

# LEGISLATIVE PACKET

July 26-27, 2007  
San Francisco, CA

for

EXECUTIVE COMMITTEE,  
DIVISIONS,  
AND  
FULL-BOARD  
MEETINGS

**Medical Board of California  
Tracker - Legislative Bill File  
7/23/2007**

<u>BILL</u>	<u>AUTHOR</u>	<u>TITLE</u>	<u>STATUS</u>	<u>POSITION</u>	<u>VER. OF BILL POS. BASED</u>	<u>LAST AMENDED</u>	<u>LETTERS</u>
AB 3	Bass	Physician Assistants	Sen. Approps.	Rec: Support	Amended	7/17/07	
AB 253	Eng	MBC: Restructuring	Sen. Approps.	Sponsor/Support	Amended	6/20/07	6/28/07
AB 329	Nakanishi	Chronic Diseases: Telemedicine	Sen. Approps.	Sponsor/Support	Amended	6/19/07	4/17/07
AB 1025	Bass	Professions: Denial of Licensure	Sen. Approps.	Neutral w/amends	Amended	7/5/07	
AB 1073	Nava	Work Comp: CA lic. Physicians on Utilization Review	Sen. Floor	Support	Amended	5/1/07	
AB 1224	Hernandez	Telemedicine: Optometrists	Sen. Approps.	Support	Amended	6/26/07	
SB 102	Migden	Blood Transfusions: Brochure	To Governor	Support	Amended	6/7/07	
SB 472	Corbett	Prescription Drugs: Labeling Requirements & Panel	Asm. Approps.	Support	Amended	6/20/07	
SB 620	Correa	Anesthesia Permit for Physicians in Dental Offices	Asm. Consent	Support	Introduced		5/30/07
SB 761	Ridley-Thomas	Diversion and Vertical Prosecution	Asm. Approps.	Sponsor/Support	Amended	7/18/07	3/13/07
SB 764	Migden	MBC Reporting Licensee Information to OSHPD	Asm. Suspense	Support w/conditions	Amended	6/19/07	4/9/07
SB 767	Ridley-Thomas	Drug Overdose Treatment: Liability	Asm. Approps.	Neutral	Amended	5/15/07	
SB 1048	Comm. B,P&ED	Healing Arts: Omnibus	Asm. Approps.	Support MBC Provisions	Amended	7/12/07	

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 3  
**Author:** Bass  
**Bill Date:** July 17, 2007, amended  
**Subject:** Physician Assistants  
**Sponsor:** California Academy of Physician Assistants (CAPA)

**STATUS OF BILL:**

This bill is currently in the Senate Appropriations Committee and is not set for hearing.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill, as amended, would allow a physician assistant to administer, provide, or issue a drug order under general protocols for Schedule II through Schedule V controlled substances without advanced approval by a supervising physician for each specific patient if the physician assistant completes specified educational requirements. This bill would increase the number of physician assistants a physician may supervise from two to four (making this consistent with the number supervised in underserved areas) and specify the services provided by a physician assistant are included as a covered benefit under the Medi-Cal program.

**ANALYSIS:**

Existing law limits each supervising physician to supervising no more than two physician assistants at a time, subject to certain very limited exceptions. This bill would increase that restriction to four, so that each individual physician and practice has more discretion in determining the number of physician assistants the supervising physician may safely supervise.

This bill would eliminate the requirement for patient-specific authority for all controlled substance drug orders. Currently, the law permits physician assistants to issue drug orders, similar to prescriptions, for medications, other than controlled substances, based on a formulary and protocols established or adopted by the supervising physician. However, advance patient-specific authority from the supervising physician is required for the physician assistant to issue a drug order for controlled substances. This bill would allow individual physicians and practices to determine which medications will require patient-specific authority, based on the complexity of the practice and the qualifications of the physician assistants being supervised.

Current Medi-Cal regulations cover and pay for only a limited range of medical services performed by physician assistants. This bill would specify that Medi-Cal coverage and reimbursement includes all Medi-Cal-covered services that physician assistants are permitted to perform under state and federal law.

CAPA's goals include expanding access to care by promoting regulatory and legislative changes that will enhance the ability of physician assistants to provide safe, cost-effective medical care to the citizens of California. CAPA is committed to team practice between physicians and physician assistants and embraces without reservation the concept of physician supervision, as a means of assuring patient safety and quality health care. CAPA has spent a considerable amount of time during the last two months meeting with the various physician and nursing associations in order to develop language that organizations can support or take a neutral position. The opposing organization, the Union of American Physicians and Dentists, has a meeting scheduled with the author this week.

Enclosed for your reference are support letters from:

- American College of Emergency Physicians
- California Academy of Family Physicians
- California Psychiatric Association
- Kaiser Permanente
- United Nurses Associations of CA/Union of Health Care Professionals

The "oppose unless amended" letter comes from:

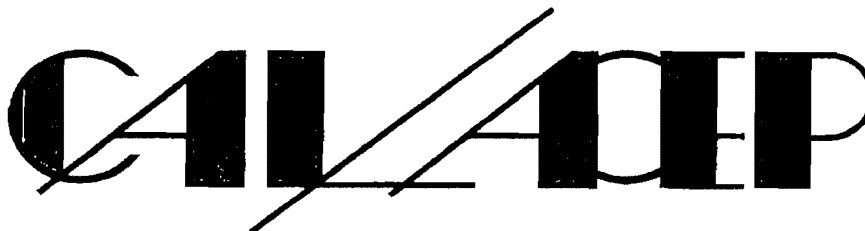
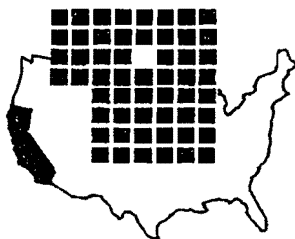
- Union of American Physicians and Dentists

**FISCAL:**                None

**POSITION:**            Recommendation:    Support

July 18, 2007





AMERICAN COLLEGE OF EMERGENCY PHYSICIANS  
STATE CHAPTER OF CALIFORNIA, INC.

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July 18, 2007

The Honorable Karen Bass  
California State Assembly  
State Capitol Building  
Sacramento, CA 95814

**RE: Support AB 3 (Bass)**

Dear Assembly Member Bass,

The California Chapter of the American College of Emergency Physicians (CAL/ACEP) is pleased to inform you that we support AB 3.

AB 3 would specify that services provided by a physician assistant are a covered benefit under the Medi-Cal program, would increase the number of physician assistants that may be supervised by a physician to four, and would allow a physician assistant to furnish a drug order for a controlled substance if the physician assistant has completed a course on controlled substances and the controlled substance was on the formulary established in conjunction with a physician.

CAL/ACEP recognizes the important role that physician assistants play in the team approach used for patient care in our emergency rooms. We believe it is vital that the services rendered by a physician assistant in the emergency room be reimbursed under the Medi-Cal program. To not be reimbursed for their services only adds to already high level of emergency services that currently go un-reimbursed as a result of treating uninsured patients.

We also believe allowing physician assistants to furnish drug orders for controlled substances, after meeting certain course requirements, will result in patient care that is more efficient. This will allow more patients to be seen in the emergency room and will reduce wait times for all patients.

Regards,

Mike Salomon, MD, MBA, FACEP  
President, CAL/ACEP

July 3, 2007

The Honorable Mark Ridley-Thomas, Chair  
Senate Business, Professions and Economic Development Committee  
State Capitol, Room 4061  
Sacramento, CA 95814



C A L I F O R N I A  
A C A D E M Y O F  
F A M I L Y  
P H Y S I C I A N S

**RE: AB 3 (Bass)**  
**CAFP Position: SUPPORT**

Dear Senator Ridley-Thomas:

The California Academy of Family Physicians (CAFP) and its more than 7,000 members urge your support of AB 3 (Bass), which would reduce capricious barriers that hinder patient access to high quality medical care provided by physician assistants, when it comes before your committee.

CAFP is committed to team practice between physicians and physician assistants and embraces without reservation the concept of physician supervision as a means of assuring patient safety and quality health care. We applaud the author for her leadership in helping physician assistants successfully accomplish this objective.

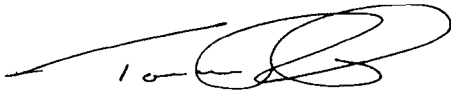
Specifically, the clinically sound and common sense approach of AB 3 would not eliminate physician supervision of physician assistants, but would instead simply eliminate unnecessary restrictions at the discretion of physicians in determining how to best exercise that supervision. To summarize, these four proposals are as follows:

- **Standardizing the Physician Assistant Supervision Ratio:** Existing law limits each supervising physician ("SP") to supervising no more than two PAs at a time, subject to certain very limited exceptions. We propose that this restriction be standardized and increased to four, so that each individual physician and practice has more discretion in determining the number of PAs the SP may safely supervise (up to four), based on the complexity of the practice and the qualifications of the PAs being supervised.
- **Standardizing the Formulary and Advanced Approval Process for All Drug Orders by Physician Assistants:** Existing law permits PAs to issue drug orders, similar to prescriptions, for all medications, including controlled substances. PA drug orders are written based on a formulary and protocols established or adopted by the SP except in the case of controlled substances. For controlled substances, advance patient-specific authority from the SP is required for the PA to issue a drug order. We recommend that the requirement for patient-specific authority for all controlled substance drug orders be amended. Under our proposed amendment, individual physicians and practices would be permitted to determine which medications will require patient-specific authority, based on the complexity of the practice and the qualifications of the PAs being supervised.

