: revocation or suspension of licensure: criminal conviction
Sponsor:	Anti-Recidivism Coalition; East Bay Community Law Center; Legal Services for Prisoners with Children; and Root & Rebound

DESCRIPTION OF CURRENT LEGISLATION:

This bill would limit the current discretion given to boards, bureaus and committees within the Department of Consumer Affairs (DCA) to apply criminal conviction history for a license denial. This bill would prohibit regulatory boards from requiring an applicant to self-disclose criminal history information. This bill would require boards to collect and publish demographic data regarding applicants who are denied licensure or who have licenses revoked or suspended, among other provisions.

ANALYSIS

This bill would amend the definition of a conviction in the Business and Professions Code to mean a judgment following a plea or verdict of guilty or a plea of nolo contendere or finding of guilt. This bill would no longer allow a conviction that has been dismissed under Penal Code Section 1203.4 to fall under the definition of a conviction.

This bill would allow a board to deny a license on the grounds that the applicant has been convicted of a crime or has been subject to formal discipline only if any of the following conditions are met:

- The applicant has been convicted of a crime for which the applicant is presently incarcerated or for a conviction occurring within the preceding seven years. However, the preceding seven year limitation would not apply to a conviction for a serious felony, as defined in Penal Code Section 1192.7.
- The applicant has been subjected to formal discipline by a board within the preceding five years based on professional misconduct that would have been cause for discipline before the board for which the present application is made and that is substantially related to the qualifications, functions, or duties of the business or profession for which the present application is made. However, prior disciplinary action by a board within the preceding seven years shall not be the basis for denial of a license if the basis for that disciplinary action was a conviction that has been dismissed pursuant to the Penal Code, or a comparable dismissal or expungement.

This bill would prohibit a board from denying a license on the basis that an applicant has been convicted of a crime, or on the basis of the acts underlying a conviction for a crime, if the applicant has obtained a certificate of rehabilitation under the Penal Code, has been granted clemency or a pardon by a state or federal executive, or has made a showing of rehabilitation. This bill prohibits a board from denying a license on the basis of any conviction, or on the basis of the acts underlying the conviction, that has been dismissed pursuant to the Penal Code, or a comparable dismissal or expungement. This bill would prohibit a board from denying a license on the basis of an arrest that resulted in a disposition other than a conviction, including an arrest that resulted in an infraction, citation, or a juvenile adjudication. This bill would prohibit a board from denying a license based solely on an applicant's failure to disclose a fact that would not have been cause for denial of the license had it been disclosed.

This bill would require a board to adhere to the following procedures in requesting or acting on an applicant's or licensee's criminal history information:

- A board must not require an applicant for licensure or licensee to disclose any information or documentation regarding the applicant's criminal history.
- If a board decides to deny an application based solely or in part on the applicant's conviction history, the board shall notify the applicant in writing of all of the following:
    - The denial or disqualification of licensure.
    - Any existing procedure the board has for the applicant to challenge the decision or to request reconsideration.
    - That the applicant has the right to appeal the board's decision.
    - The processes for the applicant to request a copy of his or her complete conviction history and question the accuracy or completeness of the record pursuant to the Penal Code.

This bill would require each board to retain, for a minimum of three years, application forms and other documents submitted by an applicant, any notice provided to an applicant, all other communications received from and provided to an applicant, and criminal history reports of applicants. This bill would require each board to retain the number of applications received for each license and the number of applications requiring inquiries regarding criminal history. This bill would require each board to retain the number of applications received for each license and the number of application requiring inquiries regarding criminal history. In addition, this bill would require each board to retain all of the following information:

- The number of applicants with a criminal record who received notice of denial or disqualification of licensure.
- The number of applicants with a criminal record who provided evidence of mitigation or rehabilitation.
- The number of applicants with a criminal record who appealed any denial or disqualification of licensure.

- The final disposition and demographic information, including, but not limited to, voluntarily provided information on race or gender, of any applicant described in the above bullets.

This bill would require each board to annually make the required reporting information available to the public through the board's internet website and through a report submitted to the appropriate policy committees of the Legislature, of the de-identified information collected. This bill would require each board to ensure confidentiality of the individual applicants.

This bill would require each board to develop criteria to aid it, when considering the denial, suspension, or revocation of a license, to determine whether a crime is substantially related to the qualifications, functions, or duties of the business or profession it regulates.

This bill would require the criteria for determining whether a crime is substantially related to the qualifications, functions, or duties of the business or profession a board regulates to include all of the following:

- The nature and gravity of the offense.
- The number of years elapsed since the date of the offense.
- The nature and duties of the profession in which the applicant seeks licensure or in which the licensee is licensed.

This bill would prohibit a board from denying a license based in whole or in part on a conviction, without considering evidence of rehabilitation. This bill would require each board to post on its website a summary of the criteria used to consider whether a crime is considered to be substantially related to the qualifications, functions, or duties of the business or profession it regulates.

This bill would require each board to consider that an applicant or licensee has made a showing of rehabilitation if any of the following are met:

- The applicant or licensee has completed the criminal sentence at issue without a violation of parole or probation.
- The applicant or licensee has satisfied criteria for rehabilitation developed by the board.

This bill would prohibit a board from categorically barring an applicant based solely on the type of conviction without considering evidence of rehabilitation.

The author's office believes this bill will reduce barriers to entry in occupational licensure for individuals with prior convictions, which the author believes will reduce recidivism and provide economic opportunity to Californians.

This bill was significantly amended and the amendments did address many of the Board's previous concerns. However, this bill still does limit the Board's current discretion to deny a license based on criminal convictions. Staff still has the following concerns: This bill would not allow the Board to consider the acts underlying the conviction for dismissed or expunged convictions; this bill would

not require an applicant to disclose criminal conviction information on the application; this bill would not allow the Board to automatically deny an application if the individual is a registered sex offender, as existing law allows; and lastly, this bill would not allow the Board to include criminal convictions for crimes that have rehabilitated, dismissed, or expunged as one of the reasons to deny a license.

This bill will still result in some fiscal impact for the record retention and reporting requirements. Although the amendments do address many of the Board's concerns, staff is suggesting that the Board oppose this bill unless amendments are made to address the remaining concerns.

FISCAL: Board staff estimates it will need one half-time office technician position to ensure the Board is meeting the record retention requirements. The Board would also need a .25 Information Technology Specialist I to create and run the annual report required by this bill. This is estimated at a cost of $61,000 per year for both positions.

SUPPORT: Anti-Recidivism Coalition (Sponsor); East Bay Community Law Center (Sponsor); Legal Services for Prisoners With Children (Sponsor); Root & Rebound (Sponsor); A New Way of Life Reentry Project; Alameda County Public Defender's Office; All of us or None; American Civil Liberties Union of California; Anchor of Hope; Bay Area Legal Aid; Bayview Hunters Point Foundation for Community Improvement, Inc.; California Immigrant Policy Center; California Labor Federation; California Landscape Contractors Association; California Pan-Ethnic Health Network; California Public Defenders Association; Center for Employment Opportunities; Center on Juvenile and Criminal Justice; City and County of San Francisco; Checkr, Inc.; Courage Campaign; Downtown Women's Center; Ella Baker Center for Human Rights; Hunters Point Family; Lawyers' Committee for Civil Rights of San Francisco Bay Area; Leadership for Urban Renewal Network; Los Angeles Regional Reenrty Partnership; National Association of Social Workers, California Chapter; National Employment Law Project; Oakland Private Industry Council, Inc.; Planting Justice; PolicyLink; REDF; Rise Together; Roots Community Health Center; Rubicon; San Francisco Conservation Corps; San Francisco Public Defender's Office; and Young Women's Freedom Center

OPPOSITION: Board for Professional Engineers, Land Surveyors and Geologists; Board of Behavioral Sciences; California Board of Accountancy; California Board of Psychology; California

State Board of Pharmacy; Contractors State License Board; Medical Board of California; and Physician Assistant Board

POSITION: Recommendation: Oppose Unless Amended

AMENDED IN SENATE JUNE 20, 2018

AMENDED IN ASSEMBLY MAY 25, 2018

AMENDED IN ASSEMBLY APRIL 2, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2138

Introduced by Assembly Members Chiu and Low

February 12, 2018

An act to amend Sections 7.5, 480, 481, 482, 488, ~~490, 492,~~ 493, and 11345.2 ~~of, and to add Section 481.5 to,~~ *of* the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 2138, as amended, Chiu. Licensing boards: denial of application: revocation or suspension of licensure: criminal conviction.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes a board to deny, suspend, or revoke a license or take disciplinary action against a licensee on the grounds that the applicant or licensee has, among other things, been convicted of a crime, as specified. Existing law provides that a person shall not be denied a license solely on the basis that the person has been convicted of a felony if he or she has obtained a certificate of rehabilitation or that the person has been convicted of a misdemeanor if he or she has met applicable requirements of rehabilitation developed by the board, as specified. Existing law also prohibits a person from being denied a license solely on the basis of a conviction that has been dismissed, as specified. Existing law requires a board to develop criteria to aid it when considering the denial, suspension, or revocation of a license to

determine whether a crime is substantially related to the qualifications, functions, or duties of the business or profession the board regulates and requires a board to develop criteria to evaluate the rehabilitation of a person when considering the denial, suspension, or revocation of a license.

This bill would revise and recast those provisions to instead authorize a board to, among other things, deny, revoke, or suspend a license on the grounds that the applicant or licensee has been convicted of a crime only if the applicant or licensee is presently incarcerated or if the conviction, as defined, occurred within the preceding ~~5~~ *7* years, except for ~~violent~~ *serious* felonies, and would require the crime to be ~~directly and adversely~~ *substantially* related to the qualifications, functions, or duties of the business or profession. The bill would prohibit a board from denying a person a license based on the conviction of a crime, or on the basis of acts underlying a conviction for a crime, if the conviction has been dismissed or expunged, if the person has ~~made a showing~~ *provided evidence* of rehabilitation, if the person has been granted clemency or a pardon, or if an arrest resulted in a disposition other than a conviction. ~~The bill would provide that these provisions relating to denial, revocation, or suspension of a license would supersede contradictory provisions in specified existing law.~~

The bill would require the board to develop criteria for determining whether a crime is ~~directly and adversely~~ *substantially* related to the qualifications, functions, or duties of the business or profession. The bill would require a board to find that a person has made a showing of rehabilitation if certain conditions are met. The bill would require a board to follow certain procedures when requesting or acting on an applicant's or licensee's criminal history information. The bill would also require a board to annually submit a report to the Legislature and post the report on its Internet Web site containing specified deidentified information regarding actions taken by a board based on an applicant or licensee's criminal history information.

Existing law authorizes a board to deny a license on the grounds that an applicant knowingly made a false statement of fact that is required to be revealed in the application for licensure.

This bill would prohibit a board from denying a license based solely on an applicant's failure to disclose a fact that would not have been cause for denial of the license had the fact been disclosed.

~~Existing law authorizes specified agencies to take disciplinary action against a licensee or deny a license for professional misconduct if the~~

~~licensee has successfully completed certain diversion programs or alcohol and drug problem assessment programs.~~

~~This bill would instead prohibit a board from taking disciplinary action against a licensee or denying a license for professional misconduct if the licensee has successfully completed certain diversion programs or alcohol and drug problem assessment programs or deferred entry of judgment.~~

Existing law authorizes a ~~board~~ *board,* after a specified hearing requested by an applicant for licensure to take various ~~actions, including imposing probationary conditions on the license.~~ *actions in relation to denying or granting the applicant the license.*

This bill would ~~additionally authorize a board to grant the license and immediately issue a public reproval. The bill would limit probationary terms or restrictions placed on a license by a board to 2 years or less and would authorize additional conditions to be imposed only if the board determines that there is clear and convincing evidence that additional conditions are necessary to address a risk shown by clear and convincing evidence. The bill would require a board to develop criteria to aid it in considering the imposition of probationary conditions and to determine what conditions may be imposed. The bill would authorize a licensee or registrant whose license or registration has been placed on probation to petition the board for a change to that probation one year from the effective date of the board's decision, would require the board to issue a decision on the petition within 90 days, and would deem the petition granted if the board does not file a decision denying the petition within 90 days.~~ *revise and recast those provisions to eliminate some of the more specific options that the board may take in these circumstances.*

This bill would also make necessary 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 7.5 of the Business and Professions Code is amended to read:

7.5. (a) A conviction within the meaning of this code means a judgment following a plea or verdict of guilty or a plea of nolo contendere or finding of guilt. Any action which a board is permitted to take following the establishment of a conviction may

be taken 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. However, a board may not deny a license to an applicant who is otherwise qualified pursuant to subdivision (b) or (c) of Section 480.

(b) *(1)* Nothing in this section shall apply to the licensure of persons pursuant to Chapter 4 (commencing with Section 6000) of Division 3.

(2) The changes made to this section by the act adding this paragraph do not in any way modify or otherwise affect the existing authority of the following entities in regard to licensure:

(A) The State Athletic Commission.

(B) The Bureau for Private Postsecondary Education.

(c) Except as provided in subdivision (b), this section controls over and supersedes the definition of conviction contained within individual practice acts under this code.

SEC. 2. Section 480 of the Business and Professions Code is amended to read:

480. (a) ~~(1)~~ Notwithstanding any other provision of this code, a board may deny a license regulated by this code on the grounds that the applicant has been convicted of a crime or has been subject to formal discipline only if either of the following conditions are met:

~~(A)~~

(1) The applicant has been convicted of a crime for which the applicant is presently incarcerated or for which the conviction occurred within the preceding ~~five~~ *seven* years. However, the preceding ~~five-year~~ *seven-year* limitation shall not apply to a conviction for a ~~violent~~ *serious* felony, as defined in ~~Section 667.5 of~~ the Penal Code.

The board may deny a license pursuant to this subparagraph only if the crime is ~~directly and adversely~~ *substantially* related to the qualifications, functions, or duties of the business or profession for which application is made.

~~(B)~~

(2) The applicant has been subjected to formal discipline by a licensing board within the preceding five years based on professional misconduct that would have been cause for discipline before the board for which the present application is made and that is ~~directly and adversely~~ *substantially* related to the qualifications,

functions, or duties of the business or profession for which the present application is made. However, prior disciplinary action by a licensing board within the preceding ~~five~~ *seven* years shall not be the basis for denial of a license if the basis for that disciplinary action was a conviction that has been dismissed pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code or a comparable dismissal or expungement.

~~(2) Denial of a license includes denial of an unrestricted license by issuance of a restricted or probationary license.~~

(b) Notwithstanding any other provision of this code, a person shall not be denied a license on the basis that he or she has been convicted of a crime, or on the basis of acts underlying a conviction for a crime, if he or she has obtained a certificate of rehabilitation under Chapter 3.5 (commencing with Section 4852.01) of Title 6 of Part 3 of the Penal Code, has been granted clemency or a pardon by a state or federal executive, or has ~~made a showing~~ *provided evidence* of rehabilitation pursuant to Section 482.

(c) Notwithstanding any other provision of this code, a person shall not be denied a license on the basis of any conviction, or on the basis of the acts underlying the conviction, that has been dismissed pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code, or a comparable dismissal or expungement. An applicant who has a conviction that has been dismissed pursuant to Section 1203.4, 1203.4a, 1203.41, or 1203.42 of the Penal Code shall provide proof of the dismissal if it is not reflected on the report furnished by the Department of Justice.

(d) Notwithstanding any other provision of this code, a board shall not deny a license on the basis of an arrest that resulted in a disposition other than a conviction, including an arrest that resulted in an infraction, citation, or a juvenile adjudication.

(e) A board may deny a license regulated by this code on the ground that the applicant knowingly made a false statement of fact that is required to be revealed in the application for the license. A board shall not deny a license based solely on an applicant's failure to disclose a fact that would not have been cause for denial of the license had it been disclosed.

(f) A board shall follow the following procedures in requesting or acting on an applicant's criminal history information:

(1) A board shall not require an applicant for licensure to disclose any information or documentation regarding the applicant's criminal history.

(2) If a board decides to deny an application based solely or in part on the applicant's conviction history, the board shall notify the applicant in writing of all of the following:

(A) The denial or disqualification of licensure.

(B) Any existing procedure the board has for the applicant to challenge the decision or to request reconsideration.

(C) That the applicant has the right to appeal the board's decision.

(D) The processes for the applicant to request a copy of his or her complete conviction history and question the accuracy or completeness of the record pursuant to Sections 11122 to 11127 of the Penal Code.

(g) (1) For a minimum of three years, each board under this code shall retain application forms and other documents submitted by an applicant, any notice provided to an applicant, all other communications received from and provided to an applicant, and criminal history reports of an applicant.

(2) Each board under this code shall retain the number of applications received for each license and the number of applications requiring inquiries regarding criminal history. In addition, each licensing authority shall retain all of the following information:

(A) The number of applicants with a criminal record who received notice of denial or disqualification of licensure.

(B) The number of applicants with a criminal record who provided evidence of mitigation or rehabilitation.

(C) The number of applicants with a criminal record who appealed any denial or disqualification of licensure.

(D) The final disposition and demographic information, including, but not limited to, voluntarily provided information on race or gender, of any applicant described in subparagraph (A), (B), or (C).

(3) (A) Each board under this code shall annually make available to the public through the board's Internet Web site and through a report submitted to the appropriate policy committees of the Legislature deidentified information collected pursuant to

this subdivision. Each board shall ensure confidentiality of the individual applicants.

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

(h) "Conviction" as used in this section shall have the same meaning as defined in Section 7.5.

~~(i) This section supersedes any contradictory provision in a licensing act under this code or initiative act referred to in Division 2 (commencing with Section 500) that authorizes license denial based on a criminal conviction, arrest, or the acts underlying an arrest or conviction.~~

(i) The changes made to this section by the act adding this subdivision do not in any way modify or otherwise affect the existing authority of the following entities in regard to licensure:

(1) The State Athletic Commission.

(2) The Bureau for Private Postsecondary Education.

SEC. 3. Section 481 of the Business and Professions Code is amended to read:

481. (a) Each board under this code shall develop criteria to aid it, when considering the denial, suspension, or revocation of a license, to determine whether a crime is ~~directly and adversely~~ *substantially* related to the qualifications, functions, or duties of the business or profession it regulates.

(b) Criteria for determining whether a crime is ~~directly and adversely~~ *substantially* related to the qualifications, functions, or duties of the business or profession a board regulates shall include all of the following:

(1) The nature and gravity of the offense.

(2) The number of years elapsed since the date of the offense.

(3) The nature and duties of the profession in which the applicant seeks licensure or in which the licensee is licensed.

(c) A board shall not deny a license based in whole or in part on a conviction without considering evidence of rehabilitation.

(d) Each board shall post on its Internet Web site a summary of the criteria used to consider whether a crime is considered to be ~~directly and adversely~~ *substantially* related to the qualifications, functions, or duties of the business or profession it regulates consistent with this section.

(e) The changes made to this section by the act adding this subdivision do not in any way modify or otherwise affect the existing authority of the following entities in regard to licensure:

(1) The State Athletic Commission.

(2) The Bureau for Private Postsecondary Education.

~~SEC. 4. Section 481.5 is added to the Business and Professions Code, to read:~~

~~481.5. (a) Probationary terms or restrictions placed on a license by a board shall be limited to two years or less. Any additional conditions may be imposed only if the board determines that there is clear and convincing evidence that additional conditions are necessary to address a risk shown by clear and convincing evidence.~~

~~(b) Each board under this code shall develop criteria to aid it when considering the imposition of probationary conditions or restrictions to determine what conditions may be imposed to address a risk shown by clear and convincing evidence.~~

~~(c) (1) A licensee or registrant whose license or registration has been placed on probation may petition the board for a change to the probation, including modification or termination of probation, one year from the effective date of the decision. The board shall issue its decision on the petition within 90 days of submission of the petition. The petition shall be deemed granted by operation of law if the board does not file a decision denying the petition within 90 days of submission of the petition.~~

~~(2) The one-year time period to petition for modification or termination of penalty shall control over longer time periods under a licensing act under this code or initiative act referred to in Division 2 (commencing with Section 500).~~

~~SEC. 5.~~

SEC. 4. Section 482 of the Business and Professions Code is amended to read:

482. (a) Each board under this code shall develop criteria to evaluate the rehabilitation of a person when doing either of the following:

(1) Considering the denial of a license by the board under Section 480.

(2) Considering suspension or revocation of a license under Section 490.

(b) Each board shall ~~find~~ *consider* that an applicant or licensee has made a showing of rehabilitation if ~~any~~ *either* of the following are met:

(1) The applicant or licensee has completed the criminal sentence at issue without a violation of parole or probation.

~~(2) (A) The applicant or licensee documents that he or she has worked in a related field continuously for at least one year prior to licensure or successfully completed a course of training in a related field, unless the board finds a public record of an official finding that the applicant committed professional misconduct in the course of that work.~~

~~(B) Work in a related field may include, but is not limited to, work performed without compensation and work performed while incarcerated.~~

~~(C) "Related field," for purposes of this paragraph, means a field of employment whose duties are substantially similar to the field regulated by the board.~~

~~(3)~~

(2) The applicant or licensee has satisfied criteria for rehabilitation developed by the board.

(c) The changes made to this section by the act adding this subdivision do not in any way modify or otherwise affect the existing authority of the following entities in regard to licensure:

(1) The State Athletic Commission.

(2) The Bureau for Private Postsecondary Education.

~~SEC. 6.~~

SEC. 5. Section 488 of the Business and Professions Code is amended to read:

488. Except as otherwise provided by law, following a hearing requested by an applicant pursuant to subdivision (b) of Section 485, the board may take any of the following actions:

(a) Grant the license effective upon completion of all licensing requirements by the applicant.

~~(b) Grant the license effective upon completion of all licensing requirements by the applicant, grant the license and immediately issue a public reproval pursuant to Section 495, immediately revoke the license, stay the revocation, and impose probationary conditions on the license, which may include suspension.~~

~~(c)~~

(b) Deny the license.

~~(d)~~

(c) Take other action in relation to denying or granting the license as the board in its discretion may deem proper.

(d) The changes made to this section by the act adding this subdivision do not in any way modify or otherwise affect the existing authority of the following entities in regard to licensure:

(1) The State Athletic Commission.

(2) The Bureau for Private Postsecondary Education.

~~SEC. 7. Section 490 of the Business and Professions Code is amended to read:~~

~~490. (a) (1) In addition to any other action that a board is permitted to take against a licensee, a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime for which the applicant is presently incarcerated or for which the conviction occurred within the preceding five years. However, the preceding five year limitation shall not apply to a conviction for a violent felony, as defined in Section 667.5 of the Penal Code.~~

~~(2) The board may suspend or revoke a license pursuant to this subdivision only if the crime is directly and adversely related to the qualifications, functions, or duties of the business or profession for which application is made.~~

~~(b) Notwithstanding any other provision of law, a board may exercise any authority to discipline a licensee for conviction of a crime that is independent of the authority granted under subdivision (a) only if both of the following are met:~~

~~(1) The crime is directly and adversely related to the qualifications, functions, or duties of the business or profession for which the licensee's license was issued.~~

~~(2) The licensee was convicted of the crime within the preceding five years or is presently incarcerated for the crime. However, the preceding five year limitation shall not apply to a conviction for a violent felony, as defined in Section 667.5 of the Penal Code.~~

~~(c) Notwithstanding any other provision of this code, a board shall not suspend or revoke a license on the basis of a conviction, or of the acts underlying a conviction, where that conviction has been dismissed pursuant to Section 1203.4, 1203.4a, 1203.41, or 1203.42 of the Penal Code or a comparable dismissal or expungement.~~

~~(d) Notwithstanding any other provision of this code, a board shall not suspend or revoke a license on the basis of an arrest that~~

~~resulted in a disposition other than a conviction, including an arrest that resulted in an infraction, citation, or juvenile adjudication.~~

~~(e) The board shall use the following procedures in requesting or acting on a licensee's criminal history information:~~

~~(1) A board shall not require a licensee to disclose any information or documentation regarding the licensee's criminal history.~~

~~(2) If a board chooses to file an accusation against a licensee based solely or in part on the licensee's conviction history, the board shall notify the licensee in writing of the processes for the licensee to request a copy of the licensee's complete conviction history and question the accuracy or completeness of his or her criminal record pursuant to Sections 11122 to 11127, inclusive, of the Penal Code.~~

~~(f) (1) For a minimum of three years, each board under this code shall retain all documents submitted by a licensee, notices provided to a licensee, all other communications received from or provided to a licensee, and criminal history reports of a licensee.~~

~~(2) Each board under this code shall retain all of the following information:~~

~~(A) The number of licensees with a criminal record who received notice of potential revocation or suspension of their license or who had their license suspended or revoked.~~

~~(B) The number of licensees with a criminal record who provided evidence of mitigation or rehabilitation.~~

~~(C) The number of licensees with a criminal record who appealed any suspension or revocation of a license.~~

~~(D) The final disposition and demographic information, including, but not limited to, voluntarily provided information on race or gender, of any applicant described in subparagraph (A), (B), or (C).~~

~~(3) (A) Each board under this code shall annually make available to the public through the board's Internet Web site and through a report submitted to the appropriate policy committees of the Legislature deidentified information collected pursuant to this subdivision. Each board shall ensure the confidentiality of the individual licensees.~~

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

~~(g) (1) This section supersedes any contradictory provision in a licensing act under this code or initiative act referred to in Division 2 (commencing with Section 500) that authorizes action based on a criminal conviction, arrest, or the acts underlying an arrest or conviction.~~

~~(2) This section shall not prohibit any agency from taking disciplinary action against a licensee for professional misconduct in the course and scope of the licensee's profession that is based on evidence that is independent of an arrest.~~

~~SEC. 8. Section 492 of the Business and Professions Code is amended to read:~~

~~492. (a) Notwithstanding any other provision of law, successful completion of any diversion program under the Penal Code, successful completion by a licensee or applicant of any nonstatutory diversion program, deferred entry of judgment, or successful completion of an alcohol and drug problem assessment program under Article 5 (commencing with Section 23249.50) of Chapter 12 of Division 11 of the Vehicle Code, shall prohibit any board from taking disciplinary action against a licensee or from denying a license for professional misconduct.~~

~~(b) This section shall not prohibit any agency established under Division 2 (commencing with Section 500) of this code, or any initiative act referred to in that division, from taking disciplinary action against a licensee for professional misconduct in the course and scope of the profession, which is based on evidence that is independent of an arrest.~~

~~SEC. 9.~~

SEC. 6. Section 493 of the Business and Professions Code is amended to read:

493. (a) Notwithstanding any other provision of law, in a proceeding conducted by a board within the department pursuant to law to deny an application for a license or to suspend or revoke a license or otherwise take disciplinary action against a person who holds a license, upon the ground that the applicant or the licensee has been convicted of a crime ~~directly and adversely~~ *substantially* related to the qualifications, functions, and duties of the licensee in question, the record of conviction of the crime shall be conclusive evidence of the fact that the conviction occurred, but only of that fact.