- **Streamlining Chart Countersignature for Physician Assistants:** Under existing regulations promulgated by the Medical Board of California, most PAs function pursuant to protocols established by the SP. When a PA functions pursuant to protocols, existing law requires the SP to review and countersign a minimum of 10% of the PA's charts within 30 days. We propose that, in lieu of this requirement, individual SPs and their practices review and countersign a minimum of 5% of the charts, with the actual percentage determined by the SP based on the complexity of the practice and the qualifications of the PAs being supervised.
- **Increasing Access to Physician Assistant Covered Services by the Medi-Cal Program:** Under existing outdated Medi-Cal regulations, Medi-Cal covers and pays for only a limited range of medical services performed by PAs. In comparison, Medicare, private insurance companies, workers compensation and the Medicaid programs of most other states pay for the full range of services that PAs are qualified to perform under state and federal law. CAPA proposes eliminating this artificial and unnecessary restriction by expanding Medi-Cal coverage and reimbursement to include all Medi-Cal-covered services which PAs are permitted to perform under state and federal law.

For the above reasons, CAFP urges your support of AB 3.

Sincerely,



Tom Riley  
Director of Government Relations

cc      Members, Senate Business, Professions and Economic Development Committee  
          Assemblymember Bass  
          Taejoon Ahn, MD, MPH, CAFP Legislative Affairs Chair  
          Susan Hogeland, CAE, CAFP Executive Vice President

**CALIFORNIA PSYCHIATRIC ASSOCIATION**

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July 9, 2007

The Honorable Karen Bass  
State Capitol, Room 319  
Sacramento, CA 95814

**RE: SUPPORT – AB 3 (BASS) – PHYSICIAN ASSISTANTS**  
**Hearing: Senate Business, Professions & Economic Development**  
**July 9, 2007**

Dear Assemblywoman Bass:

I am pleased to inform you that the California Psychiatric Association (CPA) which represents over 3,100 psychiatric physicians supports AB 3 as amended July 5, 2007.

AB 3 would allow a properly trained Physician Assistant to provide Schedule II medications without advance approval of their supervising physician if drugs within those schedules were subject to specific physician delegated services covered by written protocols, procedures and criteria including address for the illness, injury or condition for which the drug is being administered. AB 3 would also allow a properly trained Physician Assistant to provide Schedule II through Schedule V medications without advance approval of their supervising physician if the Physician Assistant has completed educational coursework as specified. AB 3 would require that 5% of the medical charts of patients treated by a Physician Assistant be reviewed and countersigned within 30 days by the supervising physician with charts selected by the physician that represent conditions and treatment that pose the most significant risk to the patient. AB 3 would provide consistency with rural underserved areas in which it is allowed that a physician supervise up to four Physician Assistants. AB 3 would specify that services provided by a Physician Assistant are included as a benefit under Medi-Cal.

Physician Assistants have received a scientific and medically based education and have become important components of the delivery of health care in California. More specifically properly trained Physician's Assistants provide for the safe and effective delivery of medications including psychotropic medications. AB 3 would increase access to medically necessary medical and psychiatric services. We applaud you for carrying this important legislation.

Randall Hagar, Legislative Director

cc: Senator Mark Ridley-Thomas, Chair, Senate Business, Professions & Economic Development  
Bill Gage, Consultant, Senate Business, Professions & Economic Development  
Gaye Breyman, CEO, California Academy of Physician Assistants  
Bryce Docherty, Legislative Advocate, California Academy of Physician Assistants

July 5, 2007

Senator Mark Ridley-Thomas, Chair  
Senate Business, Professions and Economic Development Committee  
State Capitol, Room 4061  
Sacramento, California 95814

Dear Senator Ridley-Thomas:

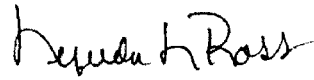
On behalf of the Kaiser Permanente Medical Care Program, I respectfully request your positive consideration of AB 3 (Bass), when it is heard before the Senate Business, Professions and Economic Development Committee on Monday, July 9.

Specifically, AB 3 proposes four specific changes to existing law governing the practice of physician assistants (PAs) in California aimed at improving the physician team practice and thereby expanding access to care.

- 1) Increase that number of PAs that each supervising physician may supervise from two to four, with the supervising physician having the discretion to base that decision on the complexity of the practice and qualifications of the PAs being supervised.
- 2) With respect to a standardized formulary and advanced approval for drug orders by PAs, give supervising physicians the authority to determine which medications will require patient-specific authority, based on the complexity of the practice and the qualifications of the PAs being supervised.
- 3) In lieu of the existing requirement for a supervising physician to countersign a minimum of 10% of the PA's charts within 30 days, require the supervising physician to countersign a minimum of 5% of the charts with the actual percentage determined by the supervising physician based on the complexity of the practice and the qualifications of the PAs being supervised.
- 4) Increase the scope of services reimbursed by Medi-Cal to cover the full range of services that PAs are qualified to perform under state and federal law.

The Kaiser Permanente Medical Care Program has a long and satisfied history of working collaboratively with Physician Assistants to provide high quality care to our members. We fully support AB 3 which proposes to appropriately utilize these health care providers.

Sincerely,

A handwritten signature in black ink, appearing to read "Lynda L. Ross". The signature is fluid and cursive, with the first name "Lynda" and last name "Ross" clearly distinguishable.

Lynda L. Ross  
Senior Legislative Representative

cc: Assembly Member Karen Bass  
Senate Business, Professions and Economic Development Committee  
Senate Republican Consultants  
Ana Matosantos, Governor's Office



# UNAC/UHCP

United Nurses Associations of California/Union of Health Care Professionals

UNAC/UHCP is affiliated with NUHHCE, AFSCME and the AFL-CIO

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July 18, 2007

The Honorable Karen Bass, PA  
Assembly Member  
Capitol Building #319  
Sacramento, CA 95814  
Fax: 916-319-2147

**RE: AB 3 Support**

Dear Assembly Member Bass,

United Nurses Associations of California/Union of Health Care Professionals, AFSCME (UNAC/UHCP) represents 16,000 Registered Nurses, Nurse Practitioners, Physician Assistants, and Optometrists in Southern California. The UNAC/UHCP members work in both public and private sectors. The Kaiser Permanente Southern California Region is the employer of the greatest number of UNAC/UHCP PAs.

As the health care reform debate moves forward we must consider the efficiency of the system when there are limited financial and health care provider resources. Increasing the ratio of PAs to supervising MD will greatly improve utilization of those resources while maintaining patient safety. The supervising MD may choose to supervise fewer than four PA's but that decision may be made in the individual practice setting based on the type and complexity of the patients.

The delivery of health care is best achieved by efficient utilization of the health care team. Physician Assistants are vital members of the team and should be utilized to their full scope of practice. AB3 removes the inefficiencies of the current regulations and allows the health care team to focus on providing safe and high quality patient care.

On behalf of the Physician Assistant members of UNAC/UHCP, we urge your support of AB 3.

Respectfully,

*Barbara L. Blake, RN*

Barbara L. Blake, RN

State Secretary

UNAC/UHCP, AFSCME



**UNION OF AMERICAN  
PHYSICIANS & DENTISTS**

Affiliated with AFSCME, AFL-CIO

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treasurer

July 2, 2007

Assemblywoman Karen Bass  
Assembly Majority Leader, State Capitol Building  
Sacramento, California 95814

Re: Assembly Bill 3 (Bass)  
Position: Oppose Unless Amended

Dear Assemblywoman Bass:

I write to you on behalf of the Union of American Physicians and Dentists (UAPD). UAPD/AFSCME represents approximately five thousand physicians employed throughout the State of California.

UAPD has reviewed AB 3 (Bass), and takes a "oppose unless amended" position on this legislation. AB 3 would, among other things, allow physician assistants to issue drug orders for controlled substances. In addition, written protocols would be written to redefine the supervisory relationship between physicians and physician assistants. Finally, AB 3 would expand the number of physician assistants a physician can supervise, from two to four.

AB 3 redefines the current relationship between physicians and physician assistants. UAPD/AFSCME has concerns about this legislation, particularly with regard to patient safety. We would welcome the opportunity to meet with you before AB 3 advances in the Senate. Thank you for your critical attention to this request. We appreciate your consideration.

Sincerely,

  
R. Douglas Chiappetta, MA  
Chief Legislative Representative

cc: Dr. Stuart Bussey, President, UAPD/AFSCME  
✓ Gary Robinson, UAPD/AFSCME  
Willie Pelote, Sr., AFSCME, International.



AMENDED IN SENATE JULY 17, 2007

AMENDED IN SENATE JULY 5, 2007

AMENDED IN SENATE JUNE 28, 2007

AMENDED IN ASSEMBLY JUNE 1, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

## **ASSEMBLY BILL**

**No. 3**

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**Introduced by Assembly Member Bass**

December 4, 2006

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An act to amend Sections 3502, 3502.1, 3516, and 3516.5 of, and to repeal Section 3516.1 of, the Business and Professions Code, and to add Section 14132.966 to the Welfare and Institutions Code, relating to physician assistants.

### **LEGISLATIVE COUNSEL'S DIGEST**

AB 3, as amended, Bass. Physician assistants.

(1) Existing law, the Physician Assistant Practice Act, establishes the Physician Assistant Committee of the Medical Board of California (the medical board) and provides for its licensure of physician assistants meeting specified criteria and for the regulation of their practice. Under the act, a physician assistant is authorized to perform medical services under the supervision of a physician and surgeon who is authorized to supervise not more than 2 physician assistants at any one time, except under specified circumstances. The act prohibits a physician assistant from administering, providing, or issuing a drug order for Schedule II through Schedule V controlled substances without advance approval from a supervising physician and surgeon.

This bill would authorize a physician assistant to administer, provide, or issue a drug order for these classes of controlled substances without advance approval by a supervising physician and surgeon if the physician assistant completes specified educational requirements. The bill would require a physician assistant and his or her supervising physician and surgeon to establish written supervisory guidelines and would specify that this requirement may be satisfied by the adoption of specified protocols. The bill would increase to 4 the number of physician assistants a physician and surgeon may supervise and would make related changes.

(2) Existing law, the Medi-Cal Act, establishes the Medi-Cal program to provide health care benefits and services to persons who meet specified eligibility criteria.

This bill would specify that services provided by a physician assistant are included as a covered benefit under the Medi-Cal program.

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

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

1 SECTION 1. This act shall be known as the California  
2 Physician Team Practice Improvement Act.

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

5 3502. (a) Notwithstanding any other provision of law, a  
6 physician assistant may perform those medical services as set forth  
7 by the regulations of the board when the services are rendered  
8 under the supervision of a licensed physician and surgeon who is  
9 not subject to a disciplinary condition imposed by the board  
10 prohibiting that supervision or prohibiting the employment of a  
11 physician assistant.

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

1 The supervising physician and surgeon shall be physically  
2 available to the physician assistant for consultation when such  
3 assistance is rendered. A physician assistant assisting a doctor of  
4 podiatric medicine shall be limited to performing those duties  
5 included within the scope of practice of a doctor of podiatric  
6 medicine.

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

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

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

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

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

28 (2) The supervising physician and surgeon shall review,  
29 countersign, and date a sample consisting of, at a minimum, 5  
30 percent of the medical records of patients treated by the physician  
31 assistant functioning under the protocols within 30 days of the date  
32 of treatment by the physician assistant. The physician and surgeon  
33 shall select for review those cases that by diagnosis, problem,  
34 treatment, or procedure represent, in his or her judgment, the most  
35 significant risk to the patient.

36 (3) Notwithstanding any other provision of law, the board or  
37 committee may establish other alternative mechanisms for the  
38 adequate supervision of the physician assistant.

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

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

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

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

8 (4) The practice of dentistry or dental hygiene or the work of a  
9 dental auxiliary as defined in Chapter 4 (commencing with Section  
10 1600).

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

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

16 3502.1. (a) In addition to the services authorized in the  
17 regulations adopted by the board, and except as prohibited by  
18 Section 3502, while under the supervision of a licensed physician  
19 and surgeon or physicians and surgeons authorized by law to  
20 supervise a physician assistant, a physician assistant may  
21 administer or provide medication to a patient, or transmit orally,  
22 or in writing on a patient's record or in a drug order, an order to a  
23 person who may lawfully furnish the medication or medical device  
24 pursuant to subdivisions (c) and (d).

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

29 (2) Each supervising physician and surgeon who delegates the  
30 authority to issue a drug order to a physician assistant shall first  
31 prepare and adopt, or adopt, a written, practice specific, formulary  
32 and protocols that specify all criteria for the use of a particular  
33 drug or device, and any contraindications for the selection.  
34 Protocols for Schedule II controlled substances shall address the  
35 diagnosis of illness, injury, or condition for which the Schedule II  
36 controlled substance is being administered, provided, or issued.  
37 The drugs listed in the protocols shall constitute the formulary and  
38 shall include only drugs that are appropriate for use in the type of  
39 practice engaged in by the supervising physician and surgeon.

1 When issuing a drug order, the physician assistant is acting on  
2 behalf of and as an agent for a supervising physician and surgeon.

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

17 (c) A drug order for any patient cared for by the physician  
18 assistant that is issued by the physician assistant shall either be  
19 based on the protocols described in subdivision (a) or shall be  
20 approved by the supervising physician and surgeon before it is  
21 filled or carried out.

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

31 (2) A physician assistant may not administer, provide, or issue  
32 a drug order to a patient for Schedule II through Schedule V  
33 controlled substances without advance approval by a supervising  
34 physician and surgeon for that particular patient unless the  
35 physician assistant has completed an education course that covers  
36 controlled substances and *that* meets standards, including  
37 pharmacological content, approved by the committee. The  
38 education course shall be provided either by an accredited  
39 continuing education provider or *by* an approved physician assistant  
40 training program. If the physician assistant will administer, provide,

1 or issue a drug order for Schedule II controlled substances, the  
2 course shall contain a minimum of three hours exclusively on  
3 Schedule II controlled substances. Completion of the requirements  
4 set forth in this paragraph shall be verified and documented in the  
5 manner established by the committee prior to the physician  
6 assistant's use of a registration number issued by the United States  
7 Drug Enforcement Administration ~~and prior to the physician~~  
8 ~~assistant administering, providing, or issuing to administer,~~  
9 *provide, or issue* a drug order to a patient for a controlled substance  
10 without advance approval by a supervising physician and surgeon  
11 for that particular patient.

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

16 (d) A written drug order issued pursuant to subdivision (a),  
17 except a written drug order in a patient's medical record in a health  
18 facility or medical practice, shall contain the printed name, address,  
19 and phone number of the supervising physician and surgeon, the  
20 printed or stamped name and license number of the physician  
21 assistant, and the signature of the physician assistant. Further, a  
22 written drug order for a controlled substance, except a written drug  
23 order in a patient's medical record in a health facility or a medical  
24 practice, shall include the federal controlled substances registration  
25 number of the physician assistant and shall otherwise comply with  
26 the provisions of Section 11162.1 of the Health and Safety Code.  
27 Except as otherwise required for written drug orders for controlled  
28 substances under Section 11162.1 of the Health and Safety Code,  
29 the requirements of this subdivision may be met through stamping  
30 or otherwise imprinting on the supervising physician and surgeon's  
31 prescription blank to show the name, license number, and if  
32 applicable, the federal controlled substances number of the  
33 physician assistant, and shall be signed by the physician assistant.  
34 When using a drug order, the physician assistant is acting on behalf  
35 of and as the agent of a supervising physician and surgeon.

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

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

5 (g) The committee shall consult with the Medical Board of  
6 California and report during its sunset review required by Division  
7 1.2 (commencing with Section 473) the impacts of exempting  
8 Schedule III and Schedule IV drug orders from the requirement  
9 for a physician and surgeon to review and countersign the affected  
10 medical record of a patient.

11 SEC. 4. Section 3516 of the Business and Professions Code is  
12 amended to read:

13 3516. (a) Notwithstanding any other provision of law, a  
14 physician assistant licensed by the committee shall be eligible for  
15 employment or supervision by any physician and surgeon who is  
16 not subject to a disciplinary condition imposed by the board  
17 prohibiting that employment or supervision.

18 (b) No physician and surgeon shall supervise more than four  
19 physician assistants at any one time, except as provided in Section  
20 3502.5.

21 (c) The board may restrict a physician and surgeon to  
22 supervising specific types of physician assistants including, but  
23 not limited to, restricting a physician and surgeon from supervising  
24 physician assistants outside of the field of specialty of the physician  
25 and surgeon.

26 SEC. 5. Section 3516.1 of the Business and Professions Code  
27 is repealed.

28 SEC. 6. Section 3516.5 of the Business and Professions Code  
29 is amended to read:

30 3516.5. (a) Notwithstanding any other provision of law and  
31 in accordance with regulations established by the board, the director  
32 of emergency care services in a hospital with an approved program  
33 for the training of emergency care physician assistants, may apply  
34 to the board for authorization under which the director may grant  
35 approval for emergency care physicians on the staff of the hospital  
36 to supervise emergency care physician assistants.

37 (b) The application shall encompass all supervising physicians  
38 employed in that service.

1 (c) Nothing in this section shall be construed to authorize any  
2 one emergency care physician while on duty to supervise more  
3 than four physician assistants at any one time.

4 (d) A violation of this section by the director of emergency care  
5 services in a hospital with an approved program for the training  
6 of emergency care physician assistants constitutes unprofessional  
7 conduct within the meaning of Chapter 5 (commencing with  
8 Section 2000).

9 (e) A violation of this section shall be grounds for suspension  
10 of the approval of the director or disciplinary action against the  
11 director or suspension of the approved program under Section  
12 3527.

13 SEC. 7. Section 14132.966 is added to the Welfare and  
14 Institutions Code, to read:

15 14132.966. (a) Services provided by a physician assistant are  
16 a covered benefit under this chapter to the extent authorized by  
17 federal law and subject to utilization controls.

18 (b) Subject to subdivision (a), all services performed by a  
19 physician assistant within his or her scope of practice that would  
20 be a covered benefit if performed by a physician and surgeon shall  
21 be a covered benefit under this chapter.