(b) (1) Criteria for determining whether a crime is ~~directly and adversely~~ *substantially* related to the qualifications, functions, or duties of the business or profession the board regulates shall include all of the following:

(A) The nature and gravity of the offense.

(B) The number of years elapsed since the date of the offense.

(C) The nature and duties of the profession.

(2) A board shall not categorically bar an applicant based solely on the type of conviction without considering evidence of rehabilitation.

(c) As used in this section, "license" includes "certificate," "permit," "authority," and "registration."

(d) The changes made to this section by the act adding this subdivision do not in any way modify or otherwise affect the existing authority of the following entities in regard to licensure:

(1) The State Athletic Commission.

(2) The Bureau for Private Postsecondary Education.

~~SEC. 10.~~

SEC. 7. Section 11345.2 of the Business and Professions Code is amended to read:

11345.2. (a) An individual shall not act as a controlling person for a registrant if any of the following apply:

(1) The individual has entered a plea of guilty or no contest to, or been convicted of, a felony. If the individual's felony conviction has been dismissed pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code, the bureau may allow the individual to act as a controlling person.

(2) The individual has had a license or certificate to act as an appraiser or to engage in activities related to the transfer of real property refused, denied, canceled, or revoked in this state or any other state.

(b) Any individual who acts as a controlling person of an appraisal management company and who enters a plea of guilty or no contest to, or is convicted of, a felony, or who has a license or certificate as an appraiser refused, denied, canceled, or revoked in any other state shall report that fact or cause that fact to be reported to the office, in writing, within 10 days of the date he or she has knowledge of that fact.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2193
Author: Maienschein
Bill Date: July 2, 2018, Amended
Subject: Maternal Mental Health
Sponsor: 2020 Mom

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require, by July 1, 2019, a licensed health care practitioner who provides prenatal or postpartum care for a patient to ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions. This bill would also require health insurers and health care service plans to develop maternal mental health clinical case management programs, as specified.

BACKGROUND

According to the author's office, 1 in 5 women will be affected by a maternal mental health disorder during pregnancy or within the first year after giving birth. In 2015, the American College of Obstetricians and Gynecologists recommended that clinicians screen perinatal patients at least once for depression and anxiety symptoms. There is currently no state or federal law regulating or mandating screening for maternal mental health disorders.

ANALYSIS

This bill would require, by July 1, 2019, a licensed health care practitioner who provides prenatal or postpartum care for a patient to ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions. This bill would specify that it does not apply to emergency services or care and that this bill would not preclude any licensed or certified provider acting within his or her scope of practice from screening for maternal mental health conditions.

This bill would define a health care practitioner as a physician, nurse practitioner, physician assistant, nurse midwife, or midwife, acting within his or her scope of practice.

This bill would define a maternal mental health condition as a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

This bill would require health insurers and health care service plans, by July 1, 2019, to develop maternal mental health clinical case management programs (programs) designed to ensure timely access to services to promote quality and cost-effective outcomes. The health insurers and health care service plans would be required to support efficacious treatment for the reduction of symptoms. This bill would require the programs to be developed consistent with sound clinical principles and processes. This bill would require the program guidelines and criteria to be made available upon request to medical providers, including obstetric providers.

This bill was significantly amended since the Board took an oppose position. Instead of requiring a set number of screenings for any health care practitioner who treats or attends to a mother of child, it would only require practitioners who provide prenatal or postpartum care for a patient, or pediatric care for an infant, to ensure that the mother is offered screening for maternal mental health conditions. As such, this bill no longer sets the standard of care in law. Board staff is suggesting that the Board now take a neutral position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: 2020 Mom (Sponsor)

OPPOSITION: America's Health insurance Plans
Association of California Life and Health Insurance Companies
Association of Health Plans

POSITION: Recommendation: Neutral

AMENDED IN SENATE JULY 2, 2018

AMENDED IN SENATE JUNE 21, 2018

AMENDED IN ASSEMBLY APRIL 30, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2193

Introduced by Assembly Member Maienschein
(Coauthors: Assembly Members Gonzalez Fletcher, Lackey, Rodriguez, and Voepel)

February 12, 2018

An act to add Section 1367.625 to, and to add Article 6 (commencing with Section 123640) to Chapter 2 of Part 2 of Division 106 to, the Health and Safety Code, and to add Section 10123.867 to the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 2193, as amended, Maienschein. Maternal mental health.

Existing law provides for the licensure and regulation of various healing arts professions, including, but not limited to, physicians and surgeons, by various boards within the Department of Consumer Affairs. Existing law imposes certain fines and other penalties for, and authorizes these boards to take disciplinary action against licensees for, violations of the provisions governing those professions.

This bill would require, by July 1, 2019, a licensed health care practitioner who provides prenatal or postpartum care for a ~~patient, or pediatric care for an infant,~~ *patient* to offer to screen *or appropriately screen* a mother for maternal mental health conditions. ~~The bill would require a licensed health care practitioner to appropriately screen for~~

~~maternal mental health conditions during pregnancy and the postpartum period if the mother agrees to be screened.~~

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age.

This bill would require health care service plans and health insurers, by July 1, 2019, to develop, consistent with sound clinical principles and processes, a maternal mental health clinical case management ~~program to address mental and behavioral issues,~~ *program,* as specified. ~~The bill would, among other things, require the health care service plan and health insurer to annually update the clinical guidelines and criteria related to the maternal mental health clinical case management program, as may be appropriate.~~ Because a willful violation of the bill's requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

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

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 1367.625 is added to the Health and Safety Code, to read:

1367.625. (a) By July 1, 2019, a health care service plan shall develop a maternal mental health clinical case management program ~~to address mental and behavioral issues.~~ *designed to ensure timely access to services and promote quality and cost-effective outcomes.* The health care service plan shall support efficacious treatment for the reduction of symptoms. The program shall be developed consistent with sound clinical principles and

processes. ~~The health care service plan shall annually update the clinical guidelines and criteria related to the maternal mental health clinical case management program, as may be appropriate, and these~~ *The program* guidelines and criteria shall be made available upon request to medical providers, including a contracting obstetric provider.

(b) For the purposes of this section, the following terms have the following meanings:

(1) "Contracting obstetric provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, and who is contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.

(2) "Maternal mental health" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

SEC. 2. Article 6 (commencing with Section 123640) is added to Chapter 2 of Part 2 of Division 106 of the Health and Safety Code, to read:

Article 6. Maternal Mental Health

123640. (a) By July 1, 2019, a licensed health care practitioner who provides prenatal or postpartum care for a ~~patient, or pediatric care for an infant,~~ *patient* shall ensure that the mother is offered screening *or is appropriately screened* for maternal mental health conditions. ~~If the mother agrees to the screening, then the licensed health care practitioner shall appropriately screen for maternal mental health conditions during pregnancy and the postpartum period.~~

(b) This section shall not apply to emergency services or care, as defined in Section 1317.1.

(c) This section does not preclude any licensed or certified provider acting within his or her scope of practice from screening for maternal mental health conditions.

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

(1) "Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

(2) "Health care practitioner" means a physician and surgeon, nurse practitioner, physician assistant, nurse midwife, or a midwife licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code or an initiative act referred to in that division and is acting within his or her scope of practice.

SEC. 3. Section 10123.867 is added to the Insurance Code, to read:

10123.867. (a) By July 1, 2019, a health insurer ~~that provides a policy of health insurance that provides coverage for the essential health benefits as set forth in the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152),~~ shall develop a maternal mental health clinical case management program ~~to address mental and behavioral issues.~~ *designed to ensure timely access to services to promote quality and cost-effective outcomes.* The health insurer shall support efficacious treatment for the reduction of symptoms. The program shall be developed consistent with sound clinical principles and processes. ~~The health insurer shall annually update the clinical guidelines and criteria related to the maternal mental health clinical case management program, as may be appropriate, and these~~ *The program* guidelines and criteria shall be made available upon request to medical providers, including a contracting obstetric provider.

(b) For the purposes of this section, the following terms have the following meanings:

(1) "Contracting obstetric provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, and who is contracted with the insured's health insurer to provide services under the insured's health insurance policy.

(2) "Maternal mental health" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

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.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2461
Author: Flora and Obernolte
Bill Date: May 25, 2018, Amended
Subject: Criminal History Information: Subsequent Arrest Notification: State Department of Social Services
Sponsor: Authors
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Department of Justice (DOJ) to provide all subsequent state and federal arrest or disposition notifications to specified entities, including the Medical Board of California (Board), for any licensee whose fingerprints are maintained on file at DOJ or the Federal Bureau of Investigation (FBI).

ANALYSIS

Existing law requires DOJ to receive federal and state criminal history and in accordance with its statutory requirements, disseminate it to appropriate state entities at the time of the initial background check at time of application. However, after the initial background check, DOJ is not required to provide these state entities, including the Medical Board of California (Board), with the subsequent federal criminal information, including arrests and convictions.

This bill would require DOJ to provide to the State Department of Social Services, the Board, and the Osteopathic Medical Board of California, pursuant to state or federal law authorizing those departments to receive state or federal summary criminal history information, subsequent state or federal arrest or disposition notifications to assist in fulfilling employment, licensing, or certification duties, or the duties of approving relative caregivers, nonrelative extended family members, and resource families, upon the arrest or disposition of any person whose fingerprints are maintained on file at the DOJ or the FBI.

This bill would also require any entity that submits the fingerprints of applicants for licensing, employment, or certification, or approval to DOJ to comply with existing law that requires the entity to immediately notify DOJ when the applicant is terminated or the license is revoked, in order to allow DOJ to terminate the state or federal subsequent notification.

The Board depends on the DOJ notifications to be informed that a licensee has been arrested or convicted of a crime. This is very important information for the Board to receive so it can look into the matter and take appropriate action. The Board currently receives subsequent arrest records for acts within California and reported to DOJ. However, the Board does not receive subsequent arrest

information from the FBI. Requiring DOJ to provide information from the FBI is essential for the Board to meet its mission of consumer protection. For these reasons the Board is supportive of this bill.

FISCAL: None

SUPPORT: Medical Board of California

OPPOSITION: None on file

AMENDED IN ASSEMBLY MAY 25, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2461

Introduced by Assembly Members Flora and Obernolte

February 14, 2018

An act to amend Section 11105.2 of the Penal Code, relating to criminal history information.

LEGISLATIVE COUNSEL'S DIGEST

AB 2461, as amended, Flora. Criminal history information: subsequent arrest ~~notification.~~ *notification: State Department of Social Services.*

Existing law authorizes the Department of Justice to provide subsequent state or federal arrest or disposition notification to an entity authorized by state or federal law to receive state or federal summary criminal history information to assist in fulfilling employment, licensing, *or* certification duties, or the duties of approving relative caregivers, nonrelative extended family members, and resource families upon the arrest or disposition of a person whose fingerprints are maintained on file at the Department of Justice or the Federal Bureau of Investigation as the result of an application for licensing, employment, certification, or approval.

This bill would require the department to provide that ~~information.~~ *subsequent arrest or disposition notification to the State Department of Social Services, the Medical Board of California, and the Osteopathic Medical Board of California.*

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 11105.2 of the Penal Code is amended to read:

11105.2. (a) *(1)* The Department of Justice shall provide *to the State Department of Social Services, the Medical Board of California, and the Osteopathic Medical Board of California, pursuant to state or federal law authorizing those departments to receive state or federal summary criminal history information, and may provide to any other entity authorized by state or federal law to receive state or federal summary criminal history information,* subsequent state or federal arrest or disposition notification ~~to any entity authorized by state or federal law to receive state or federal summary criminal history information~~ to assist in fulfilling employment, licensing, *or* certification duties, or the duties of approving relative caregivers, nonrelative extended family members, and resource families upon the arrest or disposition of any person whose fingerprints are maintained on file at the Department of Justice or the Federal Bureau of Investigation as the result of an application for licensing, employment, certification, or approval. This section does not authorize the notification of a subsequent disposition pertaining to a disposition that does not result in a conviction, unless the department has previously received notification of the arrest and has previously lawfully notified a receiving entity of the pending status of that arrest. If the department supplies subsequent arrest or disposition notification to a receiving entity, the entity shall, at the same time, expeditiously furnish a copy of the information to the person to whom it relates if the information is a basis for an adverse employment, licensing, or certification decision. If the copy is not furnished in person, the copy shall be delivered to the last contact information provided by the applicant.

(2) An entity that submits the fingerprints of applicants for licensing, employment, or certification, or approval to the Department of Justice for the purpose of establishing a record of the applicant to receive notification of subsequent state or federal arrests or dispositions pursuant to paragraph (1) shall comply with subdivision (d).

(b) For purposes of this section, "approval" means those duties described in subdivision (d) of Section 309 of the Welfare and

Institutions Code for approving the home of a relative caregiver or of a nonrelative extended family member for placement of a child supervised by the juvenile court, and those duties in Section 16519.5 of the Welfare and Institutions Code for resource families.

(c) An entity, other than a law enforcement agency employing peace officers as defined in Section 830.1, subdivisions (a) and (e) of Section 830.2, subdivision (a) of Section 830.3, subdivisions (a) and (b) of Section 830.5, and subdivision (a) of Section 830.31, shall enter into a contract with the Department of Justice in order to receive notification of subsequent state or federal arrests or dispositions for licensing, employment, or certification purposes.

(d) An entity that submits the fingerprints of applicants for licensing, employment, certification, or approval to the Department of Justice for the purpose of establishing a record of the applicant to receive notification of subsequent state or federal arrests or dispositions shall immediately notify the department when the employment of the applicant is terminated, when the applicant's license or certificate is revoked, when the applicant may no longer renew or reinstate the license or certificate, or when a relative caregiver's or nonrelative extended family member's approval is terminated. The Department of Justice shall terminate state or federal subsequent notification on any applicant upon the request of the licensing, employment, certifying, or approving authority.

(e) An entity that receives a notification of a state or federal subsequent arrest or disposition for a person unknown to the entity, or for a person no longer employed by the entity, or no longer eligible to renew the certificate or license for which subsequent notification service was established shall immediately return the subsequent notification to the Department of Justice, informing the department that the entity is no longer interested in the applicant. The entity shall not record or otherwise retain any information received as a result of the subsequent notice.

(f) An entity that submits the fingerprints of an applicant for employment, licensing, certification, or approval to the Department of Justice for the purpose of establishing a record at the department or the Federal Bureau of Investigation to receive notification of subsequent arrest or disposition shall immediately notify the department if the applicant is not subsequently employed, or if the applicant is denied licensing certification, or approval.

(g) An entity that fails to provide the Department of Justice with notification as set forth in subdivisions (c), (d), and (e) may be denied further subsequent notification service.

(h) Notwithstanding subdivisions (c), (d), and (f), subsequent notification by the Department of Justice and retention by the employing agency shall continue as to retired peace officers listed in subdivision (c) of Section 830.5.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 2487
Author:	McCarty
Bill Date:	June 18, 2018, Amended
Subject:	Physicians and Surgeons: Continuing Education: Opiate-Dependent Patient Treatment and Management
Sponsor:	Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow physicians the option of taking the currently required one-time 12 hour continuing medical education (CME) course on pain management and the treatment of terminally ill and dying patients or taking a one-time 12 hour CME course on the treatment and management of opiate-dependent patients, including 8 hours of training in buprenorphine treatment for opioid use disorders.

BACKGROUND

According to the Centers for Disease Control and Prevention, drug overdose deaths continue to increase in the United States. From 1999 to 2016, more than 630,000 people have died from a drug overdose. Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid. In 2016, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 5 times higher than in 1999. On average, 115 Americans die every day from an opioid overdose.

Existing law requires physicians and surgeons to complete at least 50 hours of approved CME during each two-year license renewal cycle. Currently, physicians and surgeons only have a mandatory one-time CME requirement of 12 hours in the subject of pain management and the treatment of the terminally ill. Pathologists and radiologists are exempted from this requirement. The 12 units may be divided in any way that is relevant to the physician's specialty and practice setting. Acceptable courses may address either topic individually or both topics together. For example, one physician might take three hours of "pain management education" and nine hours of "the appropriate care and treatment of the terminally ill;" a second physician might opt to take six hours of "pain management" and six hours of "the appropriate care and treatment of the terminally ill;" a third physician might opt to take one 12-hour course that includes both topics. The Medical Board of California (Board) will accept any combination of the two topics totaling 12 hours. Physicians must complete the mandated hours by their second license renewal date or within four years, whichever comes first. The 12 required hours would count toward the 50 hours of approved CME

each physician is required to complete during each biennial renewal cycle.

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

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

ANALYSIS

This bill would allow licensed physicians, licensed after January 1, 2019, to opt to complete a one-time mandatory 12-hour CME course on the treatment and management of opiate-dependent patients, which must include 8 hours of training in buprenorphine treatment for opioid use disorders, in lieu of the existing required CME on pain management. Physicians would be required to take one of these CME courses.

This bill would specify that physicians that are already qualified to prescribe buprenorphine are exempt from the mandated CME requirement. This bill would specify that the new option for the CME requirement does not apply to a physician who met the CME requirements before January 1, 2019. This bill would require a physician to complete this CME requirement by their next license renewal date. This bill would require the Board to determine whether a physician has met the requirements of this bill.

According to the author's office, this training is already offered and available to physicians from the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, and the American Osteopathic Association. The author's office believes that this education and training will give physicians important tools to address the opioid epidemic.

The growing opioid abuse epidemic remains a matter of concern for the Board and this bill will help to increase education in medication-assisted treatment for physicians. This bill will not mandate a new CME requirement, but will allow a physician the option of deciding which CME course they would rather take to meet the CME requirement. For these reasons, Board staff is suggesting that the Board take a neutral position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: California Chapter of the American College of Emergency Physicians

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN SENATE JUNE 18, 2018

AMENDED IN ASSEMBLY MAY 17, 2018

AMENDED IN ASSEMBLY APRIL 26, 2018

AMENDED IN ASSEMBLY APRIL 16, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2487

Introduced by Assembly Member McCarty
(Coauthor: Assembly Member Waldron)

February 14, 2018

An act to ~~add Section 2190.6 to~~ *amend Section 2190.5 of* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2487, as amended, McCarty. Physicians and surgeons: continuing education: opiate-dependent patient treatment and management.

Existing state law, the Medical Practice Act, establishes the Medical Board of California within the Department of Consumer Affairs. The board is responsible for the licensure and regulation of physicians and surgeons, and is required by the act to adopt and administer standards for the continuing education of those physicians and surgeons. *Existing law requires all physicians and surgeons to complete a mandatory continuing education course on pain management and the treatment of terminally ill and dying patients, as provided.*

Existing federal law, the Comprehensive Addiction Recovery Act of 2016, requires physicians and surgeons who dispense narcotic drugs for patient treatment to obtain a separate registration from the United States Attorney General. The United States Drug Enforcement

Administration, within the federal Office of the Attorney General, administers the registration and requires physicians and surgeons to renew that registration at specified intervals. A physician and surgeon qualifies for a waiver of the registration if he or she is licensed under state law and completes at least one specified training, such as 8 hours of training in the treatment and management of opiate-dependent patients.

This bill would require a physician and surgeon to complete a one-time continuing education course on *either pain management and the treatment of terminally ill and dying patients, or* opiate-dependent patient treatment and management, ~~as specified, within 6 months of first receiving, or next renewing, a federal Drug Enforcement Administration registration to dispense narcotic drugs for patient treatment,~~ unless the physician and surgeon ~~meets the requirements of a qualifying physician within the federal Comprehensive Addiction Recovery Act of 2016.~~ *qualifies for a specified exemption.*

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 2190.6 is added to the Business and Professions Code, to read:~~

~~2190.6. (a) Within six months of first receiving a federal Drug Enforcement Administration registration under Part 1301 (commencing with Section 1301.01) of Title 21 of the Code of Federal Regulations, a physician and surgeon shall complete a one-time mandatory continuing education course on the treatment and management of opiate-dependent patients and this course shall include one hour of training in medication-assisted treatment for opioid use disorders. However, the board may also require a physician and surgeon to complete additional hours of education when necessary to carry out the board's duties in Section 2001.1.~~

~~(b) A physician and surgeon currently or previously in possession, on January 1, 2019, of a federal Drug Enforcement Administration registration under Part 1301 (commencing with Section 1301.01) of Title 21 of the Code of Federal Regulations, as that section read on January 1, 2018, shall meet the one-time requirements of subdivision (a) within six months of next renewing his or her registration.~~

~~(c) This section shall not apply to a physician and surgeon who meets the requirements, as determined by the board, of a "qualifying physician" under clause (ii) of subparagraph (G) of paragraph (2) of subsection (g) of Section 823 of Title 21 of the United States Code, the Comprehensive Addiction Recovery Act of 2016 (Public Law 114-198), as that clause read on January 1, 2018.~~

~~(d) The board shall determine whether a physician and surgeon has met the requirements of this section.~~

SECTION 1. Section 2190.5 of the Business and Professions Code is amended to read:

2190.5. (a) All physicians and surgeons shall complete ~~a mandatory continuing education course in the subjects of pain management and the treatment of terminally ill and dying patients. For the purposes of this section, this course shall be a~~ *one of the following mandatory continuing education courses:*

(1) A one-time requirement of 12 credit ~~hours~~ *hours,* within the required minimum established by regulation, ~~to be completed by December 31, 2006. All physicians and surgeons licensed on and after January 1, 2002, shall complete this requirement within four years of their initial license or by their second renewal date, whichever occurs first. The board may verify completion of this requirement on the renewal application form.~~ *in the subjects of pain management and the treatment of terminally ill and dying patients.*

(2) A one-time requirement of 12 credit hours in the subjects of treatment and management of opiate-dependent patients, including 8 hours of training in buprenorphine treatment for opioid use disorders.

(b) By regulatory action, the board may exempt physicians and surgeons by practice status category from the requirement in subdivision (a) if the physician and surgeon does not engage in direct patient care, does not provide patient consultations, or does not reside in the State of California.

(c) This section shall not apply to physicians and surgeons practicing in pathology or radiology specialty areas.

(d) This section shall not apply to a physician and surgeon who meets the requirements, as determined by the board, of a "qualifying physician" under clause (ii) of subparagraph (G) of paragraph (2) of subsection (g) of Section 823 of Title 21 of the

United States Code, the Comprehensive Addiction Recovery Act of 2016 (Public Law 114-198), as that clause read on January 1, 2018.

(e) This section shall not apply to a physician and surgeon who met the requirements of this section before January 1, 2019.

(f) A physician and surgeon shall complete this requirement by their next license renewal date.

(g) The board shall determine whether a physician and surgeon has met the requirements of this section.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2760
Author: Wood
Bill Date: June 20, 2018, Amended
Subject: Prescription Drugs: Prescribers: Naloxone Hydrochloride and Other FDA-Approved Drugs
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a health care practitioner authorized to prescribe controlled substances (prescriber) to offer a prescription for naloxone hydrochloride (naloxone) or another drug approved by the United States Food and Drug Administration (FDA) for the complete or partial reversal of opioid depression, under specified conditions. This bill would also require a prescriber to provide education to a patient, or the patient's parent or guardian, or designee, on overdose prevention and the use of naloxone or other similar drug approved by the FDA.

BACKGROUND

According to the Centers for Disease Control and Prevention, drug overdose deaths continue to increase in the United States. From 1999 to 2016, more than 630,000 people have died from a drug overdose. Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid. In 2016, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 5 times higher than in 1999. On average, 115 Americans die every day from an opioid overdose.

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, prescription medication with the same level of regulation as ibuprofen. Naloxone only works if a person has opioids in their system, and has no effect if opioids are absent.

According to the author's office, the American Medical Association's Opioid Task Force recently issued updated naloxone guidelines recommending that family physicians and other clinicians consider a set of factors when determining whether to co-prescribe naloxone to a patient and/or their caregivers. Among others, those factors include whether the patient is on a concomitant benzodiazepine prescription and has a history of overdose or substance use disorder. (The risk of overdose death

goes up nearly fourfold when benzodiazepines are combined with opioids. Overdose deaths involving benzodiazepines increased more than sevenfold between 1999 and 2015.)

ANALYSIS

This bill would make findings and declarations regarding opioid misuse and abuse and overdose deaths. This bill would require a prescriber to offer a prescription for naloxone or another drug approved by the FDA for the complete or partial reversal of opioid depression, when one or more of the following conditions are present:

- The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.
- An opioid medication is prescribed concurrently with a prescription for benzodiazepine.
- The patient presents with an increased risk for overdose, including a patient history of overdose, a patient with a history of substance use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

This bill would also require a prescriber, consistent with the existing standard of care, to provide education to a patient, or the patient's parent or guardian, or designee, on overdose prevention and the use of naloxone or other similar drug approved by the FDA.

This bill would specify that a prescriber who fails to offer a prescription or provide education, as required by this bill, must be referred to the appropriate licensing board solely for the imposition of administrative sanctions deemed appropriate by that board. This bill would specify that it does not create a private right of action against a prescriber, and does not limit a prescriber's liability for the negligent failure to diagnose or treat a patient.

According to the author's office, offering a prescription for naloxone or other similar drug for those at high-risk places an immediate deterrent into the hands of those directly impacted or into the hands of their family and care givers. Naloxone is a tool that can immediately save lives and hopefully provide an opportunity for discussion of treatment for individuals suffering from a substance use disorder.

This bill will increase at-risk patients' access to naloxone, which will further the Board's mission of consumer protection. In addition, it will not require these prescriptions to be filled if the patient cannot fill for financial or other reasons. For these reasons, the Board is supportive of this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: A New Path; California Association of Code Enforcement Officers; California Chronic Care Coalition; California College and University Police Chiefs Association; California College of Community Behavioral Agencies; California Hepatitis C Task Force; California Narcotic Officers Association; California Pharmacists Association; Congress of California Seniors; County Behavioral Health Directors Association; County Health Executives Association of California; Drug Policy Alliance; Emergency Medical Services Medical Directors Association of California; Los Angeles County Professional Peace Officers Association; McKesson Corporation; Medical Board of California; National Health Law Program; Western Center on Law and Poverty; and three individuals

OPPOSITION: California Chapter of the American College of Emergency Physicians

California Medical Association
California Academy of Family Physicians

AMENDED IN SENATE JUNE 20, 2018

AMENDED IN ASSEMBLY APRIL 19, 2018

AMENDED IN ASSEMBLY APRIL 3, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2760

Introduced by Assembly Member Wood

February 16, 2018

An act to add Article 10.7 (commencing with Section 740) to Chapter 1 of Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2760, as amended, Wood. Prescription drugs: *prescribers:* naloxone hydrochloride *and other FDA-approved drugs*.

Existing law provides for the regulation of health care practitioners and requires prescription drugs to be ordered and dispensed in accordance with the Pharmacy Law. Existing law authorizes a pharmacist to furnish naloxone hydrochloride in accordance with standardized procedures or protocols developed by both the California State Board of Pharmacy and the Medical Board of California.

This bill would require a prescriber, as defined, to offer a prescription for naloxone hydrochloride or another ~~opioid antagonist~~ *drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression* to a patient when certain conditions are present and to provide education on overdose prevention and the use of naloxone hydrochloride or another ~~opioid antagonist~~ *drug* to the patient and specified others. The bill would ~~make a violation of the bill's provisions unprofessional conduct and would~~ subject ~~the~~

~~prescriber to discipline by~~ *a prescriber to referral to* the board charged with regulating his or her ~~license.~~ *license for the imposition of administrative sanctions, as that board deems appropriate, for violating those provisions.*

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) Abuse and misuse of opioids is a serious problem that affects the health, social, and economic welfare of the state.

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

(c) Almost 2,000,000 people in the United States suffer from substance use disorders related to prescription opioid pain relievers.

(d) Nonmedical use of prescription opioid pain relievers can be particularly dangerous when the products are manipulated for snorting or injection or are combined with other drugs.

(e) Deaths involving prescription opioid pain relievers represent the largest proportion of drug overdose deaths, greater than the number of overdose deaths involving heroin or cocaine.

(f) Driven by the continued surge in drug deaths, life expectancy in the United States dropped for the second year in a row in 2016, resulting in the first consecutive decline in national life expectancy since 1963.

(g) Should 2017 also result in a decline in life expectancy as a result of drug deaths, it would be the first three-year period of consecutive life expectancy declines since World War I and the Spanish flu pandemic in 1918.

SEC. 2. Article 10.7 (commencing with Section 740) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

Article 10.7 Opioid Medication

740. For purposes of this article, "prescriber" means a person licensed, certified, registered, or otherwise subject to regulation

pursuant to this division, or an initiative act referred to in this division, who is authorized to prescribe prescription drugs.

741. Notwithstanding any other law, a prescriber shall do the following:

(a) Offer a prescription for naloxone hydrochloride or another ~~opioid antagonist~~ *drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression* to a patient when one or more of the following conditions are present:

(1) The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.

(2) An opioid medication is prescribed concurrently with a prescription for benzodiazepine.

(3) The patient presents with an increased risk for overdose, including a patient with a history of overdose, a patient with a history of substance use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

(b) ~~Provide~~ *Consistent with the existing standard of care, provide* education to patients receiving a prescription under subdivision (a) on overdose prevention and the use of naloxone hydrochloride or another ~~opioid antagonist.~~ *drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression.*

(c) ~~Provide~~ *Consistent with the existing standard of care, provide* education on overdose prevention and the use of naloxone hydrochloride or another ~~opioid antagonist~~ *drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression* to one or more persons designated by the patient, or, for a patient who is a minor, to the minor's parent or guardian.

~~742. A violation of this article constitutes unprofessional conduct and grounds for disciplinary action by the prescriber's licensing board. Each licensing board established under this division, or under an initiative act referred to in this division, shall be charged with enforcing this article as it pertains to that board's prescribers.~~

742. A prescriber who fails to offer a prescription, as required by subdivision (a) of Section 741, or fails to provide the education and use information required by subdivisions (b) and (c) of Section

741 shall be referred to the appropriate licensing board solely for the imposition of administrative sanctions deemed appropriate by that board. This section does not create a private right of action against a prescriber, and does not limit a prescriber's liability for the negligent failure to diagnose or treat a patient.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 2789
Author:	Wood
Bill Date:	July 3, 2018, Amended
Subject:	Health Care Practitioners: Prescriptions: Electronic Data Transmission
Sponsor:	Author
Position:	Support if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require all prescriptions issued by licensed prescribers, on or after January 1, 2022, to be issued as electronic data transmission prescriptions (e-prescriptions).

BACKGROUND:

Existing law authorizes specific categories of practitioners, including physicians, to issue prescriptions for dangerous drugs and devices. Existing law defines what a prescription is and delineates that prescriptions must include certain key elements, including: name and address of the patient; name and quantity of the drug or device prescribed and the direction for use; the date of issue; and the name, address and telephone number of the prescriber, his or her license classification, and his or her federal registry number if a controlled substance is being prescribed.

Six states have now passed e-prescribing laws for controlled substances: North Carolina, Virginia, New York, Maine, Connecticut, and Rhode Island.

According to the Centers for Disease Control and Prevention, drug overdose deaths continue to increase in the United States. From 1999 to 2016, more than 630,000 people have died from a drug overdose. Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid. In 2016, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 5 times higher than in 1999. On average, 115 Americans die every day from an opioid overdose.

ANALYSIS

This bill would require a health care practitioner authorized to issue a prescription to have the capability to issue an e-prescription and to transmit an e-prescription to a pharmacy by January 1, 2022. This bill would require a pharmacy, pharmacist, or other practitioner authorized to dispense and furnish a prescription to have the capability to receive an e-prescription by January 1, 2022. This bill would require all prescriptions to be issued as e-prescriptions by January 1, 2022.

This bill would specify that the requirement to issue prescriptions as e-prescriptions does not apply to any of the following:

- A prescription issued for a controlled substance for use by a patient who has a terminal illness.
- If an e-prescription is not available due to a temporary technological or electrical failure, which is defined as a failure of a computer system, application, or device, or the loss of electrical power to that system, application, or device, or any other service interruption affecting the certified electronic transmission prescription application used to transmit the prescription.
- If the prescribing health care practitioner is issuing a prescription to be dispensed by a pharmacy located outside of California.
- If the prescription is issued by a veterinarian.
- If the prescription is for eyeglasses or contact lenses.
- If the prescribing health care practitioner and the dispenser are the same entity.
- If the prescription is issued by a prescribing health care practitioner under circumstances whereby the practitioner reasonably determines that it would be impractical for the patient to obtain controlled substances prescribed by an e-prescription in a timely manner, and the delay would adversely impact the patient's medical condition.
- If the prescription that is issued includes elements not covered by the latest version of the National Council for Prescription Drug Programs' SCRIPT standard, as amended from time to time.
- If the prescription is issued in a hospital emergency department or urgent care clinic and one or more of the following conditions are present:
    - The patient resides outside of California.
    - The patient resides outside the geographic service area of the hospital.
    - The patient is homeless or indigent and does not have a regular or preferred pharmacy.
    - The prescription is issued at a time when a patient's regular or preferred pharmacy is likely to be closed.

  For prescriptions that meet these circumstances, they may be provided directly to the patient.

This bill would specify that if a health care practitioner does not transmit the prescription as an e-prescription, he or she shall document the reason in the patient's medical record as soon as practicable, and within 72 hours of the end of the technological or electrical failure that prevented the electronic transmission of the prescription.

This bill would require a pharmacy that receives an e-prescription, who has not yet dispensed the medication to the patient, to immediately transfer or forward the e-prescription to an alternative pharmacy at the request of the patient. This bill would specify that if a pharmacy or its staff is aware that an attempted e-prescription failed, is incomplete, or not appropriately received, the pharmacy

shall immediately notify the prescriber. This bill would also specify that a pharmacist who receives a written, oral, or faxed prescription shall not be required to verify that the prescription properly falls under one of the exceptions; pharmacists may continue to dispense medications from legally valid written, oral, or fax prescriptions.

This bill would specify that a health care practitioner, pharmacist, or pharmacy who fails to meet the applicable requirements of this bill must be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board. This bill would specify that it does not create a private right of action against a health care practitioner and it does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

The author believes that the sheer number of opioid prescriptions written in California lends itself to the conclusion that many of these prescriptions are obtained through fraudulent means, such as doctor shopping, stolen or forged prescription pads, and the altering of legitimate prescriptions to increase the quantity and/or frequency of refills. The author believes the adoption of e-prescribing would significantly reduce, if not eliminate, paper-based fraud and forgery, while creating records of controlled substance transactions. Electronic controlled substance prescriptions cannot be altered or copied and are electronically trackable.

The Board's primary mission is consumer protection and the growing opioid abuse epidemic remains a matter of concern for the Board. Moving towards e-prescribing would help to eliminate fraudulent prescriptions, including prescriptions for opioids. This will further the Board's mission of consumer protection. However, the Board did raise concerns at the last meeting that some prescribers in rural areas may not have access to the technology needed to issue e-prescriptions. The Board took a support if amended position on this bill and asked for amendments to provide an exception for, or provide assistance to, prescribers in rural areas that do not have access to the technology needed to issue e-prescriptions. The latest amendments do delay implementation to 2022, which will allow physicians in rural areas more time to comply with this bill. The Board can continue to take a support if amended position, or it can change its position to support based on the further delay in implementation.

FISCAL: Minor and absorbable fiscal impact.

SUPPORT: America's Physician Groups; California Association of Health Underwriters; California Dental Association; California Pharmacists Association; California State Board of Pharmacy; Medical Board of California (if amended); and OCHIN

OPPOSITION: California Academy of Family Physicians; California Medical Association; California Society of Plastic Surgeons; and Osteopathic Physicians and Surgeons of California

AMENDED IN SENATE JULY 3, 2018

AMENDED IN SENATE JUNE 20, 2018

AMENDED IN ASSEMBLY APRIL 3, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2789

Introduced by Assembly Member Wood

February 16, 2018

An act to add Section 688 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2789, as amended, Wood. Health care practitioners: prescriptions: electronic data transmission.

Existing law provides for the regulation of health care practitioners and requires prescription drugs to be ordered and dispensed in accordance with the Pharmacy Law. The Pharmacy Law provides that a prescription is an oral, written, or electronic data transmission order and requires electronic data transmission prescriptions to be transmitted and processed in accordance with specified requirements.

This bill, on and after January 1, 2022, would require health care practitioners authorized to issue prescriptions to have the capability to transmit electronic data transmission prescriptions, and would require pharmacies to have the capability to receive those transmissions. The bill would require those health care practitioners to issue prescriptions as an electronic data transmission prescription, unless specified exceptions are met. The bill would not require the pharmacy to verify that a written, oral, or faxed prescription satisfies the specified exemptions. The bill would require the pharmacy receiving the electronic

data transmission prescription to immediately notify the prescriber if the electronic data transmission prescription fails, is incomplete, or is otherwise not appropriately received. The bill would ~~authorize~~ *require* the pharmacy to ~~transmit~~ *transfer or forward* the prescription to another pharmacy at the request of the patient, as specified. The bill would require *that* a health care ~~professional who violates specified provisions to~~ *practitioner, pharmacist, or pharmacy who fails to meet the applicable requirements imposed by this bill* be referred to the appropriate state professional licensing board solely for administrative sanctions, as provided.

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 688 is added to the Business and Professions Code, to read:

688. (a) On and after January 1, 2022, a health care practitioner authorized to issue a prescription pursuant to Section 4040 shall have the capability to issue an electronic data transmission prescription, as defined under Section 4040, on behalf of a patient and to transmit that electronic data transmission prescription to a pharmacy selected by the patient.

(b) On and after January 1, 2022, a pharmacy, pharmacist, or other practitioner authorized under California law to dispense or furnish a prescription pursuant to Section 4040 shall have the capability to receive an electronic data transmission prescription on behalf of a patient.

(c) For a prescription for a controlled substance, as defined by Section 4021, generation and transmission of the electronic data transmission prescription shall comply with Parts 1300, 1304, 1306, and 1311 of Title 21 of the Code of Federal Regulations, as amended from time to time.

(d) On and after January 1, 2022, a prescription prescribed by a health care practitioner shall be issued as an electronic data transmission prescription. This subdivision shall not apply to prescriptions issued pursuant to ~~subdivisions (e) and (f).~~ *subdivision (e).*

(e) Subdivision (d) shall not apply to any of the following:

(1) The prescription is issued pursuant to Section 11159.2 of the Health and Safety Code.

(2) An electronic data transmission prescription is not available due to a temporary technological or electrical failure. For purposes of this paragraph, "temporary technological or electrical failure" means failure of a computer system, application, or device, or the loss of electrical power to that system, application, or device, or any other service interruption affecting the certified electronic data transmission prescription application used to transmit the prescription.

(3) The prescribing health care practitioner is issuing a prescription to be dispensed by a pharmacy located outside California.

(4) (A) The prescription is issued in a hospital emergency department or urgent care clinic and one or more of the following conditions are present:

(i) The patient resides outside California.

(ii) The patient resides outside the geographic area of the hospital.

(iii) The patient is homeless or indigent and does not have a preferred pharmacy.

(iv) The prescription is issued at a time when a patient's regular or preferred pharmacy is likely to be closed.

(B) Under any of the conditions described in subparagraph (A), a prescription shall be electronically issued but does not require electronic transmission and may be provided directly to the patient.

~~(4)~~

(5) The prescription is issued by a veterinarian.

~~(5)~~

(6) The prescription is for eyeglasses or contact lenses.

~~(6)~~

(7) The prescribing health care practitioner and the dispenser are the same entity.

~~(7)~~

(8) The prescription is issued by a prescribing health care practitioner under circumstances whereby the practitioner reasonably determines that it would be impractical for the patient to obtain ~~controlled~~ substances prescribed by an electronic data transmission prescription in a timely manner, and the delay would adversely impact the patient's medical condition.

~~(8)~~

(9) The prescription that is issued includes elements not covered by the latest version of the National Council for Prescription Drug Programs' SCRIPT standard, as amended from time to time.

~~(f) (1) Subdivision (d) shall not apply when the prescription is issued in a hospital emergency department or urgent care clinic and one or more of the following conditions are present:~~

~~(A) The patient resides outside California.~~

~~(B) The patient resides outside the geographic service area of the hospital.~~

~~(C) The patient is homeless or indigent and does not have a regular or preferred pharmacy.~~

~~(D) The prescription is issued at a time when a patient's regular or preferred pharmacy is likely to be closed.~~

~~(2) A prescription issued pursuant to paragraph (1) does not require electronic transmission and may be provided directly to the patient.~~

~~(g)~~

(f) A health care practitioner who issues a prescription for a controlled substance but does not transmit the prescription as an electronic data transmission prescription shall document the reason in the patient's medical record as soon as practicable and within 72 hours of the end of the technological or electrical failure that prevented the electronic data transmission of the prescription.

~~(h)~~

(g) A pharmacy that receives an electronic data transmission prescription from a prescribing health care practitioner who has issued the prescription but has not dispensed the medication to the patient ~~may,~~ *shall,* at the request of the patient or a person authorized to make a request on behalf of the patient, immediately transfer or forward the electronic data transmission prescription to an alternative pharmacy designated by the requester.

~~(i)~~

(h) If a pharmacy, or its staff, is aware than an attempted transmission of an electronic data transmission prescription failed, is incomplete, or is otherwise not appropriately received, the pharmacy shall immediately notify the prescribing health care practitioner.

~~(j)~~

(i) A pharmacist who receives a written, oral, or faxed prescription shall not be required to verify that the prescription properly falls under one of the exceptions in subdivision ~~(e) or (f).~~ *(e).* Pharmacists may continue to dispense medications from legally valid written, oral, or fax prescriptions pursuant to this division.

~~(k)~~

(j) A health care ~~practitioner~~ *practitioner, pharmacist, or pharmacy* who fails to meet the ~~electronic capability standards of subdivisions (a) and (b) and who fails to electronically transmit prescriptions as required by subdivision (d)~~ *applicable requirements of this section* shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board. This section does not create a private right of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 944
Author: Hertzberg
Bill Date: May 25, 2018, Amended
Subject: Community Paramedicine Act of 2018
Sponsor: California Professional Firefighters

DESCRIPTION OF LEGISLATION:

This bill would create the Community Paramedicine Act of 2018 and would authorize a local emergency medical services (EMS) agency to elect to develop a community paramedicine (CP) program to provide specified CP services, until January 1, 2025.

BACKGROUND

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

ANALYSIS

This bill would authorize a local EMS agency within a county to elect to develop a CP program. If a local EMS agency elects to develop a CP program, the county board of supervisors would be required to establish an emergency medical care committee and prescribe the membership, but it must include the following members to advise the local EMS agency on the development of the CP program:

- Two emergency room physicians practicing at an emergency department within the local EMS agency's jurisdiction
- Two registered nurses practicing within the local EMS agency's jurisdiction.
- Two emergency medical technician-paramedics (EMT-P) practicing in the local EMS agency's jurisdiction. At least one of the EMT-Ps would be required to be employed by a public agency.
- The medical director for a local EMS agency.
- One acute care hospital representative with an emergency department operating within the local EMS agency jurisdiction.

This bill would state the intent of the Legislature to establish state guidelines for CP programs, that CP programs must be approved by the Emergency Medical Services

Authority (EMSA), and the intent of the CP programs. This bill would define a CP program as a program developed by a local EMS agency and approved by EMSA to provide community paramedic services consisting of one or more program specialties, under the direction of medical protocols developed by the local EMS agency, that are consistent with the minimum medical protocols established by EMSA. This bill would specify that community paramedic services may consist of the following program specialties:

- Providing short-term post-discharge follow-up for persons recently discharged from a hospital due to a serious health condition.
- Providing directly observed therapy to persons with tuberculosis.
- Providing case management services to frequent emergency medical services users.
- Providing services to treat hospice patients in their homes, in collaboration with the patient's hospice agency, in response to 911 calls.
- Providing patients with transport to an alternate destination facility.

This bill would define a community paramedic as a paramedic who has completed the core curriculum for community paramedic training, has received certification in one or more of the CP program specialties, and is accredited to provide community paramedic services by a local EMS agency as part of an approved CP program.

This bill would create the Community Paramedicine Oversight Committee (Committee) in EMSA to advise EMSA on, and approve minimum medical protocols for, the CP specialties specified in this bill. This bill would require the Committee to consist of 11 members appointed by the Governor: two full-time emergency medicine physicians, from a list of five names submitted by the California Chapter of the American College of Emergency Physicians; two registered nurses from a list of five names provided by the California Labor Federation; two EMT-Ps from a list of five names provided by the California Professional Firefighters and the California Labor Federation; two medical directors of local EMS agencies from a list of five names submitted by the EMS Medical Directors Association of California; one local EMS agency administrator from a list of three names submitted by the Emergency Medical Services Administrators Association of California; one inpatient hospitalist who is a physician and whose primary professional focus is the general medical care of hospitalized patients from a list of three names provided by the California Hospital Association; and one mental health professional from a list of three names provided by the California Psychiatric Association.

This bill would require EMSA to develop, in consultation with the Committee, regulations that establish minimum standards for the development of a CP program. This bill would require the Commission on Emergency Medical Services to review and approve the regulations before EMSA can adopt the regulations. This bill would require the regulations to be based upon, and informed by, the formation and implementation of the Community Paramedicine Pilot Program under HWPP #173.

This bill would require the regulations that establish the minimum standards for CP programs to consist of all of the following:

- Minimum standards and core curriculum for community paramedic training.
- Minimum standards for the scope of practice for each community paramedic in each program specialty.
- A process for certifying a community paramedic who completes the required core curriculum.
- Minimum standards for approval, review, withdrawal, and revocation of a CP program.
- Minimum standards for collecting and submitting data to EMSA to ensure patient safety that include consideration of both quality assurance and quality improvement. These standards shall include, but not be limited to, all of the following:
    - Intervals for CP providers, participating health facilities, and local EMS agencies to submit CP data.
    - Relevant program use data.
    - Public posting of program analysis.
    - Emergency medical response system feedback, including feedback from the Committee.
    - If the CP program utilizes an alternate destination facility, consideration of ambulance patient offload times for the alternate destination and existing emergency departments, the number of patients that are turned away, diverted, or required to be subsequently transferred to an emergency department, and the reasons.
    - An assessment of each CP program's medical protocols or other processes.
    - An assessment of the impact that implementation of a CP program has on the delivery of emergency medical services and response times in the local EMS agency's jurisdiction.

This bill would require EMSA to develop and adopt minimum medical protocols, after they are approved by the Committee, for each CP program. This bill would require the protocols to be based upon, and informed by, the formation and implementation of the Community Paramedicine Pilot Program under Health Workforce Pilot Project # 173, and further refinements provided by local EMS agencies during the course and operation of the pilot program.