22 (c) The department shall not impose chart review,  
23 countersignature, or other conditions of coverage or payment on  
24 a physician and surgeon supervising physician assistants that are  
25 more stringent than requirements imposed by Chapter 7.7  
26 (commencing with Section 3500) of Division 2 of the Business  
27 and Professions Code or regulations of the Medical Board of  
28 California promulgated under that chapter.



MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 253  
**Author:** Eng  
**Bill Date:** June 20, 2007, amended  
**Subject:** Restructuring of the Medical Board of California  
**Sponsor:** Medical Board of California

**STATUS OF BILL:**

This bill passed out of the Senate Appropriations Committee.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill:

1. Combines the two divisions of the board into one Board.
2. Revises the decision making authority of the board by allowing the board to delegate to the Executive Director the authority to adopt default decisions and stipulations to surrender a license in disciplinary proceedings.
3. Reduces the board membership from 21 members (12 physician members-57%, and 9 public members-43%) to **15 members (8 physician members-53%, and 7 public members-47%)**.

**ANALYSIS:**

The board structure was last addressed in SB 916 (1994) when legislation collapsed the three divisions into two divisions, consolidating the duties of the Division of Allied Health into the Division of Licensing, and transferring the members from the Division of Allied Health to the Division of Medical Quality to create two disciplining panels. The number of board members was not changed when this restructuring took place.

With two divisions, the members are not well versed in the issues involving the division they are not serving on, and the Board President cannot be fully knowledgeable about the programs run by both divisions. This sometimes becomes an issue in full board discussions and when it takes positions on legislation. Some discussions regarding legislation occur in division meetings only, therefore not all board members are informed and able to participate. This may result in a public perception that members of the Board are not fully informed and that the board, in its current structure, is not the most efficient policy-making body.

Consolidating the divisions will provide greater flexibility in assigning members to various committees and task forces.

Revising the decision making authority would allow for the board to delegate to the Executive Director the authority to adopt default decisions and stipulations to surrender a license in disciplinary proceedings. This would assist in completing these issues in a more timely manner, while allowing the board members to concentrate on the more complex stipulations and proposed decisions.

The composition of the board was last addressed in SB 1950 (2002). The board membership increased from 19 members (12 physician-63% and 7 public-37%) to 21 members (12 physician-57% and 9 public-43%). The concept was to increase the composition of public members without decreasing the number of physician members.

The full board voted in February to reduce the membership from 21 to 19. Reducing the number of board members will make for greater efficiencies of the board. The structure of the reduction will increase the composition of public members from 43% to 47% while still maintaining a one physician member majority.

**This bill was amended by the author with concurrence from the Executive Committee at its June 18, 2007 meeting to reduce board membership to 15 board members (8 physician, 7 public) based on a support if amended position taken by the administration. (see attached letter)**

At the Senate Business and Professions Committee hearing on July 2, 2007, the bill passed out at the reduced membership level on a 5 to 2 vote. The opposition came from Dr. Aanestad, vice chair (dentist) who felt the composition of the board should have a greater number of physician members.

**FISCAL:** There is minor fiscal impact to the board. There was no funding approved when SB 1950 (2002) was passed and two new board members were added, but the reduction of 19 to 15 members will reduce expenditures by approximately \$ 12,000.

**POSITION:** Sponsor/ Support  
The Board needs to discuss concurrence with the Executive Committee position.

July 17, 2007



STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

**DIVISION OF LEGISLATIVE & REGULATORY REVIEW**

1625 North Market Boulevard, Suite S-204

P (916) 574-7800 F (916) 574-8655



May 29, 2007

The Honorable Mike Eng  
California State Assembly  
State Capitol, Room 6025  
Sacramento, CA 95814

**RE: AB 253 – SUPPORT IF AMENDED**

Dear Assembly Member Eng:

The Department of Consumer Affairs (Department) has taken a **SUPPORT IF AMENDED** position on your bill, **AB 253** (as amended 3/08/07), which, among other things, would reduce the size of the Medical Board (Board) from 21 members to 19 members.

At 19 members, the Board would remain the largest Board under the Department. A board of this size is costly and has not been demonstrated to be more effective than a smaller board. The Department believes that the Board can function with 15 members, which is consistent with the size of comparable boards that regulate similarly large and complex licensee populations. Consequently, the Department recommends that the Board instead be reduced to 15 members consisting of 8 physicians and 7 public members, which would reduce the size of state government and improve the current ratio of public members.

Should you have any questions regarding our position, please contact me at 574-7800.

Sincerely,

A handwritten signature in cursive script that reads "Laura Zuniga".

LAURA ZUNIGA

Deputy Director

Division of Legislative and Regulatory Review

cc: Chris Kahn, Legislative Secretary, Office of the Governor  
Happy Chastain, Deputy Secretary, Legislation, State and Consumer Services Agency

AMENDED IN SENATE JUNE 20, 2007

AMENDED IN ASSEMBLY MARCH 8, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

**ASSEMBLY BILL**

**No. 253**

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**Introduced by Assembly Member Eng**

February 5, 2007

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An act to amend Sections 2001, 2002, 2004, 2012, 2013, 2014, 2015, 2017, 2018, 2041, 2224, 2228, 2230, 2311, 2317, 2335, 2506, 2529, 2529.5, 2546.2, and 2550.1 of, to add Section 2540.1 to, to repeal Sections 2003, 2005, 2009, 2035, and 2223 of, and to repeal and add Section 2008 of, the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 253, as amended, Eng. Medical Board of California.

The Medical Practice Act provides for the ~~licensing~~ *licensure* and regulation of physicians and surgeons by the Medical Board of California that consists of 21 members. Existing law establishes a Division of Licensing and a Division of Medical Quality, each consisting of specified members of the board, with each division having certain responsibilities. Under existing law, the Division of Medical Quality is responsible for implementing the disciplinary provisions of the act and is prohibited from delegating its authority to take final disciplinary action against a licensee.

This bill would reduce the board's membership to ~~19~~ 15 and would abolish the 2 divisions of the board. The bill would instead provide for the board as a whole to handle the responsibilities of the divisions. The bill would require the board to delegate to its executive director the

authority to adopt default decisions and certain stipulations in disciplinary proceedings. The bill would make other related changes.

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

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

1 SECTION 1. Section 2001 of the Business and Professions  
2 Code is amended to read:

3 2001. (a) There is in the Department of Consumer Affairs a  
4 Medical Board of California that consists of ~~19 members, nine~~ 15  
5 *members, seven* of whom shall be public members.

6 ~~The~~

7 (b) ~~The~~ Governor shall appoint ~~17~~ 13 members to the board,  
8 subject to confirmation by the Senate, ~~seven~~ five of whom shall  
9 be public members. The Senate Committee on Rules and the  
10 Speaker of the Assembly shall each appoint a public member.  
11 ~~Notwithstanding any other provision of law, to reduce the~~  
12 ~~membership to 19, any appointment made upon the expiration of~~  
13 ~~the term on June 1, 2007, of two members of the board who are~~  
14 ~~not public members shall terminate on January 1, 2008. member.~~

15 (c) ~~Notwithstanding any other provision of law, to reduce the~~  
16 ~~membership of the board to 15, the following shall occur:~~

17 (1) ~~Two positions on the board that are public members having~~  
18 ~~a term that expires on June 1, 2010, shall terminate instead on~~  
19 ~~January 1, 2008.~~

20 (2) ~~Two positions on the board that are not public members~~  
21 ~~having a term that expires on June 1, 2008, shall terminate instead~~  
22 ~~on August 1, 2008.~~

23 (3) ~~Two positions on the board that are not public members~~  
24 ~~having a term that expires on June 1, 2011, shall terminate instead~~  
25 ~~on January 1, 2008.~~

26 ~~This~~

27 (d) ~~This~~ section shall become inoperative on July 1, 2010, and,  
28 as of January 1, 2011, is repealed, unless a later enacted statute,  
29 which becomes effective on or before January 1, 2011, deletes or  
30 extends the dates on which it becomes inoperative and is repealed.  
31 The repeal of this section renders the board subject to the review  
32 required by Division 1.2 (commencing with Section 473).

1 SEC. 2. Section 2002 of the Business and Professions Code is  
2 amended to read:

3 2002. Unless otherwise expressly provided, the term “board”  
4 as used in this chapter means the Medical Board of California. As  
5 used in this chapter or any other provision of law, “Division of  
6 Medical Quality” and “Division of Licensing” shall be deemed to  
7 refer to the board.

8 SEC. 3. Section 2003 of the Business and Professions Code is  
9 repealed.

10 SEC. 4. Section 2004 of the Business and Professions Code is  
11 amended to read:

12 2004. The board shall have the responsibility for the following:

13 (a) The enforcement of the disciplinary and criminal provisions  
14 of the Medical Practice Act.

15 (b) The administration and hearing of disciplinary actions.

16 (c) Carrying out disciplinary actions appropriate to findings  
17 made by a panel or an administrative law judge.

18 (d) Suspending, revoking, or otherwise limiting certificates after  
19 the conclusion of disciplinary actions.

20 (e) Reviewing the quality of medical practice carried out by  
21 physician and surgeon certificate holders under the jurisdiction of  
22 the board.

23 (f) Approving undergraduate and graduate medical education  
24 programs.

25 (g) Approving clinical clerkship and special programs and  
26 hospitals for the programs in subdivision (f).

27 (h) Issuing licenses and certificates under the board’s  
28 jurisdiction.

29 (i) Administering the board’s continuing medical education  
30 program.