This bill would require EMSA to submit an annual report on the CP programs operating in California to the relevant policy committees of the Legislature and post the report on its website. This bill would require EMSA to submit and post its first report six months after EMS adopts the CP program regulations, and every January 1 thereafter for the next five years. This bill would allow the annual report to include recommendations for changes to, or elimination of, CP program specialties that do not achieve the goals expressed in this bill. This bill would specify that the annual report

requirements are repealed six years after EMS adopts regulations for CP programs.

This bill would require EMSA to review a local EMS agency's proposed CP program to ensure it is consistent with the regulations adopted by EMSA. This bill would allow EMSA to impose conditions as part of the approval of a CP program. This bill would require EMSA to approve, approve with conditions, or deny a proposed CP program within six months of submission. This bill would specify that a CP pilot program approved under HWPP #173 is authorized to continue operations until six months after the regulations become effective.

This bill would allow a local EMS agency to develop a CP program that is consistent with EMSA's regulations and the requirements of this bill and submit it to EMSA with evidence of compliance for approval. This bill would require a local EMS agency that opts to develop a CP program to do all of the following:

- Integrate the proposed CP program into the local EMS agency's emergency medical services plan.
- Develop a process to select CP providers at a periodic interval of no more than 10 years.
- Enter into an agreement with a CP provider for the delivery of community paramedic services that are consistent with the proposed CP program.

This bill would specify the process for local EMS agencies to solicit public agencies to provide the proposed CP program specialties and the process for local EMS agencies to follow after a CP program is selected. This bill would specify that if a CP program elects to provide services to treat hospice patients in their home or provide patients with transport to an alternate destination facility, the CP program must do all of the following:

- Develop triage protocols that will be used to determine whether a patient can be safely transported to an alternate destination.
- Develop triage protocols that will be used to determine whether to transport a hospice patient, consistent with the patient's plan of care.
- Require the triage protocol and decision of the community paramedic to transport to an alternate destination facility to not be based upon any demographic factors, as specified.
- Enter into an agreement that continues the use of existing providers in a local EMS agency's jurisdiction in a manner and scope in which that service has been provided by the existing provider.
- Certify that the alternate destination facility authorized to receive patients has adequate licensed medical staff, facilities and equipment to comply with EMSA's regulations.
- Collaborate with the emergency medical care committee to develop protocols that describe when the use of an alternate destination facility is in the best interest of the patient, and with approval of the medical director of the local EMS agency, submit the protocols to EMSA. This bill would require the

protocols to be consistent with EMSA's regulations, and include provisions to describe the following:
    - Qualified staff to care for the degree and severity of a patient's injuries and needs.
    - The equipment and services available at an alternate destination facility necessary to care for patients requiring medical services.
    - The time of day and any limitations that may apply for an alternate destination facility to treat patients requiring medical services.
- Secure an agreement with the alternate destination facility that requires the facility to notify the local EMS agency and EMSA within 24 hours if there are changes in the status of the facility with respect to the protocols and the facility's ability to care for patients.
- Secure an agreement with the alternate destination facility attesting that the facility will operate in accordance with existing law regarding emergency services and care.
- Establish a process for training and certification of community paramedics in the proposed CP program's specialties.
- Facilitate and participate in any agreements between a CP provider and public or private health system participants to provide funding to support the implementation of the local EMS agency's CP program.

This bill would only allow CP programs authorized by a local EMS agency and approved by EMSA to hold themselves out to, and to provide community paramedic services.

This bill would sunset its provisions on January 1, 2025.

According to the author, the HWPP pilot programs have had many positive results on the communities they served. Absent legislative authorization, the current programs will sunset in November of 2018.

Board staff, working with a Board Member who is a physician, provided input to OSHPD on HWPP #173 and raised patient safety concerns. One of these concerns being that persons recently discharged from the hospital should be seen by their primary care physician for follow up care. The additional training that would be required would not be sufficient enough to teach paramedics the basics of disease management or how to diagnose and treat medical conditions. The other concern raised was that the pilot project did not specifically delineate what services will be allowed to be performed by community paramedics. The Board took an oppose position on this bill at the last Board Meeting.

However, since the Board last took a position on this bill, this bill has been significantly amended. It now requires a county board of supervisors to establish an emergency medical care committee to advise the local EMS agency on the development of the

CP program, if a local EMS agency elects to develop a CP program. This bill would require EMSA, in addition to the regulation for CP programs, to develop and adopt minimum medical protocols for each CP program. This bill would require the protocols to be based upon, and informed by, the formation and implementation of the Community Paramedicine Pilot Program under Health Workforce Pilot Project # 173. This bill would require EMSA to submit a report to the Legislature and post the report on their website, with outcome data and recommendations for changes or elimination of program specialties. This bill would also require EMSA to review a local EMS agency's proposed CP program to ensure it is consistent with the regulations adopted by EMSA and it would allow EMSA to impose conditions as part of the approval of a CP program. This bill would set specific requirements for CP programs that elect to provide services to treat hospice patients in their home or provide patients with transport to an alternate destination facility, including development of triage protocols. In addition, this bill would now sunset on January 1, 2025. The Board can continue to oppose this bill, or in light of the added oversight of CP programs and the newly established sunset date, the Board could instead take a neutral position.

FISCAL: None

SUPPORT: California Professional Firefighters (Sponsor); American Civil Liberties Union; California Chapter of the American College of Emergency Physicians; California Fire Chiefs Association/Fire Districts Association of California; City of Murrieta; County of Santa Clara; Long Beach Firefighters, Local 372; Los Angeles County Fire Fighters Local 1014; Steinberg Institute; and United Firefighters of Los Angeles City, IAFF Local 112

OPPOSITION: 911 Ambulance Provider Medi-Cal Alliance; Board of Registered Nursing; California Ambulance Association; California Association for Health Services at Home; California Hospice & Palliative Care Association; California Hospital Association; California Nurses Association/National Nurses United; County of Fresno Emergency Medical Services Administrators Association of California; Emergency Medical Services Medical Directors Association of California; and Medical Board of California

AMENDED IN SENATE MAY 25, 2018

AMENDED IN SENATE MAY 2, 2018

AMENDED IN SENATE APRIL 26, 2018

AMENDED IN SENATE MARCH 21, 2018

SENATE BILL No. 944

Introduced by Senator Hertzberg

January 29, 2018

An act to amend, repeal, and add Section 1797.272 of, and to add and repeal Chapter 13 (commencing with Section 1800) of Division 2.5 of, the Health and Safety Code, relating to community paramedicine.

LEGISLATIVE COUNSEL'S DIGEST

SB 944, as amended, Hertzberg. Community Paramedicine Act of 2018.

(1) Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The act establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of emergency medical services. Among other duties, the authority is required to develop planning and implementation guidelines for emergency medical services systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of emergency medical services systems, and receive plans for the implementation of emergency medical services and trauma care systems from local EMS agencies. A violation of the act or regulations adopted pursuant to the act is punishable as a misdemeanor.

This bill would create the Community Paramedicine Act of 2018. The bill would, until January 1, 2025, authorize a local EMS agency to develop a community paramedicine program, as defined, to provide specified community paramedic services. The bill would require the authority to review a local EMS agency's proposed community paramedicine program and approve, approve with conditions, or deny the proposed program within 6 months after it is submitted by the local EMS agency. The bill would require a local EMS agency that opts to develop a community paramedicine program to, among other things, integrate the proposed program into the local EMS agency's emergency medical services plan, enter into an agreement with a community paramedicine provider for the delivery of community paramedic services within the local EMS agency's jurisdiction that is consistent with the proposed program, establish a process for training and certifying community paramedics, and facilitate and participate in any discussion between a community paramedicine provider and public or private health system participants to provide funding to support implementation of the proposed program.

The bill would create the Community Paramedicine Medical Oversight Committee to advise the authority on, and approve minimum medical protocols for, community paramedicine program specialties. The bill would require the authority to develop, in consultation with the committee, regulations that establish minimum standards for the development of a community paramedicine program. The bill would require the authority to submit an annual report on the community paramedicine programs operating in California to the relevant policy committees of the Legislature, and to post that report on its Internet Web site, beginning 6 months after the authority adopts the regulations and every January 1 thereafter for the next 5 years.

The bill would prohibit a person or organization from providing community paramedic services or representing, advertising, or otherwise implying that it is authorized to provide community paramedic services unless it is expressly authorized by a local EMS agency to provide those services as part of a community paramedicine program approved by the authority. The bill would also prohibit a community paramedic from providing community paramedic services if he or she has not been certified to perform those services and is working as an employee of an authorized community paramedicine provider. Because a violation of the act described above is punishable as a misdemeanor, and this bill

would create new requirements within the act, the violation of which would be a crime, the bill would impose a state-mandated local program.

(2) Existing law authorizes a county to establish an emergency medical care committee and requires the committee, at least annually, to review the operations of ambulance services operating within the county, emergency medical care offered within the county, and first aid practices in the county. Existing law requires the county board of supervisors to prescribe the membership, and appoint the members, of the committee.

This bill would require the committee to include additional members, as specified, and to advise a local EMS agency within the county on the development of its community paramedicine program if the local EMS agency develops a community paramedicine program.

The bill would repeal its provisions on January 1, 2025.

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

This bill would provide that 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 1797.272 of the Health and Safety Code is amended to read:

1797.272. (a) The county board of supervisors shall prescribe the membership, and appoint the members, of the emergency medical care committee. If two or more adjacent counties establish a single committee, the county boards of supervisors shall jointly prescribe the membership, and appoint the members of the committee.

(b) If a local EMS agency within the county elects to develop a community paramedicine program pursuant to Section 1840, the county board of supervisors shall establish an emergency medical care committee and shall also include the following members to advise the local EMS agency on the development of the community paramedicine program:

(1) Two emergency room physicians practicing at an emergency department within the local EMS agency's jurisdiction.

(2) Two registered nurses practicing within the local EMS agency's jurisdiction.

(3) Two emergency medical technician-paramedics practicing in the local EMS agency's jurisdiction. At least one of the emergency medical technician-paramedics shall be employed by a public agency.

(4) The medical director for the local EMS agency.

(5) One acute care hospital representative with an emergency department operating within the local EMS agency jurisdiction.

(c) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 2. Section 1797.272 is added to the Health and Safety Code, to read:

1797.272. (a) The county board of supervisors shall prescribe the membership, and appoint the members, of the emergency medical care committee. If two or more adjacent counties establish a single committee, the county boards of supervisors shall jointly prescribe the membership, and appoint the members of the committee.

(b) This section shall become operative on January 1, 2025.

SEC. 3. Chapter 13 (commencing with Section 1800) is added to Division 2.5 of the Health and Safety Code, to read:

Chapter 13. Community Paramedicine

Article 1. General Provisions

1800. This chapter shall be known, and may be cited, as the Community Paramedicine Act of 2018.

1801. (a) It is the intent of the Legislature to establish state guidelines that govern the implementation of community paramedicine programs by local EMS agencies in California.

(b) It is the intent of the Legislature that a community paramedicine program developed by a local EMS agency be submitted to the Emergency Medical Services Authority for review and approval.

(c) It is the intent of the Legislature to improve the health of individuals in their communities by authorizing emergency medical technician paramedics, working under expert medical oversight, to deliver community paramedicine in California utilizing existing

providers, promoting continuity of care, and maximizing existing efficiencies within the first response and emergency medical services system.

(d) It is the intent of the Legislature that a community paramedicine program developed by a local EMS agency and authorized by the Emergency Medical Services Authority will do all of the following:

(1) Improve coordination among providers of medical services, behavioral health services, and social services.

(2) Reduce preventable ambulance transports, emergency department visits, and hospital readmissions.

(3) Preserve, protect, and deliver the highest level of patient care to every Californian.

(e) It is the intent of the Legislature that an alternate destination facility participating as part of an approved community paramedicine program will always be staffed by a higher medical authority, such as, at minimum, a registered nurse, if ensuring transfer of a patient from a community paramedic to the higher medical authority is in the best interests of the patient.

(f) It is the intent of the Legislature that the delivery of community paramedic services is a public good to be delivered in a manner that promotes continuity of care and continuity of providers and is consistent with, coordinated with, and complementary to, the existing first response and emergency medical response system in place in a local EMS agency's jurisdiction.

(g) It is the intent of the Legislature that a community paramedicine program be designed to improve community health and be implemented in a fashion that is respectful of the current emergency medical system and its providers. Whenever possible, and in furtherance of the public interest and public good, public agencies that provide first response services should deliver care under a community paramedicine program. In most circumstances, public agency providers are first on scene in a medical emergency.

(h) It is the intent of the Legislature that the development of any community paramedicine program reflects input from all practitioners of appropriate medical authorities, including, but not limited to, medical directors, physicians, nurses, mental health professionals, first responder paramedics, hospitals, and other entities within the emergency medical response system.

(i) It is the intent of the Legislature that local EMS agencies be authorized to develop a community paramedicine program to improve patient care and community health. A community paramedicine program should not be used to reduce personnel costs, harm working conditions of emergency medical and health care workers, or otherwise compromise the emergency medical response or health care system in a way that is focused primarily on containing costs. The highest priority of any community paramedicine program should be improving patient care and providing further efficiencies in the emergency medical system.

Article 2. Definitions

1810. Unless otherwise indicated in this chapter, the definitions contained in this article shall govern the provisions of this chapter.

1811. "Alternate destination facility" means a treatment location that is an authorized mental health facility or an authorized sobering center, but not a general acute care hospital, as defined in subdivision (a) of Section 1250.

1812. "Authorized mental health facility" means a designated facility, as defined in subdivision (n) of Section 5008 of the Welfare and Institutions Code, that has at least one registered nurse staffed onsite at the facility at all times.

1813. "Authorized sobering center" means a facility that is a federally qualified health center that has at least one registered nurse staffed onsite at the facility at all times.

1814. "Community paramedic" means a paramedic licensed under this division who has completed the core curriculum for community paramedic training described in paragraph (1) of subdivision (d) of Section 1831, has received certification in one or more of the community paramedicine program specialties described in subdivisions (a) to (e), inclusive, of Section 1815, and is accredited to provide community paramedic services by a local EMS agency as part of an approved community paramedicine program.

1815. "Community paramedicine program" means a program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide community paramedic services consisting of one or more of the program specialties described in subdivisions (a) to (e), inclusive, under the direction

of medical protocols developed by the local EMS agency that are consistent with the minimum medical protocols established by the authority. Community paramedic services may consist of the following program specialties:

(a) Providing short-term postdischarge followup for persons recently discharged from a hospital due to a serious health condition.

(b) Providing directly observed therapy to persons with tuberculosis.

(c) Providing case management services to frequent emergency medical services users.

(d) Providing services to treat hospice patients in their homes, in collaboration with the patient's hospice agency, in response to 911 calls.

(e) Providing patients with transport to an alternate destination facility.

1816. "Community paramedicine provider" means an advanced life support provider who has entered into a contract to deliver community paramedic services as part of an approved community paramedicine program developed by a local EMS agency.

1817. "Public agency" means a city, county, city and county, special district, or other political subdivision of the state that provides first response services, including emergency medical care.

Article 3. State Administration

1830. (a) The Community Paramedicine Medical Oversight Committee is hereby created within the Emergency Medical Services Authority to advise the authority on, and approve minimum medical protocols for, the community paramedicine program specialties described in Section 1815.

(b) The committee shall consist of the following 11 members appointed by the Governor:

(1) Two full-time physicians and surgeons, whose primary practice is emergency medicine, from a list of five names submitted by the California Chapter of the American College of Emergency Physicians.

(2) Two registered nurses from a list of five names provided by the California Labor Federation.

(3) Two emergency medical technician paramedics (EMT-Ps), one EMT-P employed by a public agency from a list of three names provided by the California Professional Firefighters and one EMT-P employed by a private ambulance company from a list of three names provided by the California Labor Federation.

(4) Two medical directors of local EMS agencies from a list of five names submitted by the EMS Medical Directors Association of California.

(5) One local EMS agency administrator from a list of three names submitted by the Emergency Medical Services Administrators Association of California.

(6) One inpatient hospitalist who is a physician whose primary professional focus is the general medical care of hospitalized patients from a list of three names submitted by the California Hospital Association.

(7) One mental health professional from a list of three names provided by the California Psychiatric Association.

1831. (a) The Emergency Medical Services Authority shall develop, in consultation with the Community Paramedicine Medical Oversight Committee, regulations that establish minimum standards for the development of a community paramedicine program.

(b) The Commission on Emergency Medical Services shall review and approve the regulations described in this section before the authority adopts the regulations.

(c) The regulations described in this section shall be based upon, and informed by, the formation and implementation of the Community Paramedicine Pilot Program under Health Workforce Pilot Project No. 173.

(d) The regulations that establish minimum standards for the development of a community paramedicine program shall consist of all of the following:

(1) Minimum standards and core curriculum for community paramedic training.

(2) Minimum standards for the scope of practice for each community paramedic in each program specialty described in Section 1815.

(3) A process for certifying a community paramedic who completes the core curriculum training described in paragraph (1).

(4) Minimum standards for approval, review, withdrawal, and revocation of a community paramedicine program.

(5) Minimum standards for collecting and submitting data to the authority to ensure patient safety that include consideration of both quality assurance and quality improvement. These standards shall include, but not be limited to, all of the following:

(A) Intervals for community paramedicine providers, participating health facilities, and local EMS agencies to submit community paramedicine data.

(B) Relevant program use data.

(C) Public posting of program analysis.

(D) Emergency medical response system feedback, including feedback from the emergency medical care committee described in subdivision (b) of Section 1797.272.

(E) If the community paramedicine program utilizes an alternate destination facility, consideration of ambulance patient offload times for both the alternate destination facility and existing emergency departments, the number of patients that are turned away, diverted, or required to be subsequently transferred to an emergency department, and identification of the reasons for turning away, diverting, or transferring the patient.

(F) An assessment of each community paramedicine program's medical protocols or other processes.

(G) An assessment of the impact that implementation of a community paramedicine program has on the delivery of emergency medical services and response times in the local EMS agency's jurisdiction.

1832. (a) The Emergency Medical Services Authority shall develop and, after approval by the Community Paramedicine Medical Oversight Committee, adopt minimum medical protocols for each community paramedicine program specialty described in Section 1815.

(b) The protocols described in this section shall be based upon, and informed by, the formation and implementation of the Community Paramedicine Pilot Program under Health Workforce Pilot Project No. 173, and further refinements provided by local EMS agencies during the course and operation of the pilot program.

1833. (a) The Emergency Medical Services Authority shall submit an annual report on the community paramedicine programs operating in California to the relevant policy committees of the

Legislature, and shall post the annual report on its Internet Web site. The authority shall submit and post its first report six months after the authority adopts the regulations described in Section 1831, and every January 1 thereafter for the next five years.

(b) The report may include recommendations for changes to, or the elimination of, community paramedicine program specialties that do not achieve the community health and patient goals expressed in Section 1801.

(c) (1) A report to be submitted pursuant to subdivision (a) shall be submitted in compliance with Section 9795 of the Government Code.

(2) This section shall be repealed six years after the authority adopts the regulations described in Section 1831.

1834. (a) The Emergency Medical Services Authority shall review a local EMS agency's proposed community paramedicine program to ensure it is consistent with the authority's regulations and the provisions of this chapter.

(b) The authority may impose conditions as part of the approval of a community paramedicine program that the local EMS agency is required to incorporate into its program to achieve consistency with the authority's regulations and the provisions of this chapter.

(c) The authority shall approve, approve with conditions, or deny the proposed community paramedicine program within six months after it is submitted by the local EMS agency.

1835. A community paramedicine pilot program approved under Health Workforce Pilot Project No. 173 before January 1, 2019, is authorized to continue operations until six months after the regulations described in Section 1831 become effective.

Article 4. Local Administration

1840. A local EMS agency may develop a community paramedicine program that is consistent with the Emergency Medical Services Authority's regulations and the provisions of this chapter and submit evidence of compliance with the requirements of Section 1841 to the authority for approval pursuant to Section 1834.

1841. A local EMS agency that opts to develop a community paramedicine program shall do all of the following:

(a) Integrate the proposed community paramedicine program into the local EMS agency's emergency medical services plan described in Article 2 (commencing with Section 1797.250) of Chapter 4.

(b) Consistent with this article, develop a process to select community paramedicine providers at a periodic interval of no more than 10 years.

(c) (1) Enter into an agreement with a community paramedicine provider for the delivery of community paramedic services within the local EMS agency's jurisdiction that are consistent with the proposed community paramedicine program.

(2) A local EMS agency shall not include a community paramedic services agreement within an existing or proposed contract for the delivery of emergency medical services within an exclusive operating area described in a contract awarded pursuant to Section 1797.224 or the provision of, or administration of, emergency medical services authorized pursuant to Section 1797.201.

(d) If the community paramedicine program provides the program specialties described in subdivisions (a) to (c), inclusive, of Section 1815, the local EMS agency shall enter into an agreement for the provision of those specialties according to the following:

(1) A local EMS agency shall solicit every public agency that is located within its jurisdiction to provide the proposed community program specialties. If a public agency agrees to provide all of those specialties, the local EMS agency shall enter into a written agreement with the public agency to provide those specialties.

(2) If a public agency agrees to provide only some of the proposed community program specialties, the local EMS agency may establish a competitive bid process to select a community paramedicine provider to deliver the specialties not provided by the public agency.

(3) If no public agency chooses to provide the proposed community program specialties, the local EMS agency shall establish a competitive bid process to select a community paramedicine provider to deliver the specialties.

(e) If the community paramedicine program provides the ~~emergency medical services~~ program specialties described in

subdivision (d) or (e) of Section 1815, the local EMS agency shall do all of the following:

(1) (A) Develop triage protocols for use by the community paramedic that will be used to determine whether a patient can be safely transported to an alternate destination.

(B) Develop triage protocols for use by the community paramedic that will be used to determine whether to transport a hospice patient, consistent with the patient's plan of care.

(2) Require the triage protocol and decision of the community paramedic to transport to an alternate destination facility to not be based upon, or affected by, the patient's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any other characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

(3) Enter into an agreement that continues the use of existing providers operating within the local EMS agency's jurisdiction in the manner and scope in which that service has been provided by the existing provider pursuant to Section 1797.201 or Section 1797.224.

(4) Certify that the alternate destination facility authorized to receive patients has adequate licensed medical staff, facilities, and equipment that comply with the requirements of the Emergency Medical Services Authority's regulations and the provisions of this chapter.

(5) Collaborate with the emergency medical care committee to develop medical protocols that describe when the use of an alternate destination facility is in the best interests of the patient and, upon approval of the medical director of the local EMS agency, submit the protocols to the Emergency Medical Services Authority. The medical protocols shall be consistent with the requirements of the authority's regulations and the provisions of this chapter, and shall include provisions describing the following:

(A) Qualified staff to care for the degree and severity of a patient's injuries and needs.

(B) The equipment and services available at an alternate destination facility necessary to care for patients requiring medical services.

(C) The time of day and any limitations that may apply for an alternate destination facility to treat patients requiring medical services.

(6) Secure an agreement with the alternate destination facility that requires the facility to notify the local EMS agency and the Emergency Medical Services Authority within 24 hours if there are changes in the status of the facility with respect to the protocols and the facility's ability to care for patients.

(7) Secure an agreement with the alternate destination facility attesting that the facility will operate in accordance with Section 1317 and providing that failure to operate in accordance with Section 1317 will result in the immediate termination of use of the facility as part of the community paramedicine program.

(f) Establish a process for training and certification of community paramedics in the proposed community paramedicine program's specialties.

(g) Facilitate and participate in any agreements between a community paramedicine provider and public or private health system participants to provide funding to support the implementation of the local EMS agency's community paramedicine program.

Article 5. Miscellaneous

1850. A person or organization shall not provide community paramedic services or represent, advertise, or otherwise imply that it is authorized to provide community paramedic services unless it is expressly authorized by a local EMS agency to provide those services as part of a community paramedicine program approved by the Emergency Medical Services Authority.

1851. A community paramedic shall provide community paramedic services only if he or she has been certified to perform those services by a local EMS agency and is working as an employee of an authorized community paramedicine provider.

1852. The disciplinary procedures for a community paramedic shall be consistent with subdivision (d) of Section 1797.194.

1853. Entering into an agreement to be a community paramedicine provider pursuant to this chapter shall not alter or otherwise invalidate a public agency's authority to provide or administer emergency medical services pursuant to Section 1797.201 or 1797.224.

1854. The liability provisions described in Chapter 9 (commencing with Section 1799.100) shall also apply to this chapter.