31 SEC. 5. Section 2005 of the Business and Professions Code is  
32 repealed.

33 SEC. 6. Section 2008 of the Business and Professions Code is  
34 repealed.

35 SEC. 7. Section 2008 is added to the Business and Professions  
36 Code, to read:

37 2008. The board may appoint panels from its members for the  
38 purpose of fulfilling the obligations established in subdivision (c)  
39 of Section 2004. Any panel appointed under this section shall  
40 consist of seven members and shall have a minimum of three public

1 *consist of six members and shall have a minimum of two public*  
2 *members. The president of the board shall not be a member of any*  
3 *panel. Each panel shall annually elect a chair and a vice chair.*

4 SEC. 8. Section 2009 of the Business and Professions Code is  
5 repealed.

6 SEC. 9. Section 2012 of the Business and Professions Code is  
7 amended to read:

8 2012. The board shall elect a president, a vice president, and  
9 a secretary from its members.

10 SEC. 10. Section 2013 of the Business and Professions Code  
11 is amended to read:

12 2013. (a) The board and a panel appointed under this chapter  
13 may convene from time to time as deemed necessary by the board.

14 (b) Four members of a panel of the board shall constitute a  
15 quorum for the transaction of business at any meeting of the panel.  
16 ~~For~~ 8 members shall constitute a quorum for the transaction of  
17 business at any board meeting.

18 (c) It shall require the affirmative vote of a majority of those  
19 members present at a board or panel meeting, those members  
20 constituting at least a quorum, to pass any motion, resolution, or  
21 measure. A decision by a panel to discipline a physician and  
22 surgeon shall require an affirmative vote, at a meeting or by mail,  
23 of a majority of the members of that panel; except that a decision  
24 to revoke the certificate of a physician and surgeon shall require  
25 the affirmative vote of four members of that panel.

26 SEC. 11. Section 2014 of the Business and Professions Code  
27 is amended to read:

28 2014. Notice of each meeting of the board shall be given in  
29 accordance with the Bagley-Keene Open Meeting Act (Article 9  
30 (commencing with Section 11120) of Chapter 1 of Part 1 of  
31 Division 3 of Title 2 of the Government Code).

32 SEC. 12. Section 2015 of the Business and Professions Code  
33 is amended to read:

34 2015. The president of the board may call meetings of any duly  
35 appointed and created committee or panel of the board at a  
36 specified time and place.

37 SEC. 13. Section 2017 of the Business and Professions Code  
38 is amended to read:

39 2017. The board and each committee or panel shall keep an  
40 official record of all their proceedings.

1 SEC. 14. Section 2018 of the Business and Professions Code  
2 is amended to read:

3 2018. The board may adopt, amend, or repeal, in accordance  
4 with the provisions of the Administrative Procedure Act, those  
5 regulations as may be necessary to enable it to carry into effect  
6 the provisions of law relating to the practice of medicine.

7 SEC. 15. Section 2035 of the Business and Professions Code  
8 is repealed.

9 SEC. 16. Section 2041 of the Business and Professions Code  
10 is amended to read:

11 2041. The term “licensee” as used in this chapter means the  
12 holder of a physician’s and surgeon’s certificate or doctor of  
13 podiatric medicine’s certificate, as the case may be, who is engaged  
14 in the professional practice authorized by the certificate under the  
15 jurisdiction of the appropriate board.

16 SEC. 17. Section 2223 of the Business and Professions Code  
17 is repealed.

18 SEC. 18. Section 2224 of the Business and Professions Code  
19 is amended to read:

20 2224. (a) The board may delegate the authority under this  
21 chapter to conduct investigations and inspections and to institute  
22 proceedings to the executive director of the board or to other  
23 personnel as set forth in Section 2020. The board shall not delegate  
24 its authority to take final disciplinary action against a licensee as  
25 provided in Section 2227 and other provisions of this chapter. The  
26 board shall not delegate any authority of the Senior Assistant  
27 Attorney General of the Health Quality Enforcement Section or  
28 any powers vested in the administrative law judges of the Office  
29 of Administrative Hearings, as designated in Section 11371 of the  
30 Government Code.

31 (b) Notwithstanding subdivision (a), the board shall delegate to  
32 its executive director the authority to adopt a decision entered by  
33 default and a stipulation for surrender of a license.

34 SEC. 19. Section 2228 of the Business and Professions Code  
35 is amended to read:

36 2228. The authority of the board or the California Board of  
37 Podiatric Medicine to discipline a licensee by placing him or her  
38 on probation includes, but is not limited to, the following:

39 (a) Requiring the licensee to obtain additional professional  
40 training and to pass an examination upon the completion of the



1 training. The examination may be written or oral, or both, and may  
2 be a practical or clinical examination, or both, at the option of the  
3 board or the administrative law judge.

4 (b) Requiring the licensee to submit to a complete diagnostic  
5 examination by one or more physicians and surgeons appointed  
6 by the board. If an examination is ordered, the board shall receive  
7 and consider any other report of a complete diagnostic examination  
8 given by one or more physicians and surgeons of the licensee's  
9 choice.

10 (c) Restricting or limiting the extent, scope, or type of practice  
11 of the licensee, including requiring notice to applicable patients  
12 that the licensee is unable to perform the indicated treatment, where  
13 appropriate.

14 (d) Providing the option of alternative community service in  
15 cases other than violations relating to quality of care.

16 SEC. 20. Section 2230 of the Business and Professions Code  
17 is amended to read:

18 2230. (a) All proceedings against a licensee for unprofessional  
19 conduct, or against an applicant for licensure for unprofessional  
20 conduct or cause, shall be conducted in accordance with the  
21 Administrative Procedure Act (Chapter 5 (commencing with  
22 Section 11500) of Part 1 of Division 3 of Title 2 of the Government  
23 Code) except as provided in this chapter, and shall be prosecuted  
24 by the Senior Assistant Attorney General of the Health Quality  
25 Enforcement Section.

26 (b) For purposes of this article, "agency itself," as used in the  
27 Administrative Procedure Act, means any panel appointed by the  
28 board pursuant to Section 2008. The decision or order of a panel  
29 imposing any disciplinary action pursuant to this chapter and the  
30 Administrative Procedure Act shall be final.

31 SEC. 21. Section 2311 of the Business and Professions Code  
32 is amended to read:

33 2311. Whenever any person has engaged in or is about to  
34 engage in any acts or practices that constitute or will constitute an  
35 offense against this chapter, the superior court of any county, on  
36 application of the board or of 10 or more persons licensed as  
37 physicians and surgeons or as podiatrists in this state, may issue  
38 an injunction or other appropriate order restraining the conduct.  
39 Proceedings under this section shall be governed by Chapter 3

1 (commencing with Section 525) of Title 7 of Part 2 of the Code  
2 of Civil Procedure.

3 SEC. 22. Section 2317 of the Business and Professions Code  
4 is amended to read:

5 2317. If a person, not a regular employee of the board, is hired,  
6 under contract, or retained under any other arrangement, paid or  
7 unpaid, to provide expertise or nonexpert testimony to the Medical  
8 Board of California or to the California Board of Podiatric  
9 Medicine, including, but not limited to, the evaluation of the  
10 conduct of an applicant or a licensee, and that person is named as  
11 a defendant in an action for defamation, malicious prosecution, or  
12 any other civil cause of action directly resulting from opinions  
13 rendered, statements made, or testimony given to, or on behalf of,  
14 the committee or its representatives, the board shall provide for  
15 representation required to defend the defendant in that civil action.  
16 The board shall be liable for any judgment rendered against that  
17 person, except that the board shall not be liable for any punitive  
18 damages award. If the plaintiff prevails in a claim for punitive  
19 damages, the defendant shall be liable to the board for the full  
20 costs incurred in providing representation to the defendant. The  
21 Attorney General shall be utilized in those actions as provided in  
22 Section 2020.

23 SEC. 23. Section 2335 of the Business and Professions Code  
24 is amended to read:

25 2335. (a) All proposed decisions and interim orders of the  
26 Medical Quality Hearing Panel designated in Section 11371 of the  
27 Government Code shall be transmitted to the executive director  
28 of the board, or the executive director of the California Board of  
29 Podiatric Medicine as to the licensees of that board, within 48  
30 hours of filing.

31 (b) All interim orders shall be final when filed.

32 (c) A proposed decision shall be acted upon by the board or by  
33 any panel appointed pursuant to Section 2008 or by the California  
34 Board of Podiatric Medicine, as the case may be, in accordance  
35 with Section 11517 of the Government Code, except that all of the  
36 following shall apply to proceedings against licensees under this  
37 chapter:

38 (1) When considering a proposed decision, the board or panel  
39 and the California Board of Podiatric Medicine shall give great  
40 weight to the findings of fact of the administrative law judge,

1 except to the extent those findings of fact are controverted by new  
2 evidence.

3 (2) The board's staff or the staff of the California Board of  
4 Podiatric Medicine shall poll the members of the board or panel  
5 or of the California Board of Podiatric Medicine by written mail  
6 ballot concerning the proposed decision. The mail ballot shall be  
7 sent within 10 calendar days of receipt of the proposed decision,  
8 and shall poll each member on whether the member votes to  
9 approve the decision, to approve the decision with an altered  
10 penalty, to refer the case back to the administrative law judge for  
11 the taking of additional evidence, to defer final decision pending  
12 discussion of the case by the panel or board as a whole, or to  
13 nonadopt the decision. No party to the proceeding, including  
14 employees of the agency that filed the accusation, and no person  
15 who has a direct or indirect interest in the outcome of the  
16 proceeding or who presided at a previous stage of the decision,  
17 may communicate directly or indirectly, upon the merits of a  
18 contested matter while the proceeding is pending, with any member  
19 of the panel or board, without notice and opportunity for all parties  
20 to participate in the communication. The votes of a majority of the  
21 board or of the panel, and a majority of the California Board of  
22 Podiatric Medicine, are required to approve the decision with an  
23 altered penalty, to refer the case back to the administrative law  
24 judge for the taking of further evidence, or to nonadopt the  
25 decision. The votes of two members of the panel or board are  
26 required to defer final decision pending discussion of the case by  
27 the panel or board as a whole. If there is a vote by the specified  
28 number to defer final decision pending discussion of the case by  
29 the panel or board as a whole, provision shall be made for that  
30 discussion before the 90-day period specified in paragraph (3)  
31 expires, but in no event shall that 90-day period be extended.

32 (3) If a majority of the board or of the panel, or a majority of  
33 the California Board of Podiatric Medicine vote to do so, the board  
34 or the panel or the California Board of Podiatric Medicine shall  
35 issue an order of nonadoption of a proposed decision within 90  
36 calendar days of the date it is received by the board. If the board  
37 or the panel or the California Board of Podiatric Medicine does  
38 not refer the case back to the administrative law judge for the  
39 taking of additional evidence or issue an order of nonadoption  
40 within 90 days, the decision shall be final and subject to review

1 under Section 2337. Members of the board or of any panel or of  
2 the California Board of Podiatric Medicine who review a proposed  
3 decision or other matter and vote by mail as provided in paragraph  
4 (2) shall return their votes by mail to the board within 30 days  
5 from receipt of the proposed decision or other matter.

6 (4) The board or the panel or the California Board of Podiatric  
7 Medicine shall afford the parties the opportunity to present oral  
8 argument before deciding a case after nonadoption of the  
9 administrative law judge's decision.

10 (5) A vote of a majority of the board or of a panel, or a majority  
11 of the California Board of Podiatric Medicine, are required to  
12 increase the penalty from that contained in the proposed  
13 administrative law judge's decision. No member of the board or  
14 panel or of the California Board of Podiatric Medicine may vote  
15 to increase the penalty except after reading the entire record and  
16 personally hearing any additional oral argument and evidence  
17 presented to the panel or board.

18 SEC. 24. Section 2506 of the Business and Professions Code  
19 is amended to read:

20 2506. As used in this article the following definitions shall  
21 apply:

22 (a) "Board" means the Medical Board of California.

23 (b) "Licensed midwife" means an individual to whom a license  
24 to practice midwifery has been issued pursuant to this article.

25 (c) "Certified nurse-midwife" means a person to whom a  
26 certificate has been issued pursuant to Article 2.5 (commencing  
27 with Section 2746) of Chapter 6.

28 (d) "Accrediting organization" means an organization approved  
29 by the board.

30 SEC. 25. Section 2529 of the Business and Professions Code  
31 is amended to read:

32 2529. Graduates of the Southern California Psychoanalytic  
33 Institute, the Los Angeles Psychoanalytic Society and Institute,  
34 the San Francisco Psychoanalytic Institute, the San Diego  
35 Psychoanalytic Institute, or institutes deemed equivalent by the  
36 Medical Board of California who have completed clinical training  
37 in psychoanalysis may engage in psychoanalysis as an adjunct to  
38 teaching, training, or research and hold themselves out to the public  
39 as psychoanalysts, and students in those institutes may engage in  
40 psychoanalysis under supervision, if the students and graduates

1 do not hold themselves out to the public by any title or description  
2 of services incorporating the words “psychological,”  
3 “psychologist,” “psychology,” “psychometrists,” “psychometrics,”  
4 or “psychometry,” or that they do not state or imply that they are  
5 licensed to practice psychology.

6 Those students and graduates seeking to engage in  
7 psychoanalysis under this chapter shall register with the Medical  
8 Board of California, presenting evidence of their student or  
9 graduate status. The board may suspend or revoke the exemption  
10 of such persons for unprofessional conduct as defined in Sections  
11 725, 2234, and 2235.

12 SEC. 26. Section 2529.5 of the Business and Professions Code  
13 is amended to read:

14 2529.5. Each person to whom registration is granted under the  
15 provisions of this chapter shall pay into the Contingent Fund of  
16 the Medical Board of California a fee to be fixed by the Medical  
17 Board of California at a sum not in excess of one hundred dollars  
18 (\$100).

19 The registration shall expire after two years. The registration  
20 may be renewed biennially at a fee to be fixed by the board at a  
21 sum not in excess of fifty dollars (\$50). Students seeking to renew  
22 their registration shall present to the board evidence of their  
23 continuing student status.

24 The money in the Contingent Fund of the Medical Board of  
25 California shall be used for the administration of this chapter.

26 SEC. 27. Section 2540.1 is added to the Business and  
27 Professions Code, to read:

28 2540.1. Any reference to the “Division of Medical Quality”  
29 or to the “Division of Licensing” in this chapter shall be deemed  
30 to refer to the Medical Board of California.

31 SEC. 28. Section 2546.2 of the Business and Professions Code  
32 is amended to read:

33 2546.2. All references in this chapter to the division shall mean  
34 the Medical Board of California.

35 SEC. 29. Section 2550.1 of the Business and Professions Code  
36 is amended to read:

1       2550.1. All references in this chapter to the board or the Board  
2 of Medical Examiners or division shall mean the Medical Board  
3 of California.

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MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 329  
**Author:** Nakanishi  
**Bill Date:** June 19, 2007, amended  
**Subject:** Chronic Diseases: Telemedicine  
**Sponsor:** Author / Medical Board of California

**STATUS OF BILL:**

This bill passed out of the Senate Appropriations Committee.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill has been amended to allow the Medical Board to establish a telemedicine pilot program. It authorizes the Board to implement the program by convening a working group of interested parties. The Board would be required to make recommendations to the legislature within one calendar year of the commencement date of the pilot program.

**ANALYSIS:**

Chronic diseases, such as diabetes and obesity, cost California tens-of-billions of dollars annually. For example, over 2 million Americans currently suffer from diabetes, with this number expected to double by 2025. Similarly, obesity constitutes the second leading cause of preventable death in California and costs the State \$28.5 billion annually in health care costs, lost productivity, and workers' compensation. Consequently, developing a state-wide best practices model by which to manage these and other chronic diseases could result in thousands of saved lives and significant cost reductions within the State's health care system.

Developing innovative health information technologies has been proposed as a means by which to tout nationally accepted chronic disease management techniques throughout the State. As a result of such a system, all California physicians would have readily available access to treatment knowledge often held exclusively by specialists.

Recognizing the significant cost savings posed by such a disease management system, Governor Schwarzenegger signed Executive Order S-12-06 in July 2006, directing state agencies to allocate at least \$240 million for health information technology expansion. The Governor's more recent Executive Order S-06-07 further acts to increase access to health care, using the potential of health information technology to provide the tools that can aid health system participants to improve the quality and affordability of health care services.

By establishing a telemedicine model, significant cost savings would be accrued due to more expedient and professional care, as well as a reduction in the number of medical errors resulting from inaccessible or inadequate disease management guidelines. Furthermore, such a system would both increase investment in rural health care economies and access to expert treatment within those communities. Ultimately, it could save more than 23,000 lives and \$4 billion annually within the State.

The bill, as introduced declared the intent of the Legislature to encourage the Medical Board to bring together all interested parties in order to develop a mechanism by which to deliver health care, and deliver information about disease management best practices, using a telemedicine model. This outreach would bring together health care providers, state health-related agencies, information technology groups, and groups representing underserved health care consumers.

The Medical Board, through its Access to Care Committee, has already begun moving in the direction suggested by this bill. A Physician Volunteer Program was launched, and the Medical Board is hoping to expand traditional telemedicine by using these volunteers as educators, offering technology-based distant learning seminars. Yet through the Medical Board's outreach during the last 12 to 15 months, we have become aware that there are many organizations who are moving forward with their own concepts of telemedicine. By having one agency act as the central coordinator for all telemedicine efforts in California, this could bring together under one roof a truly solid and motivated base of supporters for this project, with a unique public/private pairing.

The June 19, 2007 amendments to this bill allow the board to establish a pilot program to expand the practice of telemedicine. The board may implement this pilot program by convening a working group of interested parties from the public and private sectors. This work group would discuss ways of delivering health care to those with chronic diseases using telemedicine. The board would be required to make recommendations regarding its findings to the Legislature within one calendar year of the commencement date of the pilot program.

**FISCAL:** Coordination of the work group could be accomplished within existing resources.

**POSITION:** Sponsor/ Support

July 17, 2007



AMENDED IN SENATE JUNE 19, 2007  
AMENDED IN ASSEMBLY MARCH 29, 2007  
CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

**ASSEMBLY BILL**

**No. 329**

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**Introduced by Assembly Member Nakanishi**  
***(Coauthors: Assembly Members Arambula, Fuller, and Maze)***  
***(Coauthors: Senators Cogdill and Ridley-Thomas)***

February 13, 2007

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An act to add Section 2028.5 to the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 329, as amended, Nakanishi. Chronic diseases: telemedicine.