1855. This chapter shall remain in effect only until January 1, 2025, and as of that date is repealed.

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.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1109
Author: Bates
Bill Date: June 19, 2018, Amended
Subject: Controlled Substances: Schedule II Drugs: Opioids
Sponsor: San Diego District Attorney Summer Stephan
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require existing pain management continuing education courses to include the risks of addiction associated with the use of Schedule II drugs. This bill would also require a warning label on all Schedule II controlled substance prescription bottles on the associated addiction and overdose risks. This bill would require a prescriber to discuss specified information with the minor or the minor's parent or guardian before prescribing an opioid for the first time. Lastly, this bill would require a youth sports organization to annually give the Opioid Factsheet for Patients to each athlete, and for the athlete's parent or guardian to sign a document acknowledging receipt before participation in an organized sports team.

BACKGROUND

According to the Centers for Disease Control and Prevention, drug overdose deaths continue to increase in the United States. From 1999 to 2016, more than 630,000 people have died from a drug overdose. Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid. In 2016, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 5 times higher than in 1999. On average, 115 Americans die every day from an opioid overdose.

Existing law requires physicians and surgeons to complete at least 50 hours of approved CME during each two-year license renewal cycle. Currently, physicians and surgeons only have a mandatory one-time CME requirement of 12 hours in the subject of pain management and the treatment of the terminally ill. Pathologists and radiologists are exempted from this requirement. The 12 units may be divided in any way that is relevant to the physician's specialty and practice setting. Acceptable courses may address either topic individually or both topics together. For example, one physician might take three hours of "pain management education" and nine hours of "the appropriate care and treatment of the terminally ill;" a second physician might opt to take six hours of "pain management" and six hours of "the appropriate care and treatment of the terminally ill;" a third physician might opt to take one 12-hour course

that includes both topics. The Medical Board of California (Board) will accept any combination of the two topics totaling 12 hours. Physicians must complete the mandated hours by their second license renewal date or within four years, whichever comes first. The 12 required hours would count toward the 50 hours of approved CME each physician is required to complete during each biennial renewal cycle.

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

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

ANALYSIS

This bill would make findings and declarations regarding opioid addiction, misuse and overdose and would state the intent to ensure that health care providers and young athletes receive necessary education on this topic.

This bill would require existing mandated pain management continuing education courses to include the risks of addiction associated with the use of Schedule II drugs for physicians licensed on or after January 1, 2019. This bill would require the information and educational material regarding pain management techniques and procedures disseminated by the Board to include the risks of addiction associated with the use of Schedule II drugs. This bill would also make the same continuing education changes for other prescribers.

This bill would require a prescriber, with exceptions for treatment of addicts or those with chronic pain, to discuss all of the following with the minor, with the minor's parent or guardian, or with another adult authorized to consent to the minor's medical treatment before directly dispensing or issuing for a minor the first prescription in a single course of treatment for a controlled substance containing an opioid:

- The risks of addiction and overdose associated with the use of opioids.
- The increased risk of addiction to an opioid to an individual who is suffering from both mental and substance abuse disorders.
- The danger of taking an opioid with a benzodiazepine, alcohol, or another central nervous system depressant.
- Any other information required by law.

This bill would specify that the discussion requirements would not apply in any of the following circumstances:

- If the minor's treatment includes emergency services and care.
- If the minor's treatment is associated with or incident to an emergency surgery, regardless of whether the surgery is performed on an inpatient or outpatient basis.
- If, in the prescriber's professional judgment, fulfilling the requirements would be detrimental to the minor's health or safety, or in violation of the minor's legal rights regarding confidentiality.

This bill would specify that failure to comply with the discussion requirements would not constitute a criminal offense.

Lastly, this bill would require a youth sports organization to annually give the Opioid Factsheet for Patients to each athlete, and for the athlete's parent or guardian to sign a document acknowledging receipt before participation in an organized sports team.

According to the author's office, this bill is needed to continue educating everyone who comes in contact with opioid prescriptions. Ensuring that patients, minors, parents, and prescribers have the necessary information will help prevent future addiction and overdoses.

The growing opioid abuse epidemic remains a matter of concern for the Board. This bill will increase education for physicians and patients, which will further the Board's mission of consumer protection. The Board took a support if amended position on this bill and requested amendments to align the informed consent requirements in this bill with other bills going through the legislative process. These amendments were made, as the written consent requirements were removed and the verbal consent requirements now align with the other bill that was moving through the legislative process. As such, the Board now has a support position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: San Diego County District Attorney Summer Stephan (Sponsor); Association of California Life and Health Insurance Companies; California Dental Association; California District Attorneys Association; California Medical Association; Dental Board of California; McKesson Corporation; and Medical Board of California

OPPOSITION: None on file

AMENDED IN ASSEMBLY JUNE 19, 2018

AMENDED IN ASSEMBLY JUNE 6, 2018

AMENDED IN SENATE MAY 8, 2018

AMENDED IN SENATE MAY 2, 2018

AMENDED IN SENATE APRIL 18, 2018

AMENDED IN SENATE APRIL 4, 2018

SENATE BILL No. 1109

Introduced by Senator Bates
(Coauthors: Senators Nguyen and Stone)
(Coauthors: Assembly Members ~~Brough~~ *Arambula, Brough, Dahle,* and Mathis)

February 13, 2018

An act to amend Sections 1645, 2190.5, 2191, 2196.2, 2454.5, 2746.51, 2836.1, 3059, and 3502.1 of, and to add Section 4076.7 to, the Business and Professions Code, to add Section 49476 to the Education Code, and to add Sections 11158.1 and 124236 to the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 1109, as amended, Bates. Controlled substances: Schedule II drugs: opioids.

(1) The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under that act, the board is required to adopt and administer standards for the continuing education of physicians and surgeons. Existing law requires a physician and surgeon to complete a mandatory continuing education

course in the subjects of pain management and the treatment of terminally ill and dying patients. That act requires the board to give its highest priority to considering a course in pain management among its continuing education requirements for licensees, and requires the board to periodically develop and disseminate information and educational material on pain management techniques and procedures to licensees and general acute care hospitals.

This bill would require, for physicians and surgeons licensed on or after January 1, 2019, the mandatory continuing education course to also include the subject of the risks of addiction associated with the use of Schedule II drugs. The bill would require the board to give its highest priority to considering a course in the risks of addiction associated with the use of Schedule II drugs among its continuing education requirements for physicians and surgeons and would require the board to periodically develop and disseminate information and educational material on the risks of addiction associated with the use of Schedule II drugs to physicians and surgeons and general acute care hospitals.

(2) The Nursing Practice Act provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing and makes a violation of its provisions a crime. Existing law authorizes a certified nurse-midwife to furnish or order drugs or devices under specified circumstances, including board certification that the certified nurse-midwife has completed a course in pharmacology, as specified.

This bill would require the pharmacology course to include the risks of addiction and neonatal abstinence syndrome associated with the use of opioids.

Existing law also authorizes a nurse practitioner to furnish or order drugs or devices under specified circumstances, including board certification that the nurse practitioner has completed a course in pharmacology, as specified. Existing law requires nurse practitioners who are authorized to furnish Schedule II controlled substances to complete a mandatory continuing education course in Schedule II controlled substances.

This bill would require the mandatory continuing education course to include the risks of addiction associated with their use.

By expanding the scope of a crime under the Nursing Practice Act, the bill would impose a state-mandated local program.

(3) The Physician Assistant Practice Act provides for licensure and regulation of physician assistants by the Physician Assistant Board and authorizes a physician assistant to perform medical services as set forth

by regulations when those services are rendered under the supervision of a licensed physician and surgeon, as specified. The act prohibits a physician assistant from administering, providing, or issuing a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that meets specific standards.

This bill would require that course to include the risks of addiction associated with the use of Schedule II controlled substances.

(4) The Pharmacy Law provides for the licensure and regulation of pharmacists, pharmacy technicians, and pharmacies by the California State Board of Pharmacy. Existing law requires the board to promulgate regulations that require a standardized, patient-centered, prescription drug label on all prescription medicine dispensed to patients in California. The act makes a violation of its provisions a crime.

This bill would require a pharmacy or practitioner dispensing an opioid to a patient for outpatient use to prominently display on the label or container a notice that warns of the risk of overdose and addiction, as specified. Because a violation of that requirement would be a crime, the bill would impose a state-mandated local program.

(5) The Dental Practice Act provides for the licensure and regulation of persons engaged in the practice of dentistry by the Dental Board of California, which is within the Department of Consumer Affairs. The act authorizes the board, as a condition of license renewal, to require licentiates to successfully complete a portion of required continuing education hours in specific areas, including patient care, health and safety, and law and ethics.

This bill would include the risks of addiction associated with the use of Schedule II drugs in those specific areas of continuing education.

(6) Existing law, the Osteopathic Act, establishes the Osteopathic Medical Board of California, which issues certificates to, and regulates, osteopathic physicians and surgeons. Existing law requires the board to require each licensed osteopathic physician and surgeon to complete a minimum of 100 hours of American Osteopathic Association continuing education hours during each 2-year cycle, of which 40 hours must be completed in American Osteopathic Association Category 1 continuing education hours as a condition for renewal of an active license.

This bill would additionally require licensed osteopathic physician and surgeons to complete a course on the risks of addiction associated with the use of Schedule II drugs.

(7) The Optometry Practice Act provides for the licensure and regulation of the practice of optometry by the State Board of Optometry. The act requires an optometrist certified to use therapeutic pharmaceutical agents to complete a total of 50 hours of continuing education every 2 years in order to renew his or her certificate. Existing law requires 35 of the 50 hours of continuing education to be on the diagnosis, treatment, and management of ocular disease in any combination of specified areas, including pain medication.

This bill would expand the areas of continuing education to include risks of addiction associated with the use of Schedule II drugs.

(8) The California Uniform Controlled Substances Act classifies opioids as Schedule II controlled substances and places restrictions on the prescription of those drugs, including prohibiting refills and specifying the requirements of a prescription for these drugs. The act makes a violation of its provisions a crime.

This bill would require a prescriber to discuss specified information with the minor, the minor's parent or guardian, or other adult authorized to consent to the minor's medical treatment before directly dispensing or issuing for a minor the first prescription in a single course of treatment for a controlled substance containing an opioid. This bill would provide that a violation of these requirements is not a criminal offense.

(9) Existing law requires a school district, charter school, or private school that elects to offer an athletic program to take specified actions if an athlete is suspected to have sustained a concussion and to obtain a signed concussion and head injury information sheet from the athlete and athlete's parent or guardian before the athlete initiates practice or competition.

This bill would require a youth sports organization, as defined, that elects to offer an athletic program to annually give a specified Opioid Factsheet for Patients to each athlete, and would require each athlete and his or her parent to sign a document acknowledging receipt of that factsheet, as specified.

(10) Existing law requires a youth sports organization, as defined, that elects to offer an athletic program to, among other things, annually give a concussion and head injury information sheet to each athlete and requires that the sheet be signed, as specified.

This bill would also require a youth sports organization that elects to offer an athletic program to annually give a specified Opioid Factsheet for Patients to each athlete, and would require ~~that~~ each athlete and his or her parent to sign a document verifying receipt of that factsheet, as specified.

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

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

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

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

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

(a) Addiction, misuse, and overdose of prescription opioids is a public health crisis affecting both adults and children.

(b) Urgent measures are needed to better inform the public of the risks associated with both the long-term and short-term use of opioids in an effort to address this problem.

(c) Both short-term and long-term prescriptions of opioids to minors fall within situations that require counseling of patients and their parents or guardians by their prescribers.

(d) It is the intent of the Legislature to ensure that health care providers and young athletes receive necessary education on this topic.

SEC. 2. Section 1645 of the Business and Professions Code is amended to read:

1645. (a) Effective with the 1974 license renewal period, if the board determines that the public health and safety would be served by requiring all holders of licenses under this chapter to continue their education after receiving a license, it may require, as a condition to the renewal thereof, that they submit assurances satisfactory to the board that they will, during the succeeding two-year period, inform themselves of the developments in the practice of dentistry occurring since the original issuance of their licenses by pursuing one or more courses of study satisfactory to the board or by other means deemed equivalent by the board.

The board shall adopt regulations providing for the suspension of the licenses at the end of the two-year period until compliance with the assurances provided for in this section is accomplished.

(b) The board may also, as a condition of license renewal, require licentiates to successfully complete a portion of the required continuing education hours in specific areas adopted in regulations by the board. The board may prescribe this mandatory coursework within the general areas of patient care, health and safety, law and ethics, and the risks of addiction associated with the use of Schedule II drugs. The mandatory coursework prescribed by the board shall not exceed ~~fifteen~~ *15* hours per renewal period for dentists, and ~~seven and one-half~~ *7.5* hours per renewal period for dental auxiliaries. Any mandatory coursework required by the board shall be credited toward the continuing education requirements established by the board pursuant to subdivision (a).

(c) For a retired dentist who provides only uncompensated care, the board shall not require more than 60 percent of the hours of continuing education that are required of other licensed dentists. Notwithstanding subdivision (b), all of the hours of continuing education as described in this subdivision shall be gained through courses related to the actual delivery of dental services to the patient or the community, as determined by the board. Nothing in this subdivision shall be construed to reduce any requirements imposed by the board pursuant to subdivision (b).

(d) The board shall report on the outcome of subdivision (c) pursuant to, and at the time of, its regular sunset review process, as provided in Section 1601.1.

SEC. 3. Section 2190.5 of the Business and Professions Code is amended to read:

2190.5. (a) (1) All physicians and surgeons shall complete a mandatory continuing education course in the subjects of pain management and the treatment of terminally ill and dying patients. For the purposes of this section, this course shall be a one-time requirement of 12 credit hours within the required minimum established by regulation, to be completed by December 31, 2006. All physicians and surgeons licensed on and after January 1, 2002, shall complete this requirement within four years of their initial license or by their second renewal date, whichever occurs first. The board may verify completion of this requirement on the renewal application form.

(2) For physicians and surgeons licensed on or after January 1, 2019, the course described in paragraph (1) shall also include the subject of the risks of addiction associated with the use of Schedule II drugs.

(b) By regulatory action, the board may exempt physicians and surgeons by practice status category from the requirement in subdivision (a) if the physician and surgeon does not engage in direct patient care, does not provide patient consultations, or does not reside in the State of California.

(c) This section shall not apply to physicians and surgeons practicing in pathology or radiology specialty areas.

SEC. 4. Section 2191 of the Business and Professions Code is amended to read:

2191. (a) In determining its continuing education requirements, the board shall consider including a course in human sexuality, defined as the study of a human being as a sexual being and how he or she functions with respect thereto, and nutrition to be taken by those licensees whose practices may require knowledge in those areas.

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

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

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

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

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

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

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

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

(1) Pain and symptom management.

(2) The psycho-social dynamics of death.

(3) Dying and bereavement.

(4) Hospice care.

(j) In determining its continuing education requirements, the board shall give its highest priority to considering a course on pain management and the risks of addiction associated with the use of Schedule II drugs.

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

SEC. 5. Section 2196.2 of the Business and Professions Code is amended to read:

2196.2. The board shall periodically develop and disseminate information and educational material regarding pain management techniques and procedures, including the risks of addiction associated with the use of Schedule II drugs, to each licensed physician and surgeon and to each general acute care hospital in this state. The board shall consult with the State Department of Public Health in developing the materials to be distributed pursuant to this section.

SEC. 6. Section 2454.5 of the Business and Professions Code is amended to read:

2454.5. In order to ensure the continuing competence of licensed osteopathic physicians and surgeons, the board shall adopt and administer standards for the continuing education of those licensees. The board shall require each licensed osteopathic physician and surgeon to demonstrate satisfaction of the continuing education requirements as a condition for the renewal of a license at intervals of not less than one year nor more than two years. Commencing January 1, 2018, the board shall require each licensed osteopathic physician and surgeon to complete a minimum of 100 hours of American Osteopathic Association continuing education hours during each two-year cycle, of which 40 hours shall be completed in American Osteopathic Association Category 1 continuing education hours and the remaining 60 hours shall be either American Osteopathic Association or American Medical Association accredited as a condition for renewal of an active license. Licensed osteopathic physicians and surgeons shall complete a course on the risks of addiction associated with the use of Schedule II drugs.

For purposes of this section, "American Osteopathic Association Category 1" means continuing education activities and programs approved for Category 1 credit by the Committee on Continuing Medical Education of the American Osteopathic Association.

SEC. 7. Section 2746.51 of the Business and Professions Code is amended to read:

2746.51. (a) Neither this chapter nor any other provision of law shall be construed to prohibit a certified nurse-midwife from furnishing or ordering drugs or devices, including controlled substances classified in Schedule II, III, IV, or V under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code), when all of the following apply:

(1) The drugs or devices are furnished or ordered incidentally to the provision of any of the following:

(A) Family planning services, as defined in Section 14503 of the Welfare and Institutions Code.

(B) Routine health care or perinatal care, as defined in subdivision (d) of Section 123485 of the Health and Safety Code.

(C) Care rendered, consistent with the certified nurse-midwife's educational preparation or for which clinical competency has been established and maintained, to persons within a facility specified in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the Health and Safety Code, a clinic as specified in Section 1204 of the Health and Safety Code, a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code, a licensed birth center as defined in Section 1204.3 of the Health and Safety Code, or a special hospital specified as a maternity hospital in subdivision (f) of Section 1250 of the Health and Safety Code.

(2) The drugs or devices are furnished or ordered by a certified nurse-midwife in accordance with standardized procedures or protocols. For purposes of this section, standardized procedure means a document, including protocols, developed and approved by the supervising physician and surgeon, the certified nurse-midwife, and the facility administrator or his or her designee. The standardized procedure covering the furnishing or ordering of drugs or devices shall specify all of the following:

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

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

(C) The extent of physician and surgeon supervision.

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

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

(4) The furnishing or ordering of drugs or devices by a certified nurse-midwife occurs under physician and surgeon supervision. For purposes of this section, no physician and surgeon shall

supervise more than four certified nurse-midwives at one time. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:

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

(B) Approval of the standardized procedure or protocol.

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

(b) (1) The furnishing or ordering of drugs or devices by a certified nurse-midwife is conditional on the issuance by the board of a number to the applicant who has successfully completed the requirements of paragraph (2). The number shall be included on all transmittals of orders for drugs or devices by the certified nurse-midwife. The board shall maintain a list of the certified nurse-midwives that it has certified pursuant to this paragraph and the number it has issued to each one. The board shall make the list available to the California State Board of Pharmacy upon its request. Every certified nurse-midwife who is authorized pursuant to this section to furnish or issue a drug order for a controlled substance shall register with the United States Drug Enforcement Administration.

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section, including the risks of addiction and neonatal abstinence syndrome associated with the use of opioids. The board shall establish the requirements for satisfactory completion of this paragraph.

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

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

(5) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized through standardized procedures or protocols to furnish Schedule

II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

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

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

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

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

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

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

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

this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 8. Section 2836.1 of the Business and Professions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

(h) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance

with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

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

SEC. 9. Section 3059 of the Business and Professions Code is amended to read:

3059. (a) It is the intent of the Legislature that the public health and safety would be served by requiring all holders of licenses to practice optometry granted under this chapter to continue their education after receiving their licenses. The board shall adopt regulations that require, as a condition to the renewal thereof, that all holders of licenses submit proof satisfactory to the board that they have informed themselves of the developments in the practice of optometry occurring since the original issuance of their licenses by pursuing one or more courses of study satisfactory to the board or by other means deemed equivalent by the board.

(b) The board may, in accordance with the intent of this section, make exceptions from continuing education requirements for reasons of health, military service, or other good cause.

(c) If for good cause compliance cannot be met for the current year, the board may grant exemption of compliance for that year, provided that a plan of future compliance that includes current requirements as well as makeup of previous requirements is approved by the board.

(d) The board may require that proof of compliance with this section be submitted on an annual or biennial basis as determined by the board.

(e) An optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 shall complete a total of 50 hours

of continuing education every two years in order to renew his or her certificate. Thirty-five of the required 50 hours of continuing education shall be on the diagnosis, treatment, and management of ocular disease in any combination of the following areas:

(1) Glaucoma.

(2) Ocular infection.

(3) Ocular inflammation.

(4) Topical steroids.

(5) Systemic medication.

(6) Pain medication, including the risks of addiction associated with the use of Schedule II drugs.

(f) The board shall encourage every optometrist to take a course or courses in pharmacology and pharmaceuticals as part of his or her continuing education.

(g) The board shall consider requiring courses in child abuse detection to be taken by those licensees whose practices are such that there is a likelihood of contact with abused or neglected children.

(h) The board shall consider requiring courses in elder abuse detection to be taken by those licensees whose practices are such that there is a likelihood of contact with abused or neglected elder persons.

SEC. 10. Section 3502.1 of the Business and Professions Code is amended to read:

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

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

(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary

and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

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

(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

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

(2) A physician assistant shall not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V

controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances, including the risks of addiction associated with their use. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

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

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

of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

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

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

(2) If the physician assistant has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course (A) meets the standards, including pharmacological content, established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of Regulations, and (B) is provided either by an accredited continuing education provider or by an approved physician assistant training program, the supervising physician and surgeon shall review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established in Section 1399.612 of Title 16 of the California Code of Regulations. Physician assistants who have a certificate of completion of the course described in paragraph (2) of subdivision (c) shall be deemed to have met the education course requirement of this subdivision.

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

(g) The board shall consult with the Medical Board of California and report during its sunset review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code the impacts of

exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient.

SEC. 11. Section 4076.7 is added to the Business and Professions Code, to read:

4076.7. In addition to the requirements of Sections 4076 and 4076.5, whenever a prescription drug containing an opioid is dispensed to a patient for outpatient use, the pharmacy or practitioner dispensing the drug shall prominently display on the label or container, by means of a flag or other notification mechanism attached to the container, a notice that states "Caution: Opioid. Risk of overdose and addiction."

SEC. 12. Section 49476 is added to the Education Code, to read:

49476. (a) If a school district, charter school, or private school elects to offer an athletic program, the school district, charter school, or private school shall annually give the Opioid Factsheet for Patients published by the Centers for Disease Control and Prevention to each athlete. The athlete and, if the athlete is 17 years of age or younger, the athlete's parent or guardian shall sign a document acknowledging receipt of the Opioid Factsheet for Patients and return that document to the school district, charter school, or private school before the athlete initiates practice or competition. The Opioid Factsheet for Patients may be sent and returned through an electronic medium, including, but not limited to, fax or email.

(b) This section does not apply to an athlete engaging in an athletic activity during the regular schoolday or as part of a physical education course required pursuant to subdivision (d) of Section 51220.

SEC. 13. Section 11158.1 is added to the Health and Safety Code, to read:

11158.1. (a) Except when a patient is being treated as set forth in Sections 11159, 11159.2, and 11167.5, and Article 2 (commencing with Section 11215) of Chapter 5, pertaining to the treatment of addicts, or for a diagnosis of chronic intractable pain as used in Section 124960 of this code and Section 2241.5 of the Business and Professions Code, a prescriber shall discuss all of the following with the minor, the minor's parent or guardian, or another adult authorized to consent to the minor's medical

treatment before directly dispensing or issuing for a minor the first prescription in a single course of treatment for a controlled substance containing an opioid:

(1) The risks of addiction and overdose associated with the use of opioids.

(2) The increased risk of addiction to an opioid to an individual who is suffering from both mental and substance abuse disorders.

(3) The danger of taking an opioid with a benzodiazepine, alcohol, or another central nervous system depressant.

(4) Any other information required by law.

(b) This section does not apply in any of the following circumstances:

(1) If the minor's treatment includes emergency services and care as defined in Section 1317.1.

(2) If the minor's treatment is associated with or incident to an emergency surgery, regardless of whether the surgery is performed on an inpatient or outpatient basis.

(3) If, in the prescriber's professional judgment, fulfilling the requirements of subdivision (a) would be detrimental to the minor's health or ~~safety.~~ *safety, or in violation of the minor's legal rights regarding confidentiality.*

(c) Notwithstanding any other law, including Section 11374, failure to comply with this section shall not constitute a criminal offense.

SEC. 14. Section 124236 is added to the Health and Safety Code, to read:

124236. (a) A youth sports organization, as defined in paragraph (3) of subdivision (b) of Section 124235, that elects to offer an athletic program shall annually give the Opioid Factsheet for Patients published by the Centers for Disease Control and Prevention to each athlete. The athlete and, if the athlete is 17 years of age or younger, the athlete's parent or guardian shall sign a document acknowledging receipt of the Opioid Factsheet for Patients and return that document to the youth sports organization before the athlete initiates practice or competition. The Opioid Factsheet for Patients may be sent and returned through an electronic medium, including, but not limited to, fax or email.

(b) This section shall apply to all athletes participating in the activities of a youth sports organization, irrespective of their ages. This section shall not be construed to prohibit a youth sports

organization, or any other appropriate entity, from adopting and enforcing rules intended to provide a higher standard of safety for athletes than the standard established under this section.

SEC. 15. 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.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1163
Author: Galgiani
Bill Date: June 25, 2018, Amended
Subject: Postmortem Examination or Autopsy: Attending Physician and Surgeon
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a postmortem examination or autopsy on an unidentified body or human remains be conducted by an attending physician, the chief medical examiner, or a resident physician or a board-eligible forensic pathologist. This bill would also require agencies tasked with specified exhumations to perform the exhumation under the direction of a board-certified forensic pathologist.

BACKGROUND

SB 1189 (Pan and Jackson, Chapter 787, Statutes of 2016) required that forensic autopsies be conducted by a licensed physician and surgeon and required that the results of a forensic autopsy only be determined by a licensed physician and surgeon. SB 1189 defined a forensic autopsy as an examination of a body of a decedent to generate medical evidence for which the cause and manner of death is determined.

ANALYSIS

This bill would expressly state that a postmortem examination or autopsy on an unidentified body or human remains must only be conducted by an attending physician, the chief medical examiner who is a board-certified forensic pathologist certified by the American Board of Pathology, or an attending physician or a board-eligible forensic pathologist if the postmortem examination or autopsy is performed under the supervision of a licensed physician or the chief medical examiner who is a board-certified forensic pathologist.

This bill would define an attending physician as a physician and surgeon licensed to practice medicine in this state performing a postmortem examination or autopsy pursuant to this section.

This bill would require any agency tasked with the exhumation of a body or skeletal remains of a deceased person that has suffered significant deterioration or decomposition, where the circumstances surrounding the death afford a reasonable

basis to suspect that the death was caused by or related to the criminal act of another, to perform the exhumation under the direction of a board-certified forensic pathologist certified by the American Board of Pathology. This bill would allow the board-certified forensic pathologist to, at his or her discretion when necessary, retain the services of an anthropologist.

This bill would require for an unidentified body or human remains, appropriate samples of tissue and bone to be retained by the attending physician or chief medical examiner before the body or human remains are cremated or buried. The types of samples of tissue and bone that are taken must be determined by an attending physician and surgeon or chief medical examiner who is a board-certified forensic pathologist certified by the American Board of Pathology. This bill would require the samples obtained, the method of procurement or dissection of samples, and the handling, processing, and storage of samples to be within, and guided by, the generally accepted standards of practice of medicine and the generally accepted principles of medicine.

This bill contains other technical and clarifying changes.

According to the author's office, this bill would make clarifying changes to update existing law. This bill is in line with SB 1189 from 2016, which the Board supported. This bill will make it clear that postmortem examinations or autopsies on an unidentified body or human remains must be conducted by an attending physician and surgeon or the chief medical examiner, which is appropriate. The Board is supportive of this bill.

FISCAL: None

SUPPORT: California Public Defenders Association
Medical Board of California

OPPOSITION: California State Coroners' Association

AMENDED IN ASSEMBLY JUNE 25, 2018

AMENDED IN SENATE APRIL 16, 2018

AMENDED IN SENATE APRIL 3, 2018

SENATE BILL No. 1163

Introduced by Senator Galgiani

February 14, 2018

An act to amend Section 27521 of the Government Code, relating to autopsies.

LEGISLATIVE COUNSEL'S DIGEST

SB 1163, as amended, Galgiani. Postmortem examination or autopsy: unidentified body or human remains: medical examiner: attending physician and surgeon.

Existing law makes it the duty of a coroner to inquire into and determine the circumstances, manner, and cause of deaths under prescribed conditions, including deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another or if the surviving spouse of the deceased requests the coroner to do so in writing. Existing law makes a postmortem examination or autopsy conducted at the discretion of a coroner, medical examiner, or other agency upon an unidentified human body or human remains subject to certain specified provisions of law.

This bill would require a postmortem examination or autopsy upon an unidentified body or human remains to only be conducted by an attending physician and ~~surgeon or~~ *surgeon,* chief medical examiner who is a board-certified forensic ~~pathologist.~~ *pathologist, or a resident physician and surgeon, or a board-eligible forensic pathologist, if the postmortem examination or autopsy is performed under the supervision*

of a licensed physician and surgeon or the chief medical examiner. The bill would require an agency tasked with the exhumation of a body or skeletal remains of a deceased person that has suffered significant deterioration or decomposition, where the circumstances surrounding the death afford a reasonable basis to suspect that the death was caused by or related to the criminal act of another, to perform the exhumation under the direction of a board-certified forensic pathologist and would authorize that board-certified forensic pathologist to retain the services of an anthropologist.

Existing law requires a postmortem examination or autopsy to include certain procedures, including, but not limited to, a dental examination that is authorized to be conducted by a qualified dentist as determined by the coroner. Existing law authorizes the postmortem examination or autopsy of the unidentified body or remains to include full body X-rays.

This bill would instead provide that the dental examination is authorized to be conducted by a qualified dentist as determined by the coroner, medical examiner, or attending physician and surgeon. The bill would additionally authorize the postmortem examination or autopsy of the unidentified body or remains to include computed tomography scans.

Existing law authorizes the use of an electronic image system during an autopsy at the sole discretion of a coroner, medical examiner, or other agency tasked with performing an autopsy, except as specified. Existing law requires a coroner, medical examiner, or other agency tasked with performing a postmortem examination or an autopsy to, among other things, submit dental charts, dental X-rays, and the final report of investigation to the Department of Justice, as specified. Existing law, unless the coroner, medical examiner, or other agency performing a postmortem examination or autopsy determines the body of the unidentified deceased person has suffered significant deterioration or decomposition, prohibits the jaws from being removed until immediately before the body is cremated or buried and requires the coroner, medical examiner, or other agency to retain the jaws and other tissue samples for a specified period of time.

This bill would additionally apply those above-described provisions to an attending physician and surgeon. The bill would require the coroner, medical examiner, attending physician and surgeon, or other agency to, instead, retain the samples of tissue and bone for a specified period of time.

Existing law prohibits the body of an unidentified deceased person from being cremated or buried until the jaws and other ~~tissues~~ *tissue* samples are retained for future possible use.

This bill would require the appropriate samples of tissue and bone to be retained by an attending physician and surgeon or a chief medical examiner who is a board-certified forensic pathologist for future possible use, including, but not limited to, identification purposes. The bill would, for an unidentified body or human remains, require that appropriate samples of tissue and bone be taken before the unidentified body or human remains are cremated or buried, as specified.

This bill would define "attending physician and surgeon" for the purposes of these provisions as a physician and surgeon licensed to practice medicine in this state performing a postmortem examination or autopsy, as specified.

By placing new requirements on local governments for performing postmortem examinations or autopsies, this bill would impose a state-mandated local program.

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

This bill would provide that, 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 the statutory provisions noted above.

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

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

SECTION 1. Section 27521 of the Government Code is amended to read:

27521. (a) A postmortem examination or autopsy conducted at the discretion of a coroner, medical examiner, or other agency upon an unidentified body or human remains is subject to this section.

(b) A postmortem examination or autopsy upon an unidentified body or human remains shall only be conducted by an attending physician and ~~surgeon or~~ *surgeon,* the chief medical examiner who is a board-certified forensic pathologist certified by the American Board of ~~Pathology.~~ *Pathology, or a resident physician and*

surgeon, or a board-eligible forensic pathologist, if the postmortem examination or autopsy is performed under the supervision of a licensed physician and surgeon or the chief medical examiner who is a board-certified forensic pathologist.

(c) Any agency tasked with the exhumation of a body or skeletal remains of a deceased person that has suffered significant deterioration or decomposition, where the circumstances surrounding the death afford a reasonable basis to suspect that the death was caused by or related to the criminal act of another, shall perform the exhumation under the direction of a board-certified forensic pathologist certified by the American Board of Pathology. The board-certified forensic pathologist may, at his or her discretion when necessary, retain the services of an anthropologist.

(d) A postmortem examination or autopsy shall include, but shall not be limited to, the following procedures:

(1) Taking of all available fingerprints and palm prints.

(2) A dental examination consisting of dental charts and dental X-rays of the deceased person's teeth, which may be conducted on the body or human remains by a qualified dentist as determined by the coroner, medical examiner, or attending physician and surgeon.

(3) The collection of tissue, including a hair sample, or body fluid samples for future DNA testing, if necessary.

(4) Frontal and lateral facial photographs with the scale indicated.

(5) Notation and photographs, with a scale, of significant scars, marks, tattoos, clothing items, or other personal effects found with or near the body.

(6) Notations of observations pertinent to the estimation of the time of death.

(7) Precise documentation of the location of the remains.

(e) The postmortem examination or autopsy of the unidentified body or remains may include full body X-rays or computed tomography scans.

(f) (1) At the sole and exclusive discretion of a coroner, medical examiner, attending physician and surgeon, or other agency tasked with performing an autopsy pursuant to Section 27491, an electronic image system, including, but not limited to, an X-ray machine or computed tomography scanning system, may be used to fulfill the requirements of subdivision (d) or of a postmortem

examination or autopsy required by other law, including, but not limited to, Section 27520.

(2) This subdivision does not impose a duty upon any coroner, medical examiner, attending physician and surgeon, or other agency tasked with performing autopsies pursuant to Section 27491 to use an electronic image system to perform autopsies or to acquire the capability to do so.

(3) A coroner, medical examiner, attending physician and surgeon, or other agency tasked with performing an autopsy pursuant to Section 27491 shall not use an electronic imaging system to conduct an autopsy in any investigation where the circumstances surrounding the death afford a reasonable basis to suspect that the death was caused by or related to the criminal act of another and it is necessary to collect evidence for presentation in a court of law. If the results of an autopsy performed using electronic imaging provides the basis to suspect that the death was caused by or related to the criminal act of another, and it is necessary to collect evidence for presentation in a court of law, then a dissection autopsy shall be performed in order to determine the cause and manner of death.

(4) An autopsy may be conducted using an X-ray or computed tomography scans notwithstanding the existence of a certificate of religious belief properly executed in accordance with Section 27491.43.

(g) The coroner, medical examiner, attending physician and surgeon, or other agency performing a postmortem examination or autopsy shall prepare a final report of investigation in a format established by the Department of Justice. The final report shall list or describe the information collected pursuant to the postmortem examination or autopsy conducted under subdivision ~~(d)~~ *(d)*.

(h) The body of an unidentified deceased person shall not be cremated or buried until the appropriate samples of tissue and bone are retained by an attending physician and surgeon or the chief medical examiner who is a board-certified forensic pathologist certified by the American Board of Pathology for future possible use, including, but not limited to, identification purposes.

(i) For an unidentified body or human remains, appropriate samples of tissue and bone shall be taken before the body or human remains are cremated or buried. The types of samples of tissue and bone that are taken shall be determined by an attending physician

and surgeon or chief medical examiner who is a board-certified forensic pathologist certified by the American Board of Pathology. The samples obtained, the method of procurement or dissection of those samples, and the handling, processing, and storage of samples shall be within, and guided by, the generally accepted standards of practice of medicine and the generally accepted principles of medicine.

(j) The coroner, medical examiner, attending physician and surgeon, or other agency responsible for a postmortem examination or autopsy shall retain the samples of tissue and bone for one year after a positive identification is made, and no civil or criminal challenges are pending, or indefinitely.

(k) If the coroner, medical examiner, attending physician and surgeon, or other agency performing a postmortem examination or autopsy with the aid of the dental examination and any other identifying findings is unable to establish the identity of the body or human remains, the coroner, medical examiner, or other agency shall submit dental charts and dental X-rays of the unidentified deceased person to the Department of Justice on forms supplied by the Department of Justice within 45 days of the date the body or human remains were discovered.

(*l*) If the coroner, medical examiner, attending physician and surgeon, or other agency performing a postmortem examination or autopsy with the aid of the dental examination and other identifying findings is unable to establish the identity of the body or human remains, the coroner, medical examiner, attending physician and surgeon, or other agency shall submit the final report of investigation to the Department of Justice within 180 days of the date the body or human remains were discovered. The final report of investigation shall list or describe the information collected pursuant to the postmortem examination or autopsy conducted under subdivision (b), (d), or (i) and any anthropology report, fingerprints, photographs, and autopsy report.

(m) For the purposes of this section, "attending physician and surgeon" means a physician and surgeon licensed to practice medicine in this state performing a postmortem examination or autopsy pursuant to this section.

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.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1238
Author: Roth
Bill Date: June 28, 2018, Amended
Subject: Patient Records: Maintenance and Storage
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require health care providers and group practices to notify their patients, using the patient's last known contact information, before the patient's medical records are destroyed.

BACKGROUND

Existing law, Health and Safety Code Section 123100 et seq. establishes a patient's right to view and receive copies of his or her medical records, under specified conditions. The law only addresses the patient's request for copies of his or her own medical records and does not cover a patient's request to transfer records between health care providers.

Section 123110 of the Health and Safety Code specifically provides that any adult patient, or any minor patient who by law can consent to medical treatment (or certain patient representatives), is entitled to inspect patient records upon written request to a physician and upon payment of reasonable clerical costs to make such records available. The physician must then permit the patient to view his or her records during business hours within five working days after receipt of the written request. The patient or patient's representative may be accompanied by one other person of his or her choosing. Prior to inspection or copying of records, physicians may require reasonable verification of identity, so long as this is not used oppressively or discriminatorily to frustrate or delay compliance with this law.

The patient or patient's representative is entitled to copies of all or any portion of his or her records that he or she has a right to inspect, upon written request to the physician. The physician may charge a fee to defray the cost of copying, not to exceed 25 cents per page or 50 cents per page for records that are copied from microfilm, along with reasonable clerical costs. By law, a patient's records are defined as records relating to the health history, diagnosis, or condition of a patient, or relating to treatment provided or proposed to be provided to the patient. Physicians must provide patients with copies within 15 days of receipt of the request.

ANALYSIS

This bill would require a health care provider who creates patient records, no later than the date of the first service delivery, or as soon as reasonably practicable after an emergency treatment situation, to provide a statement to be signed by the patient or the patient's representative, that sets forth both of the following:

- The patient's rights to inspect his or her medical records, obtain copies of his or her medical records, and provide a written addendum, with respect to any item or statement in the records that the patient believes to be incomplete or incorrect.
- The intended retention period for the records, as specified in law or by the health care provider's retention policy.

This bill would exempt a health care provider from the signed statement requirements if he or she utilizes electronic health records and those records are stored in perpetuity.

This bill would specify that if the patient refuses to sign the statement, the record shall indicate that fact. This bill would allow the statement to be included in another form or statement provided to the patient or the patient's representative, if the form or statement is provided no later than the date of the first service delivery, or as soon as reasonably practicable after an emergency treatment situation.

This bill would require the health care provider to notify the patient not fewer than 60 days before the health care provider plans to destroy the patient's records. The health care provider would be required to mail the notification via first-class mail, or by electronic mail, or both. The notification would be required to inform the patient this his or her records are scheduled to be destroyed, the date of the proposed destruction, and inform the patient of his or her rights to inspect the medical records. The health care provider would be required to provide a patient with the original medical records earlier than the retention period in the signed statement if the patient makes a request for the records before the date of the proposed destruction of the records. This bill would allow the patient to designate the method of delivery and would allow the health care provider to charge a patient for the actual costs incurred for copying, mailing, or shipping the records. This bill would not authorize charges for maintenance of patient records.

This bill would specify that a health care provider that violates this section may be cited and assessed an administrative penalty. This bill would not allow a citation to be issued or a penalty to be assessed upon the first violation, but only upon the second and each subsequent violation.

This bill would exempt patient records created by a psychiatrist from the requirements of this bill. This bill would also exempt medical records that are created for a patient

who is referred solely for diagnostic evaluation, if the provider did not provide treatment and reports the results of the diagnostic evaluation to the patient's referring provider.

This bill would specify that if a group practice or clinic comprised of health care providers is the custodian of patient records for those health care providers, then the group practice or clinic, rather than the individual health care provider, is required to comply with the requirements of this bill. This bill would exempt clinics licensed by the California Department of Public Health (CDPH) from the requirements of this bill.

According to the author's office, existing law does not establish a standard on the number of years a health provider or plan must maintain medical records. Requiring a health care provider to notify patient prior to the destruction of records will help patients maintain and protect their personal health records as they pursue long-term treatment.

The Board receives many calls and inquiries from consumers regarding medical records and where to find them if a physician retires, moves away, or dies. There is no law requiring a physician to notify patients before destroying their medical records and there is no law requiring physicians to notify patients of their medical records retention schedule. Requiring this notification will help consumers gain access to their medical records before they are destroyed. This will help to ensure that a patient's future physicians are well informed of their medical history, so they can be provided high quality medical care.

The Board took a support in concept position on this bill at the last Board Meeting. The Board supported the concept of this bill; however, the Board did have some concerns with holding physicians liable for patient records not in their control. The author's office did take amendments to require group practices and clinics that are the custodian of patient records to be responsible for complying with the requirements of this bill, instead of the individual providers. These amendments are intended to address the Board's concern. However, it is still unclear who would enforce the bill's requirements for group practices and clinics that are not licensed by CDPH. The Board could not enforce these requirements since it does not have oversight over these entities. In addition, this bill would not require clinics licensed by CDPH to comply with the requirements of this bill. Patients in clinics licensed by CDPH should have the same access to records and notification as other patients. Board staff suggests that the Board support this bill if it is amended to address these issues.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: California Association of Health Underwriters; California Nurses Association/National Nurses United; California Labor Federation; California School Employees Association, AFL-CIO; Congress of

California Seniors; Consumer Attorneys of California; Consumer Union-Advocacy Division of Consumer Reports; Health Access California; and Western Center on Law and Poverty

OPPOSITION: California Chiropractic Association (unless amended); California Dental Association (unless amended); California Health Information Management Association; California Medical Association (unless amended); California Optometric Association; and California Society of Plastic Surgeons

POSITION: Recommendation: Support if Amended

AMENDED IN ASSEMBLY JUNE 28, 2018

AMENDED IN ASSEMBLY JUNE 20, 2018

AMENDED IN SENATE APRIL 9, 2018

AMENDED IN SENATE MARCH 19, 2018

SENATE BILL **No. 1238**

Introduced by Senator Roth

February 15, 2018

An act to add Sections 123106 and 123107 to the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 1238, as amended, Roth. Patient records: maintenance and storage.

Existing law establishes procedures for providing access to various types of health care records, including patient records, as defined, by patients and persons having responsibility for decisions respecting the health care of others. Existing law gives health care providers, as defined, various responsibilities in connection with providing access to these records.

This bill would require certain health care ~~providers at the time of creation of a patient record~~ *providers, no later than the date of the first service delivery, or as soon as reasonably practicable after an emergency treatment situation,* to provide a statement to the patient, or the patient's representative, that sets forth the patient's rights and the intended retention period for the records. The bill would require those health care providers that plan to destroy patient records to notify the patient at least 60 days before a patient's records are to be destroyed, as provided. The bill would require a health care provider to provide a patient with his or her original medical records that the provider plans

to destroy if the patient makes a request for the records to the provider before the date of the proposed destruction of the records. The bill would authorize a health care provider to charge a patient for the actual costs of copying, mailing, or shipping the patient's records under that provision. The bill would authorize the issuance of citations and the assessment of administrative penalties for violations. Under the bill, if a group practice or clinic comprised of health care providers subject to the bill is the custodian of patient records for those health care providers, the group practice or clinic, rather than the individual health care provider, would be required to comply with the bill's provisions.

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 123106 is added to the Health and Safety Code, to read:

123106. (a) A health care provider described in paragraphs (4), (5), (6), (8), and (9) of subdivision (a) of Section 123105, who creates patient records, as defined in subdivision (d) of Section 123105, shall, ~~at the time the initial patient record is created,~~ *no later than the date of the first service delivery, or as soon as reasonably practicable after an emergency treatment situation,* provide a statement to be signed by the patient, or the patient's representative, that sets forth both of the following:

(1) The patient's rights under this chapter to inspect his or her medical records, obtain copies of his or her medical records, and to provide a written addendum, pursuant to Section 123111, with respect to any item or statement in the patient's records that the patient believes to be incomplete or incorrect.

(2) The intended retention period for the records, as specified in applicable law or by the health care provider's retention policy.

(b) A copy of the signed statement required pursuant to subdivision (a) shall be provided to the patient.

(c) If a patient, or the patient's representative, is provided a statement ~~at the time that the initial patient record is created,~~ *pursuant to subdivision (a),* and the patient refuses to sign the statement, the patient's record shall indicate that the patient refused to sign the statement.

(d) The statement required by subdivision (a) may be included in another form or statement provided to the patient, or the patient's representative, ~~at the time the initial patient record is created.~~ *if the form or statement is provided no later than the date of the first service delivery, or as soon as reasonably practicable after an emergency treatment situation.*

(e) If a health care provider to whom subdivision (a) applies plans to destroy patient records, the health care provider shall, no fewer than 60 days before a patient's records are to be destroyed, notify the patient, via first-class mail, electronic mail, or both, to the patient's last known mailing or electronic mail address, or both. The notification shall inform the patient that his or her records are scheduled to be destroyed and the date of the proposed destruction of records. The notification shall also inform the patient of his or her rights under this chapter to inspect his or her medical records. A health care provider to whom subdivision (a) applies shall provide a patient with his or her original medical records that the provider plans to destroy earlier than the period specified in the signed statement if the patient makes a request for the records to the health care provider before the date of the proposed destruction of the records. The patient or the patient's authorized representative may designate delivery of patient records either by personal pickup, mail, overnight delivery, or other delivery means. This section does not reduce the length of record retention as otherwise required by law.

(f) A health care provider may charge a patient for the actual costs incurred by the health care provider for copying, mailing, or shipping the patient's records under this section in accordance with subdivision (k) of Section 123110. This section does not authorize a health care provider to charge a patient for maintenance of any patient records that the health care provider is obligated by law to maintain.

(g) A health care provider to whom subdivision (a) applies shall not be subject to this section for medical records that are created for a patient who is referred to the provider solely for a diagnostic evaluation, if the provider does not provide treatment to the patient and reports the results of the diagnostic evaluation to the patient's referring provider.

(h) A health care provider to whom subdivision (a) applies shall not be subject to this section if the health care provider utilizes electronic health records and those records are stored in perpetuity.

(i) A health care provider who violates this section may be cited and assessed an administrative penalty in accordance with Section 125.9 of the Business and Professions Code. A citation shall not be issued and a penalty shall not be assessed upon the first violation by a licensee of this section. Upon the second and each subsequent violation by a health care provider of this section, a citation may be issued and an administrative penalty may be assessed after appropriate notice and opportunity for hearings. Notwithstanding any other law, the remedy described in this subdivision constitutes the exclusive remedy for a violation of this section. This section does not affect other existing rights, duties, or remedies provided by law.

(j) The patient records created by a psychiatrist, including psychotherapy notes, as defined in Section 164.501 of Title 45 of the Code of Federal Regulations, are not subject to this section. For the purposes of this subdivision, "psychiatrist" means a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or pursuant to the Osteopathic Initiative Act, who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry.

SEC. 2. Section 123107 is added to the Health and Safety Code, to read:

123107. (a) Notwithstanding Section 123106, if a group practice or clinic comprised of health care providers described in paragraph (4), (5), (6), (8), or (9) of subdivision (a) of Section 123105 is the custodian of patient records for those health care providers, the group practice or clinic, rather than the individual health care provider, shall be required to comply with the requirements of Section 123106.

(b) This section does not apply to a clinic described in paragraph (2) of subdivision (a) of Section 123105.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1448
Author: Hill
Bill Date: June 11, 2018, Amended
Subject: Healing Arts Licensees: Probation Status: Disclosure
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill, the Patient's Right to Know Act of 2018, would require, on and after July 1, 2019, physicians and surgeons and osteopathic physicians and surgeons to notify patients of their probationary status for specified cases. This bill would also require podiatrists, acupuncturists, chiropractors and naturopathic doctors to notify patients of their probationary status before seeing a patient for the first time, as specified.

BACKGROUND

The Medical Board of California's (Board's) Manual of Model Disciplinary Orders and Disciplinary Guidelines currently require a licensee to provide a copy of the disciplinary decision and accusation to the Chief of Staff or Chief Executive Officer at every hospital where privileges or membership are extended to the licensee. A copy of the decision or accusation must also be provided at any facility where the licensee engages in the practice of medicine, and to the Chief Executive Officer at every malpractice insurance carrier that extends malpractice insurance coverage to the licensee. Under optional condition 25 in the Board's Disciplinary Guidelines, the Board may require a licensee to provide written notification to patients in circumstances where the licensee is required to have a third-party chaperone present during the consultation, examination, or treatment by the licensee. Notification to patients may also be required if optional condition 26, regarding prohibited practice, is included in the licensee's probationary order.