Existing law, the Medical Practice Act, creates the Medical Board of California that is responsible for issuing a ~~physician~~ *physician's* and surgeon's certificate to practice medicine and for regulating the practice of physicians and surgeons. The act also regulates the practice of telemedicine, defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

This bill would ~~require~~ *authorize* the board to establish a pilot program to expand the practice of telemedicine and would authorize the board to implement the program by convening a working group ~~to discuss the means~~. *The bill would specify that the purpose of the pilot program shall be to develop methods, using a telemedicine model, of delivering health care to those with chronic diseases—using and delivering other health information technologies.* The bill would require the board to make recommendations regarding its findings to the Legislature ~~on or~~

before January 1, 2009 within one calendar year of the commencement date of the pilot program.

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

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

1 SECTION 1. Section 2028.5 is added to the Business and  
2 Professions Code, to read:

3 2028.5. (a) The board ~~shall~~ *may* establish a pilot program to  
4 expand the practice of telemedicine in this state.

5 ~~(b) The board may implement this pilot program by convening~~

6 *(b) To implement this pilot program, the board may convene a*  
7 *working group of interested parties from the public and private*  
8 *sectors, including, but not limited to, state health-related agencies,*  
9 *health care providers, health plan administrators, information*  
10 *technology groups, and groups representing health care consumers.*

11 ~~(c) The members of the working group shall discuss the means~~  
12 ~~of delivering health care to those with chronic diseases, and assist~~  
13 ~~in developing a plan for offering the best practices in a telemedicine~~  
14 ~~model in order to reach all Californians, using innovative health~~  
15 ~~information technologies as a means by which to share nationally~~  
16 ~~accepted chronic disease management techniques throughout the~~  
17 ~~state.~~

18 *(c) The purpose of the pilot program shall be to develop*  
19 *methods, using a telemedicine model, to deliver throughout the*  
20 *state health care to persons with chronic diseases as well as*  
21 *information on the best practices for chronic disease management*  
22 *services and techniques and other health care information as*  
23 *deemed appropriate.*

24 (d) The board shall make a report with its recommendations  
25 regarding its findings to the Legislature ~~on or before January 1,~~  
26 ~~2009 within one calendar year of the commencement date of the~~  
27 ~~pilot program.~~ The report shall include an evaluation of the  
28 improvement and affordability of health care services and the  
29 reduction in the number of complications achieved by the pilot  
30 program.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1025  
**Author:** Bass  
**Bill Date:** July 5, 2007, amended  
**Subject:** Denial of Licensure  
**Sponsor:** Author

**STATUS OF BILL:**

This bill is currently in the Senate Appropriations Committee and has not been set for hearing.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill creates more additional screening for all professions regulated by the Department of Consumer Affairs (DCA). Provisions of this bill enact limitations on disqualifying offenses, while also incorporating consumer protections that would allow applicants to obtain a copy of their criminal history record when they are being denied employment or licensing so that they can immediately correct any mistakes and avoid unnecessary and unfair appeal delays. Specifically this bill does the following:

- Provides that a person may not be denied licensure based on a felony conviction that has been dismissed if certain criteria have been met.
- Provides that an arrest of over a year old does not constitute grounds for denial of a license if no disposition is reported.
- Requires the board to provide an applicant or ex-licensee whose application has been denied or whose license has been suspended or revoked based upon a crime with a copy of their criminal history record information used in making the determination.
- Limits disqualifying offenses such as expunged convictions and arrests with no disposition reported that are more than one year old and establishes a statute of limitations for disqualifying offenses (e.g., three years for misdemeanors and seven years for felonies) for the Department of Consumer Affairs.

As amended this bill requires all boards to maintain information pertaining to the provision of criminal history records and to make that information available upon request by the Department of Justice of the Federal Bureau of Investigation.

This bill was amended on July 5, 2007 to specify that a person cannot be denied licensure solely on a criminal conviction if that person has been rehabilitated or if the conviction has been dismissed on specific grounds. The licensing agency must provide substantial evidence justifying any denial of suspension or revocation that is based on a criminal conviction. The department would now be required to prepare annual reports to the Legislature documenting the denial, suspension, or revocation of licenses based on the bill's provisions.

### **ANALYSIS:**

Under current law, a board may suspend or revoke a license on the grounds that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued. Following the conviction, a board may take action when the time for appeal has elapsed, the judgment of conviction has been affirmed, or when an order granting probation is made suspending the imposition of a sentence. This bill would add that the board cannot suspend or revoke a license based on any criminal conviction that has been dismissed.

When a license is suspended or revoked for reasons of convictions, the board is required to send a copy of the Government code provisions that states the authority to take this action and the criteria relating to rehabilitation to the ex-licensee. This bill would add the requirement that a board send a copy of the criminal history record that was relied upon in making the determination to suspend or revoke the license to the ex-licensee.

The DCA has reviewed the implications of this bill to the various licensing boards. This would have a negative impact on consumer protection in the licensing of physicians. If an applicant has a criminal conviction that was expunged, the Division of Licensing (DOL) would have no right to look at the conviction. An example might be a sex offender who was not required to register. This bill takes away one of the reviews the DOL uses in licensing physicians.

The April 16<sup>th</sup> amendments to the bill require a board to record and maintain the name and address of applicants, along with the date the criminal history record was provided to the applicant. Boards must also make this information available to the Department of Justice or the Federal Bureau of Investigation upon request. These amendments do not address the concerns raised by the Board to the author's staff. If these amendments cannot be achieved, then the Board should oppose this bill.

The July 5<sup>th</sup> amendments to this bill specify that a person cannot be denied licensure solely on a criminal conviction if that person has been rehabilitated or if the conviction has been dismissed on specific grounds. The Board must provide substantial evidence justifying any denial of suspension or revocation that is based on a criminal conviction. The bill has been amended to require that the department prepare annual

reports to the Legislature documenting the denial, suspension, or revocation of licenses based on the bill's provisions.

Per DCA legal office, this bill, in its current form, will not protect consumers and the Board should oppose.

**FISCAL:**               None

**POSITION:**           Neutral if amended to exclude physicians from the provisions.

Recommend: Oppose unless author will amend bill to exclude physicians.

July 18, 2007

AMENDED IN SENATE JULY 5, 2007

AMENDED IN ASSEMBLY MAY 31, 2007

AMENDED IN ASSEMBLY APRIL 16, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1025**

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**Introduced by Assembly Member Bass**

February 22, 2007

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An act to amend Sections 480, 485, 490, and 491 of the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 1025, as amended, Bass. Professions and vocations: licensure.

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 licensure on certain bases, including an applicant's conviction of a crime regardless of whether the conviction has been dismissed on specified grounds, an applicant's performance of any act involving dishonesty, fraud, or deceit with the intent to substantially benefit himself or herself or another or to substantially injure another, or an applicant's performance of any act that would be grounds for suspension or revocation of the license. Existing law requires a board that denies an application for licensure to provide the applicant with notice of the denial, as specified. Existing law authorizes a board to suspend or revoke a license on the basis that a licensee has been convicted of a crime that is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued, regardless of whether the conviction has

been dismissed on specified grounds, and requires the board to provide the ex-licensee with certain information upon doing so.

This bill would provide that a person may not be denied licensure based ~~solely on a felony criminal conviction that has been dismissed on specified grounds if certain requirements have been met if the person has been rehabilitated, as specified.~~ The bill would also provide that a person may not be denied licensure ~~based on a misdemeanor conviction that has been dismissed on specified grounds.~~ The bill would also ~~provide that a person may not~~ or have his or her license suspended or revoked ~~solely~~ based on a criminal conviction that has been dismissed on specified grounds, *unless the board provides substantial evidence, as specified, justifying the denial suspension, or revocation.* The bill would require the board to provide an applicant or ex-licensee whose application has been denied or whose license has been suspended or revoked based upon a crime with a copy of his or her criminal history record, as specified. The bill would require the board to maintain specified information pertaining to the provision of criminal history records and to make that information available upon request by the Department of Justice or the Federal Bureau of Investigation. *The bill would require the department, to prepare annual reports to the Legislature documenting the board's denial, suspension, or revocation of licenses based on 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:*

- 1 SECTION 1. Section 480 of the Business and Professions Code
- 2 is amended to read:
- 3 480. (a) A board may deny a license regulated by this code
- 4 on the grounds that the applicant has done one of the following:
- 5 (1) Been convicted of a crime. A conviction within the meaning
- 6 of this section means a plea or verdict of guilty or a conviction
- 7 following a plea of nolo contendere. Any action which a board is
- 8 permitted to take following the establishment of a conviction may
- 9 be taken when the time for appeal has elapsed, or the judgment of
- 10 conviction has been affirmed on appeal, or when an order granting
- 11 probation is made suspending the imposition of sentence.

1 (2) Done any act involving dishonesty, fraud or deceit with the  
2 intent to substantially benefit himself or another, or substantially  
3 injure another; or

4 (3) Done any act which if done by a licentiate of the business  
5 or profession in question, would be grounds for suspension or  
6 revocation of license.

7 The board may deny a license pursuant to this subdivision only  
8 if the crime or act is substantially related to the qualifications,  
9 functions or duties of the business or profession for which  
10 application is made.