The Board's website currently includes disciplinary information for all physicians, including if the physician is currently, or has been, on probation. This information is posted on the Board's website indefinitely. In addition, the Board has a call center that members of the public can contact to obtain any public disciplinary information for Board licensees, including probationary status and history.

The Board supported the probation notification requirements in SB 798. This bill would have required probation notification for cases when the legal conclusions of an administrative law judge find or in a stipulated settlement the licensee admits, or if no admissions, the accusation or the statement of issues charges, that the licensee is implicated in sexual misconduct, drug or alcohol abuse during practice, criminal

conviction involving the practice of medicine, if the licensee has previously been ordered on probation or had his or her license revoked, and any violation constituting a threat to public health and safety where the Board believes notification is appropriate. This language was removed from SB 798 due to opposition.

ANALYSIS

This bill would require, on and after July 1, 2019, the Board to require a licensee on probation, pursuant to a probationary order made on or after July 1, 2019, before a patient's first visit following the probationary order, to provide the patient or the patient's guardian or health care surrogate, with a separate disclosure that includes: the licensee's probationary status; the length of the probation and the end date; all practice restrictions placed on the licensee by the Board; the Board's telephone number; and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the Board's online license information website. This disclosure would be required in any of the following circumstances:

- A final adjudication by the Board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:
    - The commission of any act of sexual abuse, misconduct, or relations with a patient or client, including, but not limited to, any of the acts described in Business and Professions Code Sections 726 or 729.
    - Drug or alcohol abuse directly resulting in harm to patients, or the extent that such use impairs the ability of the licensee to practice safely.
    - Criminal conviction involving harm to patient safety or health.
    - Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.
- An accusation or statement of issues alleged that the licensee committed any of the above acts, and a stipulated settlement based upon a nolo contender or other similar compromise that does not include any prima facie showing or admission of guilt or fact, but does include an express acknowledgement that the disclosure requirements would serve to protect the public interest.

This bill would specify that a licensee required to provide a disclosure shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of the disclosure.

This bill would specify that a licensee on probation is not required to provide a disclosure if any of the following applies:

- The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.
- The visit occurs in an emergency room or an urgent care facility or the visit is

unscheduled, including consultations in inpatient facilities.
- The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.
- The licensee does not have a direct treatment relationship with the patient.

This bill would require the Board, on and after July 1, 2019, to provide the following information for licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the Board's website:

- For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.
- For probation imposed by an adjudicated decision of the Board, the causes for probation stated in the final probationary order.
- For a licensee granted a probationary license, the causes by which a probationary license was imposed.
- The length of the probation and end date.
- All practice restrictions placed on the license by the Board.

The Board took a support if amended position on the previous version of this bill at its last Board Meeting. The Board believes that ensuring that patients are informed promotes the Board's mission of consumer protection. However, the Board requested that the language in this bill be amended to mirror that language that was included in SB 798 (Hill), and only require patient notification for sexual misconduct cases, cases that include drug or alcohol abuse during practice, criminal convictions involving the practice of medicine, if the licensee has previously been ordered on probation or had his or her license revoked, and any violation constituting a threat to public health and safety where the Board believes notification is appropriate. The Board also believes probation notification should be required for all healing arts licensees.

Board staff met with Governor's Office staff, interested parties, Senator Hill and his staff, and other legislative staff on this issue. The language included in this bill is a result of those meetings. This bill now narrows the types of cases where patient notification is required; however, the categories are not exactly the same as what the Board requested. The categories of previous discipline and Board discretion are no longer included, instead this bill includes inappropriate prescribing resulting in harm to patients with a probationary period of five years or more. In addition, the sexual misconduct category is expanded. However, this bill is now significantly narrowed to serious cases, and all categories of cases except one have been agreed upon by interested parties.

FISCAL: Using data from the Board's last Annual Report, 83 cases would likely fall into the categories of this bill. 75% of the 83 (the amount that are stipulated to) equates to 62 cases. Board staff is

estimating that 10% of those cases would go to hearing instead of settling because of patient notification. Board staff is only estimating 10% because not all of those cases would actually fall into the narrower categories of this bill and many of the cases would be so egregious that they would likely rather stipulate to a settlement then go to hearing. Using this estimate, six cases would go to hearing instead of settling because of patient notification. The cost difference between going to hearing and stipulating to a settlement is $38,000. As such, the total fiscal impact would be $228,000.

SUPPORT: Center for Public Interest Law; Consumer Attorneys of California; Consumer Federation of California; Consumer Watchdog Consumers Union; and Medical Board of California (if amended)

OPPOSITION: California Medical Association (unless amended)

AMENDED IN ASSEMBLY JUNE 11, 2018

AMENDED IN SENATE MAY 25, 2018

AMENDED IN SENATE APRIL 9, 2018

SENATE BILL No. 1448

Introduced by Senator Hill
(Principal coauthor: Assembly Member Low)

February 16, 2018

An act to add Sections 1007, 2228.1, 2228.5, 2459.4, 3663.5, and 4962 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1448, as amended, Hill. Healing arts licensees: probation status: disclosure.

Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. Existing law establishes the California Board of Podiatric Medicine within the Medical Board of California for the licensing, regulation, and discipline of podiatrists. Existing law, the Osteopathic Act, enacted by an initiative measure, establishes the Osteopathic Medical Board of California for the licensing and regulation of osteopathic physicians and surgeons and requires the Osteopathic Medical Board of California to enforce specified provisions of the Medical Practice Act with respect to its licensees. Existing law, the Naturopathic Doctors Act, establishes the Naturopathic Medicine Committee within the Osteopathic Medical Board of California for the licensing and regulation of naturopathic doctors. Existing law, the Chiropractic Act, enacted by an initiative measure, establishes the State Board of Chiropractic Examiners for the licensing and regulation of

chiropractors. Existing law, the Acupuncture Licensure Act, establishes the Acupuncture Board for the licensing and regulation of acupuncturists. Existing law authorizes each of these regulatory entities to discipline its licensee by placing her or him on probation, as specified.

This bill, on and after July 1, 2019, would require the California Board of Podiatric Medicine, the Naturopathic Medicine Committee, the State Board of Chiropractic Examiners, and the Acupuncture Board to require a licensee to provide a separate disclosure, as specified, to a patient or a patient's guardian or health care surrogate before the patient's first visit if the licensee is on probation pursuant to a probationary order made on and after July 1, 2019. The bill, on and after July 1, 2019, would require the Medical Board of California and the Osteopathic Medical Board of California to require a licensee to provide a separate disclosure, as specified, to a patient or a patient's guardian or health care surrogate before the patient's first visit if the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, under specified circumstances. The bill would also require the California Board of Podiatric Medicine, the Naturopathic Medicine Committee, the State Board of Chiropractic Examiners, the Acupuncture Board, the Medical Board of California, and the Osteopathic Medical Board of California to provide specified information relating to licensees on probation on the regulatory entity's online license information Internet Web site.

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. This act shall be known, and may be cited, as the Patient's Right to Know Act of 2018.

SEC. 2. Section 1007 is added to the Business and Professions Code, to read:

1007. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the ~~probation and~~ *probation,* the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license

information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) "Board" for purposes of this section means the State Board of Chiropractic Examiners.

SEC. 3. Section 2228.1 is added to the Business and Professions Code, to read:

2228.1. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the ~~probation and~~ *probation*, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client, including, but not limited to, any of the acts described in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction involving harm to patient safety or health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraph (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's

guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

SEC. 4. Section 2228.5 is added to the Business and Professions Code, to read:

2228.5. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the ~~probation and~~ *probation,* the probation

end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

(f) For purposes of this section:

(1) "Board" means the California Board of Podiatric Medicine.

(2) "Licensee" means a person licensed by the California Board of Podiatric Medicine.

SEC. 5. Section 2459.4 is added to the Business and Professions Code, to read:

2459.4. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the ~~probation and~~ *probation,* the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client, including, but not limited to, any of the acts described in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction involving harm to patient safety or health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraph (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon

a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) A violation of this section shall not be punishable as a crime.

(f) For purposes of this section:

(1) "Board" means the Osteopathic Medical Board of California.

(2) "Licensee" means a person licensed by the Osteopathic Medical Board of California.

SEC. 6. Section 3663.5 is added to the Business and Professions Code, to read:

3663.5. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the committee shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the ~~probation and~~ *probation*, the probation end date, all practice restrictions placed on the licensee by the committee, the committee's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the committee's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the committee shall provide the following information, with respect to licensees on probation and

licensees practicing under probationary licenses, in plain view on the licensee's profile page on the committee's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the committee, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the committee.

(e) A violation of this section shall not be punishable as a crime.

SEC. 7. Section 4962 is added to the Business and Professions Code, to read:

4962. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the ~~probation and~~ *probation,* the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure

pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) A violation of this section shall not be punishable as a crime.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1495
Author: Committee on Health
Bill Date: June 14, 2018, Amended
Subject: Health
Sponsor: Author
Position: Neutral

DESCRIPTION OF LEGISLATION:

This bill would make technical and clarifying changes to SB 512 from last year, regarding non- United States Food and Drug Administration (FDA) approved stem cell therapies. This bill would specify that the stem cell therapies that require a notice do not include therapies that meet the criteria of the Code of Federal Regulations, Title 21, Sections 1271.10 and 1271.15, which are those that do not require FDA premarket review or clearance, but are still regulated by the FDA, or those that qualify for an exception, as specified. This bill also contains other technical clean up not related to the Medical Board of California (Board).

BACKGROUND

SB 512 (Hernandez, Chapter 428, Statutes of 2017) required health care practitioners that perform a stem cell therapy not approved by the FDA, to communicate this to his or her patients on a notice displayed in his or her office. This bill required the Board to report citations issued and discipline imposed, with regard to violations by licensees who provide stem cell therapies, in its Annual Report beginning with the 2018-19 Annual Report. The Board took a neutral position on this bill.

ANALYSIS

This bill is a clean-up bill to SB 512 from last year. SB 512 was meant to apply to experimental stem cell therapies. The way the language was written it also applied to some therapies that qualified for an exception with the FDA, and also to some therapies that are already regulated by the FDA. This bill makes technical and clarifying changes to ensure that the notice requirements only apply to non-FDA approved, experimental therapies. The Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: American Association of Tissue Banks; California Statewide Law Enforcement Association; County Health Executives Association of California; Department of Health Care Services; Department of Public Health; Department of State Hospitals; MiMedx; and Rural County Representatives of California

OPPOSITION: None on file

AMENDED IN ASSEMBLY JUNE 14, 2018

AMENDED IN SENATE APRIL 10, 2018

SENATE BILL No. 1495

Introduced by Committee on Health (Senators Hernandez (Chair), Leyva, Mitchell, Monning, Newman, Nguyen, Nielsen, Pan, and Roth)

February 28, 2018

An act to amend Section 684 of the Business and Professions Code, to amend Sections *1728.7,* 1797.188 and 101080 ~~of~~ *of, and to add Section 1751.5 to,* the Health and Safety Code, and to amend Sections 4300, 4301, 4311, 4313, 5349, 5651, and 5897 of, to add Section 4005.8 to, to repeal Sections 5651.2 and 5666 of, and to repeal and add Section 5650 of, the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1495, as amended, Committee on Health. Health.

(1) Existing law provides for the licensure and regulation of various health care practitioners by boards within the Department of Consumer Affairs. Existing law requires licensed health care practitioners who perform stem cell therapies that are not approved by the United States Food and Drug Administration (FDA) to communicate to their patients specified information regarding the therapies in a notice and in writing prior to providing the initial stem cell therapy. Under existing law, for these purposes, a "stem cell therapy" is a therapy involving the use of HCT/Ps, defined as human cells, tissues, or cellular- or tissue-based products in accordance with specified federal law. Under existing law, these requirements do not apply to a health care practitioner who has obtained approval for an investigational new drug or device from the FDA for the use of HCT/Ps.

This bill would exclude from the definition of "stem cell therapy" those therapies involving HCT/Ps that meet specified criteria pursuant to, or that qualify for an exception under, federal law. The bill would require only health care practitioners who perform a stem cell therapy that is subject to FDA regulation, and that is not FDA-approved, to provide the notice and writing to their patients. The bill would exempt from these requirements a health care practitioner who has obtained clearance for an investigational new drug, or an investigational device exemption, from the FDA.

(2) Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, establishes the Emergency Medical Services Authority. The authority is responsible for the coordination and integration of all statewide activities concerning emergency medical services.

The act requires health facilities to notify prehospital emergency medical care personnel who have provided emergency medical or rescue services, and have been exposed to a person afflicted with a reportable communicable disease or condition, that they have been exposed. If the affected prehospital emergency medical care person has not provided the health facility infection control officer, as defined, with his or her name and telephone number, existing law requires the health facility infection control officer to immediately notify the designated officer of the employer of the prehospital emergency medical care person and the county health officer under specified circumstances. Otherwise, existing law requires the health facility infection control officer to notify the prehospital emergency medical care person consistent with certain state regulations.

This bill would instead require the health facility infection control officer, in the latter circumstance, to notify the designated officer, not the prehospital emergency medical care person, consistent with those regulations.

(3) Existing law authorizes a local health officer to declare a local health emergency under specified circumstances, including when the release or escape of a hazardous waste or medical waste is an immediate threat to the public health, or upon an imminent and proximate threat of the introduction of certain diseases, chemical agents, toxins, or radioactive agents. Existing law authorizes the local health emergency to remain in effect for 7 days unless the board of supervisors or city council ratifies the local health emergency for a longer period of time. Existing law thereafter requires the board of supervisors or city council

to review the need for continuing that local health emergency at least every 14 days.

This bill would instead require the board of supervisors or city council to review the need for continuing that local health emergency at least every 30 days.

(4) Existing law provides the State Department of State Hospitals with jurisdiction over the execution of laws relating to care and treatment of persons with mental health disorders under the custody of the department. Existing law provides that the Chief, Deputy Chief, supervising investigators, and investigators of the Office of Protective Services of the department are peace officers whose authority extends to any place in the state for the purpose of performing their primary duty or when making an arrest, as specified.

This bill would designate the Chief of the Office of Protective Services of the department as the deputy director of the office, with oversight of all protective service components within the department's law enforcement and fire protection services. The bill would require that the deputy director be an experienced law enforcement officer, as specified.

Existing law requires the Director of State Hospitals to appoint and define the duties of the clinical director and the hospital administrator for each state hospital. Existing law requires the Director of State Hospitals to appoint either the clinical director or the hospital administrator to be the hospital director.

This bill would additionally require the Director of State Hospitals to appoint and define the duties of the chief of police services and the hospital director for each state hospital, and would repeal the above provision requiring the appointment of the clinical director or hospital administrator as hospital director. The bill would make conforming changes to related provisions.

Existing law requires the hospital administrator to be responsible for preserving the peace in the hospital buildings and grounds and authorizes him or her to arrest persons, as specified.

This bill would transfer that duty and that authority to the chief of police services at the hospital, and would require the chief of police services to be an experienced law enforcement officer, as specified.

Existing law authorizes the hospital administrator of each state hospital to designate, as a police officer, one or more of the bona fide employees of the hospital. Under existing law, the hospital administrator and each of those police officers have the powers and authority conferred

by law upon peace officers, as specified. Existing law prohibits those police officers from receiving compensation, as specified.

This bill would repeal the authority of the hospital administrator to designate hospital employees as police ~~officers. The bill would replace the hospital administrator with the chief of police services for purposes of peace officer powers, and would remove the prohibition on compensation of the police officers. The bill would further make conforming changes to related provisions and would add that the chief of police services and the hospital police officers~~ *officers, and would delete the provision that prohibits the compensation of those police officers. The bill would instead provide that the chief of police services, supervising investigators, investigators, and each hospital police officer have the powers and authority provided to them under existing laws that apply to peace officers, and* are required to help ensure integration of treatment, safety, and security, as directed by the hospital director. *The bill would make further conforming changes to related provisions.*

(5) Existing law, the Bronzan-McCorquodale Act, contains provisions governing the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law requires the board of supervisors of each county, or boards of supervisors of counties acting jointly, to adopt, and submit to the Director of Health Care Services in the form and according to the procedures specified by the director, a proposed annual county mental health services performance contract for mental health services in the county or counties. Existing law requires the State Department of Health Care Services to develop and implement the requirements, format, procedure, and submission dates for the preparation and submission of the proposed performance contract. Existing law requires the Director of Health Care Services, or his or her ~~designees,~~ *designee,* to review each proposed county mental health services performance contract to determine that it complies with specified requirements.

This bill would repeal those provisions relating to an annual county mental health services performance contract, and would instead require the department and each county to have a performance contract for community mental health services, the Mental Health Services Act, the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other federal grants or county mental health programs for the term of 3 years, as specified. The bill would authorize the department to extend the term

of the contract for 2 one-year periods, as specified. The bill would further authorize the department to amend the contract at any time during the term of the contract, as specified.

Existing law requires the proposed annual county mental health services performance contract to include specified provisions, and authorizes the county to choose to include contract provisions for other state-directed mental health managed programs within the performance contract.

This bill would delete that authorization and would instead authorize the department to include contract provisions for other federal grants or county mental health programs in the performance contract. The bill would also delete obsolete provisions and make related, conforming changes.

(6) The California Hospice Licensure Act of 1990 provides for the licensure and regulation by the State Department of Public Health of persons or agencies that provide hospice, to ensure the health and safety of patients experiencing the last phases of life due to the existence of a terminal disease.

This bill would require the department to issue a hospice license to a hospice applicant that meets certain requirements, including, among others, that it is accredited by an entity approved by the federal Centers for Medicare and Medicaid Services as a national accreditation organization, and it meets any other additional licensure requirements under the act that are more stringent than the accreditation requirements of the organization, as specified.

The bill would authorize the department to conduct a survey of an accredited hospice to ensure the accreditation requirements are met, and to conduct a survey to investigate complaints against an accredited hospice for substantial noncompliance with the accreditation standards. The bill would make conforming changes to a related provision for purposes of a home health agency.

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 684 of the Business and Professions Code is amended to read:

684. (a) For the purpose of this section:

(1) "FDA" means the United States Food and Drug Administration.

(2) "HCT/Ps" means human cells, tissues, or cellular or tissue-based products, as defined in Section 1271.3 of Title 21 of the Code of Federal Regulations, as amended August 31, 2016, as published in the Federal Register (81 Fed. Reg. 60223).

(3) "Stem cell therapy" means a therapy involving the use of HCT/Ps, but shall not include a therapy involving HCT/Ps that meets the criteria set out in Section 1271.10 of Title 21 of the Code of Federal Regulations, as amended May 25, 2004, as published in the Federal Register (69 Fed. Reg. 29829), or that qualifies for any of the exceptions described in Section 1271.15 of Title 21 of the Code of Federal Regulations, as amended May 25, 2004, as published in the Federal Register (69 Fed. Reg. 29829).

(b) (1) A health care practitioner licensed under this division who performs a stem cell therapy that is subject to FDA regulation, but is not FDA-approved, shall communicate to a patient seeking stem cell therapy the following information in English:

"THIS NOTICE MUST BE PROVIDED TO YOU UNDER CALIFORNIA LAW. This health care practitioner performs one or more stem cell therapies that have not been approved by the United States Food and Drug Administration. You are encouraged to consult with your primary care physician prior to undergoing a stem cell therapy."

(2) The information in paragraph (1) shall be communicated to the patient in all of the following ways:

(A) In a prominent display in an area visible to patients in the health care practitioner's office and posted conspicuously in the entrance of the health care practitioner's office. These notices shall be at least eight and one-half inches by 11 inches and written in no less than 40-point type.

(B) Prior to providing the initial stem cell therapy, a health care practitioner shall provide the patient with the notice described in paragraph (1) in writing. The notice shall be at least eight and one-half inches by 11 inches and written in no less than 40-point type.

(c) This section does not apply to a health care practitioner licensed under this division who has obtained approval or clearance

for an investigational new drug, or an investigational device exemption, from the FDA for the use of HCT/Ps.

(d) (1) The licensing board having jurisdiction of the health care practitioner may cite and fine the health care practitioner, not to exceed one thousand dollars ($1,000) per violation of this section.

(2) No citation shall be issued and no fine shall be assessed upon the first complaint against a health care practitioner who violates this section.

(3) Upon a second or subsequent violation of this section, a citation and administrative fine not to exceed one thousand dollars ($1,000) per violation may be assessed.

(e) The Medical Board of California shall indicate in its annual report, commencing with the 2018–19 annual report, all of the following with regard to licensees who provide stem cell therapies:

(1) The number of complaints received.

(2) Any disciplinary actions taken.

(3) Any administrative actions taken.

SEC. 2. Section 1728.7 of the Health and Safety Code is amended to read:

1728.7. (a) Notwithstanding any other provision of this chapter, the department shall issue a license to a home health agency that applies to the department for a home health agency license and meets all of the following requirements:

(1) Is accredited as a home health agency by an entity approved by the federal Centers for Medicare and Medicaid Services as a national accreditation organization, and the national accreditation organization forwards to the department copies of all initial and subsequent survey and other accreditation reports or findings.

(2) Files an application with fees pursuant to this chapter.

(3) Meets any other additional licensure requirements of, or regulations adopted pursuant to, this chapter that the department identifies, after consulting with the national accreditation organizations, as more stringent than the accreditation requirements of the national accreditation organizations.

(b) The department may ~~require~~ *conduct* a survey of an accredited home health agency to ensure the accreditation requirements are met. These surveys shall be conducted using a selective sample basis.

(c) The department may ~~require~~ *conduct* a survey of an accredited home health agency to investigate complaints against an accredited home health agency for substantial noncompliance, as determined by the department, with these accreditation standards.

(d) Notwithstanding subdivisions (a), (b), and (c), the department shall retain its full range of authority over accredited home health agencies to ensure the licensure and accreditation requirements are met. This authority shall include the entire scope of enforcement sanctions and options available for unaccredited home health agencies.

SEC. 3. Section 1751.5 is added to the Health and Safety Code, immediately following Section 1751, to read:

1751.5. (a) Notwithstanding any other provision of this chapter, the department shall issue a license to a hospice that applies to the department for a hospice license and meets all of the following requirements:

(1) Is accredited as a hospice by an entity approved by the federal Centers for Medicare and Medicaid Services as a national accreditation organization, and the national accreditation organization forwards to the department copies of all initial and subsequent survey and other accreditation reports or findings.

(2) Files an application with fees pursuant to this chapter.

(3) Meets any other additional licensure requirements of, or regulations adopted if necessary pursuant to, this chapter that the department identifies, after consulting with the national accreditation organization, as more stringent than the accreditation requirements of the national accreditation organization.

(b) The department may conduct a survey of an accredited hospice to ensure the accreditation requirements are met. These surveys shall be conducted using a selective sample basis.

(c) The department may conduct a survey of an accredited hospice to investigate complaints against an accredited hospice for substantial noncompliance, as determined by the department, with these accreditation standards.

(d) Notwithstanding subdivisions (a), (b), and (c), the department shall retain its full range of authority over accredited hospices to ensure the licensure and accreditation requirements are met. This authority shall include the entire scope of

enforcement sanctions and options available for unaccredited hospices.

~~SEC. 2.~~

SEC. 4. Section 1797.188 of the Health and Safety Code is amended to read:

1797.188. (a) As used in this section:

(1) "Prehospital emergency medical care person or personnel" means any of the following: an authorized registered nurse or mobile intensive care nurse, emergency medical technician-I, emergency medical technician-II, emergency medical technician-paramedic, lifeguard, firefighter, or peace officer, as defined or described by Sections 1797.56, 1797.80, 1797.82, 1797.84, 1797.182, and 1797.183, respectively, or a physician and surgeon who provides prehospital emergency medical care or rescue services.

(2) "Reportable communicable disease or condition" or "a communicable disease or condition listed as reportable" means those diseases prescribed by Subchapter 1 (commencing with Section 2500) of Chapter 4 of Title 17 of the California Code of Regulations, as may be amended from time to time.

(3) "Exposed" means at risk for contracting the disease, as defined by regulations of the state department.

(4) "Health facility" means a health facility, as defined in Section 1250, including a publicly operated facility.

(5) "Health facility infection control officer" means the official or officer who has been designated by the health facility to communicate with a designated officer, or his or her designee.

(6) "Designated officer" means the official or officer of an employer of a prehospital emergency medical care person or personnel who has been designated by the state's public health officer or the employer.

(7) "Urgency reporting requirement" means a disease required to be reported immediately by telephone or reported by telephone within one working day pursuant to subdivisions (h) and (i) of Section 2500 of Title 17 of the California Code of Regulations.

(b) In addition to the communicable disease testing and notification procedures applicable under Chapter 3.5 (commencing with Section 120260) of Part 1 of Division 105, all prehospital emergency medical care personnel, whether volunteers, partly paid, or fully paid, who have provided emergency medical or rescue

services and have been exposed to a person afflicted with a communicable disease or condition listed as reportable, which can, as determined by the county health officer, be transmitted through physical or oral contact or secretions of the body, including blood, shall be notified that they have been exposed to the disease or condition in accordance with the following:

(1) If the prehospital emergency medical care person, who has rendered emergency medical or rescue services and believes that he or she may have been exposed to a person afflicted with a reportable communicable disease or condition in a manner that could result in transmission of a reportable communicable disease or condition, and provides the health facility infection control officer with his or her name and telephone number at the time the patient is transferred from that prehospital emergency medical care person to the admitting health facility; or the party transporting the person afflicted with the reportable communicable disease or condition provides that health facility with the name and telephone number of the prehospital emergency medical care person who provided the emergency medical or rescue services and believes he or she may have been exposed to a person afflicted with a reportable communicable disease or condition in a manner that could result in transmission of a communicable disease or condition, the health facility infection control officer, upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services is diagnosed as being afflicted with a reportable communicable disease or condition, and that the reportable communicable disease or condition may have been transmitted during the provision of emergency medical or rescue services, shall immediately notify the designated officer of the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the health facility infection control officer shall notify the designated officer consistent with Section 2500 of Title 17 of the California Code of Regulations. The health facility infection control officer

shall also report the name and telephone number of the prehospital emergency medical care person to the county health officer. The designated officer shall immediately notify the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the designated officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations.

(2) If the prehospital emergency medical care person who has rendered emergency medical or rescue services and has been exposed to a person afflicted with a reportable communicable disease or condition, but has not provided the health facility infection control officer with his or her name and telephone number pursuant to paragraph (1), the health facility infection control officer, upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services is diagnosed as being afflicted with a reportable communicable disease or condition that may have been transmitted during provision of emergency medical or rescue services, shall immediately notify the designated officer of the employer of the prehospital emergency medical care person and the county health officer if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the health facility infection control officer shall notify the designated officer consistent with Section 2500 of Title 17 of the California Code of Regulations. The designated officer shall immediately notify the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected

skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the designated officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations.

(c) The county health officer shall immediately notify the prehospital emergency medical care person who has provided emergency medical or rescue services and has been exposed to a person afflicted with a communicable disease or condition listed as reportable, which can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition, upon receiving the report from a health facility pursuant to paragraph (1) of subdivision (b). Otherwise, the county health officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations. The county health officer shall not disclose the name of the patient or other identifying characteristics to the prehospital emergency medical care person.

(d) An employer of a prehospital emergency medical care person or personnel that maintains an Internet Web site shall post the title and telephone number of the designated officer in a conspicuous location on its Internet Web site accessible from the home page. A health facility that maintains an Internet Web site shall post the title and telephone number of the health facility infection control officer in a conspicuous location on its Internet Web site accessible from the home page.

(e) (1) The health facility infection control officer, or his or her designee, shall be available either onsite or on call 24 hours per day.

(2) The designated officer, or his or her designee, shall be available either onsite or on call 24 hours per day.

(f) An employer of a health facility infection control officer and an employer of a prehospital emergency medical care person or personnel shall inform those employees of this law as part of the Cal-OSHA Injury and Illness Prevention Program training required by paragraph (7) of subdivision (a) of Section 3203 of Title 8 of the California Code of Regulations.

(g) Nothing in this section shall be construed to authorize the further disclosure of confidential medical information by the health facility, the designated officer, or any prehospital emergency medical care personnel described in this section except as otherwise authorized by law.

(h) In the event of the demise of the person afflicted with the reportable communicable disease or condition, the health facility or county health officer shall notify the funeral director, charged with removing the decedent from the health facility, of the reportable communicable disease or condition prior to the release of the decedent from the health facility to the funeral director.

(i) Notwithstanding Section 1798.206, a violation of this section is not a misdemeanor.

~~SEC. 3.~~

SEC. 5. Section 101080 of the Health and Safety Code is amended to read:

101080. Whenever a release, spill, escape, or entry of waste occurs as described in paragraph (2) of subdivision (b) of Section 101075 and the director or the local health officer reasonably determines that the waste is a hazardous waste or medical waste, or that it may become a hazardous waste or medical waste because of a combination or reaction with other substances or materials, and the director or local health officer reasonably determines that the release or escape is an immediate threat to the public health, or whenever there is an imminent and proximate threat of the introduction of any contagious, infectious, or communicable disease, chemical agent, noncommunicable biologic agent, toxin, or radioactive agent, the director may declare a health emergency and the local health officer may declare a local health emergency in the jurisdiction or any area thereof affected by the threat to the public health. Whenever a local health emergency is declared by a local health officer pursuant to this section, the local health emergency shall not remain in effect for a period in excess of seven days unless it has been ratified by the board of supervisors, or city

council, whichever is applicable to the jurisdiction. The board of supervisors, or city council, if applicable, shall review, at least every 30 days until the local health emergency is terminated, the need for continuing the local health emergency and shall proclaim the termination of the local health emergency at the earliest possible date that conditions warrant the termination.

~~SEC. 4.~~

SEC. 6. Section 4005.8 is added to the Welfare and Institutions Code, to read:

4005.8. (a) The Deputy Director of the Office of Protective Services of the *State* Department of State Hospitals has oversight of all protective service components within the department's law enforcement and fire protection services, including those at each state hospital. The deputy director shall be an experienced law enforcement officer who has completed the management training course prescribed by the Commission on Peace Officer Standards and Training, with extensive management experience directing uniformed peace officers and investigation officers.

(b) Wherever the term "Chief of the Office of Protective Services" is used in reference to the State Department of State Hospitals, the term shall be deemed to mean the Deputy Director of the Office of Protective Services of the State Department of State Hospitals.

~~SEC. 5.~~

SEC. 7. Section 4300 of the Welfare and Institutions Code is amended to read:

4300. As used in this chapter, "officers" of a state hospital means:

(a) Clinical director.

(b) Hospital administrator.

(c) Hospital director.

(d) Chief of police services at the hospital.

~~SEC. 6.~~

SEC. 8. Section 4301 of the Welfare and Institutions Code is amended to read:

4301. (a) The Director of State Hospitals shall appoint and define the duties, subject to the laws governing civil service, of the clinical director, the hospital administrator, the hospital director, and the chief of police services for each state hospital.

(b) The Director of State Hospitals shall appoint a program director for each program at a state hospital.

~~SEC. 7.~~

SEC. 9. Section 4311 of the Welfare and Institutions Code is amended to read:

4311. (a) The chief of police services at the hospital shall be responsible for preserving the peace in the hospital buildings and grounds and may arrest or cause the arrest and appearance before the nearest magistrate for examination, of all persons who attempt to commit or have committed a public offense thereon.

(b) The chief of police services shall be an experienced law enforcement officer who has completed the management training course prescribed by the Commission on Peace Officer Standards and Training, with management experience directing uniformed peace officers and investigation officers.

~~SEC. 8.~~

SEC. 10. Section 4313 of the Welfare and Institutions Code is amended to read:

4313. The chief of police ~~services~~ *services, supervising investigators, investigators,* and each hospital police officer have the powers and authority conferred by law upon ~~peace officers listed in~~ *each respectively as set forth in subdivision (v) of Section 830.3 and* Section 830.38 of the Penal Code. When and as directed by the hospital director, the chief of police ~~services and those~~ *services, supervising investigators, investigators, and hospital* police officers shall enforce the rules and regulations of the hospital, preserve peace and order on the premises thereof, protect and preserve the property of the state, and help ensure integration of treatment, safety, and security.

~~SEC. 9.~~

SEC. 11. Section 5349 of the Welfare and Institutions Code is amended to read:

5349. This article shall be operative in those counties in which the county board of supervisors, by resolution or through the county budget process, authorizes its application and makes a finding that no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of the implementation of this article. To the extent otherwise permitted under state and federal law, counties that elect to implement this article may pay for the provision of services under Sections 5347

and 5348 using funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund 2011, funds from the Mental Health Services Fund when included in county plans pursuant to Section 5847, and any other funds from which the Controller makes distributions to the counties for those purposes. Compliance with this section shall be monitored by the State Department of Health Care Services.

~~SEC. 10.~~

SEC. 12. Section 5650 of the Welfare and Institutions Code is repealed.

~~SEC. 11.~~

SEC. 13. Section 5650 is added to the Welfare and Institutions Code, to read:

5650. (a) The State Department of Health Care Services and each county shall have a performance contract for community mental health services, the Mental Health Services Act, the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other federal grants or other county mental health programs.

(b) The department shall develop the county mental health services performance contract, which shall be effective for an initial period of three years. The department shall provide the three-year performance contract to the county by January 2 of the year the existing performance contract expires. The county shall adopt, execute, and return the performance contract by May 1 of the year the existing contract expires.

(c) The department may extend the term of the contract for two one-year periods. If the department extends the term of the performance contract, the department shall notify the county by January 2 of the year the existing performance contract expires. The county shall adopt, execute, and return the extension to the performance contract by May 1 of the year the existing contract expires.

(d) The department may amend the contract at any time during the term of the contract and the county shall have 90 days from receipt of an amendment to adopt, execute, and return the amendment to the department.

(e) For the purposes of this chapter, provisions of law referring to the county shall be construed to include counties, counties acting jointly, and cities receiving funds pursuant to Section 5701.5.

~~SEC. 12.~~

SEC. 14. Section 5651 of the Welfare and Institutions Code is amended to read:

5651. (a) Counties shall comply with the terms of the county mental health services performance contract.

(b) The county mental health services performance contract shall include all of the following provisions:

(1) That the county shall comply with the expenditure requirements of Section 17608.05.

(2) That the county shall provide services to persons receiving involuntary treatment as required by Part 1 (commencing with Section 5000) and Part 1.5 (commencing with Section 5585).

(3) That the county shall comply with all requirements necessary for Medi-Cal reimbursement for mental health treatment services and case management programs provided to Medi-Cal eligible individuals, including, but not limited to, the provisions set forth in Chapter 3 (commencing with Section 5700), and that the county shall submit cost reports and other data to the department in the form and manner determined by the State Department of Health Care Services.

(4) That the local mental health advisory board has reviewed and approved procedures ensuring citizen and professional involvement at all stages of the planning process pursuant to Section 5604.2.

(5) That the county shall comply with all provisions and requirements in law pertaining to patient rights.

(6) That the county shall comply with all requirements in federal law and regulation, and all agreements, certifications, assurances, and policy letters, pertaining to federally funded mental health programs, including, but not limited to, the Projects for Assistance in Transition from Homelessness *grant* and Community Mental Health Services Block Grant programs.

(7) That the county shall provide all data and information set forth in Sections 5610 and 5664.

(8) That the county, if it elects to provide the services described in Chapter 2.5 (commencing with Section 5670), shall comply

with guidelines established for program initiatives outlined in that chapter.

(9) That the county shall comply with all applicable laws and regulations for all services delivered, including all laws, regulations, and guidelines of the Mental Health Services Act.

(10) The State Department of Health Care Services' ability to monitor the county's three-year program and expenditure plan and annual update pursuant to Section 5847.

(11) Other information determined to be necessary by the director, to the extent this requirement does not substantially increase county costs.

(c) The State Department of Health Care Services may include contract provisions for other federal grants or county mental health programs in this performance contract.

~~SEC. 13.~~

SEC. 15. Section 5651.2 of the Welfare and Institutions Code is repealed.

~~SEC. 14.~~

SEC. 16. Section 5666 of the Welfare and Institutions Code is repealed.

~~SEC. 15.~~

SEC. 17. Section 5897 of the Welfare and Institutions Code is amended to read:

5897. (a) Notwithstanding any other state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. For purposes of this section, a county mental health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of those mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with

Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through the county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2.

(d) The department shall conduct program reviews of performance contracts to determine compliance. Each county performance contract shall be reviewed at least once every three years, subject to available funding for this purpose.

(e) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements. The department shall post on its Internet Web site any plans of correction requested and the related findings.

(f) Contracts awarded by the State Department of Health Care Services, the State Department of Public Health, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890), may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to those contracts.

(g) For purposes of Section 14712, the allocation of funds pursuant to Section 5892 that are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 11	McCarty	Early and Periodic Screening, Diagnosis, and Treatment Program	Sen. Approps.	07/03/18
AB 64	Bonta	Cannabis: Licensure and Regulation	Sen. Approps.	06/27/17
AB 183	Lackey	Bill of Rights for State Excluded Employees	Asm. Inactive	05/25/17
AB 186	Eggman	Controlled Substances: Safer Drug Consumption Program	Sen. Inactive	09/08/17
AB 238	Steinorth	Emergency Response; Trauma Kits	Sen. Rules	02/21/18
AB 251	Bonta	Health and Care Facilities: Dialysis Clinics	Senate	06/29/17
AB 254	Thurmond	Local Educational Agency Behavioral Health Pilot Program	Sen. Approps.	06/28/17
AB 263	Rodriguez	Emergency Medical Services Workers	Sen. Rules	06/21/17
AB 349	McCarty	Drug Medi-Cal Treatment Program: Rate Setting Process	Sen. Approps.	06/07/18
AB 479	Gonzalez Fletcher	Workers' Compensation: Permanent Disability	Sen. 3rd Reading	05/21/18
AB 613	Nazarian	Healing Arts: Clinical Laboratories	Sen. Inactive	08/29/17
AB 767	Quirk-Silva	Go-Biz Information Technology	Sen. Approps.	07/02/18
AB 1116	Grayson	Peer Support and Crisis Referral Services Act	Sen. 3rd Reading	05/15/18
AB 1136	Eggman	Health Facilities: Residential Mental or Substance Use Disorder	Sen. Approps.	07/02/18
AB 1372	Levine	Crisis Stabilization Units: Psychiatric Patients	Sen. Inactive	06/13/17
AB 1659	Low	Healing Arts Boards: Inactive Licenses	Sen. 3rd Reading	01/03/18
AB 1753	Low	Controlled Substances: CURES Database	Sen. Approps.	04/18/18
AB 1787	Salas	Reporting: Valley Fever	Sen. 3rd Reading	06/06/18
AB 1790	Salas	Valley Fever Education, Early Diagnosis & Treatment Act	Assembly	06/19/18
AB 1801	Nazarian	Newborns: Cytomegalovirus Public Education and Testing	Sen. Approps.	06/26/18
AB 1860	Limon	Health Care Coverage: Cancer Treatment	Sen. Approps.	05/25/18
AB 1893	Maienschein	Maternal Mental Health: Federal Funding	Enrollment	04/09/18
AB 2018	Maienschein	Mental Health Workforce: Loan Repayment	Sen. Approps.	06/12/18
AB 2046	Daly	Workers' Compensation Insurance Fraud Reporting	Sen. Approps.	06/14/18
AB 2088	Santiago	Patient Records: Addenda	Sen. 3rd Reading	

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2099	Gloria	Mental Health: Detention and Evaluation	Sen. 3rd Reading	05/25/18
AB 2122	Reyes	Medi-Cal: Blood Lead Screening Tests	Sen. Approps.	07/03/18
AB 2143	Caballero	Mental Health: Licensed Mental Health Service Provider Ed. Prog.	Sen. Approps.	06/11/18
AB 2167	Chau	Information Privacy: Digital Health Feedback Systems	Sen. Approps.	07/03/18
AB 2182	Levine	Privacy: DOJ: Online Platforms: Personal Data Privacy	Sen. Approps.	06/18/18
AB 2196	Cooper	Public Employees' Retirement: Service Credit: Payments	Assembly	06/13/18
AB 2198	Obernolte	State Government: FI$Cal: Transparency	Senate	03/14/18
AB 2202	Gray	University of California: School of Medicine	Sen. Approps.	04/16/18
AB 2215	Kalra	Cannabis: Veterinarians: Animals	Sen. Approps.	06/27/18
AB 2256	Santiago	Law Enforcement Agencies: Opioid Antagonist	Senate	06/06/18
AB 2275	Arambula	Medi-Cal Managed Care: Quality Assessment and Performance Improvement	Sen. Approps.	07/02/18
AB 2302	Baker	Child Abuse: Sexual Assault: Mandated Reporters	Sen. 3rd Reading	07/05/18
AB 2315	Quirk-Silva	Pupil Health: Mental and Behavioral Health: Telehealth	Sen. Approps.	04/16/18
AB 2342	Burke	Breas and Ovarian Cancer Susceptibility Screening	Sen. Approps.	07/02/18
AB 2384	Arambula	Medication Assisted Treatment	Sen. Approps.	07/03/18
AB 2423	Holden	Physical Therapists: Direct Access to Services	Sen. Approps.	06/28/18
AB 2457	Irwin	Podiatry: Podiatric Medical Board of California	Enrollment	04/02/18
AB 2476	Rubio	Health and Care Facilities	Sen. Health	05/15/18
AB 2481	Voepel	State Employees: Infant at Work Programs	Sen. Approps.	04/10/18
AB 2486	McCarty	Opioid Prevention and Rehabilitation Act	Sen. Health	06/18/18
AB 2502	Wood	Health Care Payments Database	Sen. Health	05/08/18
AB 2576	Aguiar-Curry	Emergencies: Healthcare	Sen. Approps.	06/27/18
AB 2587	Levine	Disability Compensation: Paid Family Leave	Enrolled	04/02/18
AB 2668	Allen, T.	Pupil Immunizations: Pupils Not Immunized	Asm. Health	04/02/18
AB 2674	Aguiar-Curry	Health Care Service Plans: Disciplinary Actions	Sen. Approps.	06/14/18

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2678	Irwin	Privacy: Personal Information: Breach: Notification	Sen. 3rd Reading	06/21/18
AB 2689	Gray	Contribution and Gift Ban: Senate Confirmation	Sen. Approps.	04/17/18
AB 2777	Daly	State Employees: Travel Reimbursements	Sen. Approps.	05/24/18
AB 2783	O'Donnell	Controlled Substances: Hydrocodone Combination Products	Sen. Approps.	04/11/18
AB 2813	Irwin	California Cybersecurity Integration Center	Sen. Approps.	06/19/18
AB 2859	Caballero	Pharmacy: Safe Storage Products	Sen. Approps.	06/21/18
AB 2861	Salas	Medi-Cal: Telehealth: Substance Use Disorder Services	Sen. Approps.	05/25/18
AB 2863	Nazarian	Health Care Coverage: Prescriptions	Sen. Approps.	07/03/18
AB 2941	Berman	Health Care Coverage: State of Emergency	Sen. 3rd Reading	06/19/18
AB 2958	Quirk	State Bodies: Meetings: Teleconference	Sen. Approps.	06/18/18
AB 2976	Quirk	Childhood Lead Poisoning Prevention	Sen. Approps.	07/02/18
AB 2983	Arambula	Health Care Facilities: Voluntary Psychiatric Care	Sen. Approps.	07/02/18
AB 3018	Low	State Contracts: Skilled and Trained Workforce	Sen. Approps.	06/20/18
AB 3032	Frazier	Maternal Mental Health Conditions	Sen. Approps.	06/19/18
AB 3110	Mullin	Athletic Trainers	Sen. Approps.	06/20/18
AB 3179	Salas	State Agencies: Bilingual Services	Sen. Approps.	04/17/18
AB 3189	Cooper	Consent by Minors to Treatment for Intimate Partner Violence	Sen. 3rd Reading	05/30/18
AB 3211	Kalra	Advance Health Care Directives	Sen. 3rd Reading	07/05/18
AB 3245	PERS Comm.	Public Employees' Retirement	Senate	04/09/18
ACA 23	Melendez	Legislative Committees: Prohibition on Holding Bills	Assembly	
ACR 158	Baker	Cancer Screen Week	Asm. Rules	02/27/18
ACR 203	Quirk-Silva	Donate Life/DMV Partnership Month	Chaptered, #51	
HR 6	Burke	Relative to Women's Reproductive Health	Adopted	
HR 83	Caballero	Relative to Prescription Drug Abuse Awareness Month	Adopted	03/01/18
SB 76	Nielsen	Excluded Employees: Arbitration	Asm. Inactive	06/29/17

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 212	Jackson	Medical Waste	Asm. Approps.	06/18/18
SB 244	Lara	Privacy: Agencies: Personal Information	Asm. Inactive	09/08/17
SB 275	Portantino	Children, Adolescents, and Young Adults Alcohol and Drug Treatment and Recovery Act	Asm. Approps.	06/28/17
SB 399	Portantino	Health Care Coverage: Pervasive Developmental Disorder/Autism	Asm. Approps.	06/20/18
SB 538	Monning	Hospital Contracts	Asm. Health	06/11/18
SB 641	Lara	Mexican Prepaid Health Plans	Asm. Approps.	07/03/18
SB 695	Lara	Professions and Vocations: Individual Tax ID Number	Asm. Approps.	05/25/18
SB 715	Newman	DCA: Regulatory Boards: Removal of Board Members	Asm. Inactive	04/25/17
SB 820	Leyva	Settlement Agreements: Confidentiality	Asm. 3rd Reading	06/20/18
SB 906	Beall	Medi-Cal: Mental Health Services	Asm. Approps.	05/25/18
SB 984	Skinner	State Boards and Commissions: Representation: Women	Asm. Approps.	07/03/18
SB 992	Hernandez	Alcoholism or Drug Abuse Recovery or Treatment Facilities	Asm. Approps.	06/21/18
SB 997	Monning	Health Care Service Plans: Physician to Enrollee Ratios	Enrollment	
SB 1003	Roth	Respiratory Therapy	Senate	05/08/18
SB 1021	Wiener	Prescription Drugs	Asm. Approps.	06/14/18
SB 1023	Hernandez	Reproductive Health Care Coverage	Asm. Approps.	05/25/18
SB 1034	Mitchell	Health Care: Mammograms	Asm. Approps.	06/21/18
SB 1041	Leyva	Childhood Lead Poisoning Prevention	Asm. Approps.	04/09/18
SB 1045	Wiener	Conervatorship: Serious Mental Illness and Substance Use Disorders	Asm. Approps.	07/02/18
SB 1047	Nielsen	Medi-Cal: Reimbursement Rates: Rural Counties	Sen. Rules	
SB 1060	Mendoza	Public Employees' Retirement Law: Employer Contributions	Sen. Rules	
SB 1062	Mendoza	Retirement Systems: Employer Contributions: Notification	Senate	
SB 1123	Jackson	Disability Compensation: Paid Family Leave	Asm. Approps.	04/26/18
SB 1124	Leyva	Public Employees' Retirement System: Collective Bargaining	Asm. Approps.	05/25/18

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1125	Atkins	Federally Qualified Health Center and Rural Health Clinics	Asm. Approps.	05/25/18
SB 1127	Hill	Pupil Health: Administration of Medicinal Cannabis: Schoolsites	Asm. 3rd Reading	05/15/18
SB 1180	Newman	California Disabled Veteran Business Enterprise Program	Asm. J, ED, &E	03/19/18
SB 1186	Hill	Law Enforcement Agencies: Surveillance Policies	Asm. Approps.	05/25/18
SB 1228	Lara	Substance Use Disorder: Licensed and Certified Treatment Programs	Asm. Approps.	06/28/18
SB 1244	Wieckowski	Public Records: Disclosure	Assembly	07/05/18
SB 1254	Stone	Hospital Pharmacies: Medication Profiles	Asm. Approps.	06/28/18
SB 1264	Stone	Medi-Cal: Hypertension Medication Management Services	Asm. Approps.	05/01/18
SB 1287	Hernandez	Medi-Cal: Medically Necessary Services	Asm. Approps.	06/20/18
SB 1303	Pan	Coroner: County Office of the Medical Examiner	Asm. Approps.	04/16/18
SB 1312	Jackson	State Public Employees: Sick Leave: Veterans	Asm. Approps.	06/20/18
SB 1396	Galgiani	Accessible State Technology	Asm. Approps.	06/26/18
SB 1423	Hernandez	Medi-Cal: Oral Interpretation Services	Asm. Approps.	04/09/18
SB 1447	Hernandez	Pharmacy: Automated Drug Delivery Systems	Asm. Approps.	07/03/18
SB 1480	Hill	Professions and Vocations	Asm. Approps.	06/21/18
SCR 104	Hertzberg	National Nutrition Month	Assembly	02/27/18
SB 115	McGuire	Opioid Crisis	Asm. Approps.	04/09/18
SR 12	Atkins	Relative to Women's Reproductive Health	Adopted	
SR 26	Hernandez	Relative to the Patient Protection and Affordable Care Act	Adopted	03/09/17
SR 82	Gaines	Relative to Opioid Death Awareness Week	Sen. Inactive	