11 (b) Notwithstanding any other provision of this ~~code~~ *code*:

12 (1) No person shall be denied a license solely on the basis that  
13 he or she has been convicted of a felony if either of the following  
14 apply:

15 (A) He or she has obtained a certificate of rehabilitation under  
16 Chapter 3.5 (commencing with Section 4852.01) of Title 6 of Part  
17 3 of the Penal Code.

18 (B) The felony conviction has been dismissed pursuant to  
19 Section 1203.4 of the Penal Code, ~~there have been no subsequent~~  
20 ~~felony convictions, and either at least three years have passed since~~  
21 ~~the dismissal of the conviction or at least five years have passed~~  
22 ~~since the person completed his or her sentence. This paragraph~~  
23 ~~shall not apply if the conviction was for any offense defined in~~  
24 ~~subdivision (c) of Section 667.5 of the Penal Code as a violent~~  
25 ~~felony or any offense defined in subdivision (c) of Section 1192.7~~  
26 ~~of the Penal Code as a serious felony. which creates a presumption~~  
27 ~~of rehabilitation for purposes of this paragraph, unless the board~~  
28 ~~provides substantial evidence to the contrary in writing to the~~  
29 ~~person justifying the board's denial of the license based solely on~~  
30 ~~his or her dismissed felony conviction that is substantially related~~  
31 ~~to the qualifications, functions, or duties of the business or~~  
32 ~~profession for which application is made.~~

33 (2) No person shall be denied a license solely on the basis that  
34 he or she has been convicted of a misdemeanor if either of the  
35 following apply:

36 (A)

37 (A) He or she has met all applicable requirements of the criteria  
38 of rehabilitation developed by the board to evaluate the  
39 rehabilitation of a person when considering the denial of a license  
40 under subdivision (a) of Section 482.



1 (B) The misdemeanor conviction has been dismissed pursuant  
2 to either Section 1203.4 or 1203.4a of the Penal Code, *which*  
3 *creates a presumption of rehabilitation for purposes of this*  
4 *paragraph, unless the board provides substantial evidence to the*  
5 *contrary in writing to the person justifying the board's denial of*  
6 *the license based solely on his or her dismissed misdemeanor*  
7 *conviction that is substantially related to the qualifications,*  
8 *functions, or duties of the business or profession for which*  
9 *application is made.*

10 (c) A board may deny a license regulated by this code on the  
11 ground that the applicant knowingly made a false statement of fact  
12 required to be revealed in the application for such license.

13 (d) *The department shall annually prepare a report, to be*  
14 *submitted to the Legislature on October 1, that documents board*  
15 *denials of licenses based solely on dismissed felony or*  
16 *misdemeanor convictions as specified in subdivision (b).*

17 SEC. 2. Section 485 of the Business and Professions Code is  
18 amended to read:

19 485. (a) Upon denial of an application for a license under this  
20 chapter or Section 496, the board shall do either of the following:

21 (1) File and serve a statement of issues in accordance with  
22 Chapter 5 (commencing with Section 11500) of Part 1 of Division  
23 3 of Title 2 of the Government Code.

24 (2) Notify the applicant that the application is denied, stating  
25 (A) the reason for the denial, and (B) that the applicant has the  
26 right to a hearing under Chapter 5 (commencing with Section  
27 11500) of Part 1 of Division 3 of Title 2 of the Government Code  
28 if a written request for a hearing is made within 60 days after  
29 service of the notice of denial. Unless a written request for a  
30 hearing is made within the 60-day period, the applicant's right to  
31 a hearing is deemed waived.

32 Service of the notice of denial may be made in the manner  
33 authorized for service of summons in civil actions, or by registered  
34 mail addressed to the applicant at the latest address filed by the  
35 applicant in writing with the board in his or her application or  
36 otherwise. Service by mail is complete on the date of mailing.

37 (b) If the denial of a license is due at least in part to the  
38 applicant's state or federal criminal history record, the board shall  
39 include with the information provided pursuant to paragraph (1)

1 or (2) of subdivision (a) a copy of the applicant's criminal history  
2 record.

3 (1) The state or federal criminal history record shall not be  
4 modified or altered from its form or content as provided by the  
5 Department of Justice.

6 (2) The criminal history record shall be provided in such a  
7 manner as to protect the confidentiality and privacy of the  
8 applicant's criminal history record, and the criminal history record  
9 shall not be made available by the board to any employer.

10 (3) The board shall record and maintain the name of the  
11 applicant, the applicant's address, and the date the criminal history  
12 record was provided by the board to the applicant pursuant to this  
13 section. The board shall make that information available upon  
14 request by the Department of Justice or the Federal Bureau of  
15 Investigation.

16 SEC. 3. Section 490 of the Business and Professions Code is  
17 amended to read:

18 490. (a) A board may suspend or revoke a license on the  
19 ground that the licensee has been convicted of a crime, if the crime  
20 is substantially related to the qualifications, functions, or duties of  
21 the business or profession for which the license was issued. A  
22 conviction within the meaning of this section means a plea or  
23 verdict of guilty or a conviction following a plea of nolo  
24 contendere. Any action which a board is permitted to take  
25 following the establishment of a conviction may be taken when  
26 the time for appeal has elapsed, or the judgment of conviction has  
27 been affirmed on appeal, or when an order granting probation is  
28 made suspending the imposition of sentence. ~~No~~

29 (b) *No license shall be suspended or revoked based solely on*  
30 *any criminal conviction that has been dismissed pursuant to Section*  
31 *1203.4 or 1203.4a of the Penal Code, since that dismissal creates*  
32 *a presumption of rehabilitation for purposes of this section, unless*  
33 *the board provides substantial evidence to the contrary in writing*  
34 *to the person justifying the board's suspension or revocation of*  
35 *the license based solely on his or her dismissed conviction that is*  
36 *substantially related to the qualifications, functions, or duties of*  
37 *the business or profession for which the license was made.*

38 (c) *The department shall annually prepare a report, to be*  
39 *submitted to the Legislature on October 1, that documents board*

1 *suspensions or revocations of licenses based solely on dismissed*  
2 *criminal convictions as specified in subdivision (b).*

3 SEC. 4. Section 491 of the Business and Professions Code is  
4 amended to read:

5 491. (a) Upon suspension or revocation of a license by a board  
6 on one or more of the grounds specified in Section 490, the board  
7 shall do both of the following:

8 (1) Send a copy of the provisions of Section 11522 of the  
9 Government Code to the ex-licensee.

10 (2) Send a copy of the criteria relating to rehabilitation  
11 formulated under Section 482 to the ex-licensee.

12 (b) If the suspension or revocation of a license is due at least in  
13 part to the ex-licensee's state or federal criminal history record,  
14 the board shall include with the information provided pursuant to  
15 subdivision (a) a copy of the ex-licensee's criminal history record.

16 (1) The state or federal criminal history record shall not be  
17 modified or altered from its form or content as provided by the  
18 Department of Justice.

19 (2) The criminal history record shall be provided in such a  
20 manner as to protect the confidentiality and privacy of the  
21 ex-licensee's criminal history record, and the criminal history  
22 record shall not be made available by the board to any employer.

23 (3) The board shall record and maintain the name of the  
24 ex-licensee, the ex-licensee's address, and the date the criminal  
25 history record was provided by the board to an ex-licensee pursuant  
26 to this section. The board shall make that information available  
27 upon request by the Department of Justice or the Federal Bureau  
28 of Investigation.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1073  
**Author:** Nava  
**Bill Date:** May 1, 2007, amended  
**Subject:** Workers' Compensation: medical treatment utilization schedule  
**Sponsor:** Author

**STATUS OF BILL:**

This bill passed out of the Senate Labor and Industrial Relations Committee and was sent to the Senate floor.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would make two important changes in the Workers' Compensation law that will benefit injured workers. AB 1073 will provide that the current limit of 24 visits shall not apply to visits for post-surgical physical medicine and rehabilitation services.

**ANALYSIS:**

The strict limit on number of visits for physical therapy, chiropractic and occupational therapy was enacted to curb perceived over-utilization and abuse of these services. It has been successful in limiting physical medicine services. The Workers' Compensation Insurance Rating Bureau (WCIRB) of California has reported that chiropractic services have been reduced by 77% and physical therapy services by 61%.

Under current law, an employer may authorize additional physical medicine services, however, many utilization reviews will not approve the additional visits. What this means for injured workers who need surgery is that they may end up with a frozen shoulder because their surgeon was not able to get approval for the post-surgical physical therapy services needed to restore motion to their shoulder. The inability of the surgeon to get approval for the post-surgical rehabilitation services is having a negative impact on the injured worker's recovery.

Another example is a worker who has a knee injury. The conservative first treatment may be to prescribe physical therapy. If that treatment ultimately fails to relieve the condition, the worker may need surgery, followed by post-surgical rehabilitation. The worker may have already used up most or all of his or her 24-visit limit, and thus the surgeon may not be able to get the carrier's utilization review department to approve physical therapy following surgery. The utilization review is

overriding the medically necessary treatment due to an arbitrary limit or visits that has been placed in law.

This bill would avoid this consequence by providing that the 24 visit limit does not apply to post-surgical physical medicine and rehabilitation services. This will ensure that injured workers quickly receive the important post-surgical services they require. This places medical treatment decisions back into the hands of physicians.

Existing law also requires all carriers and self-insured employers to have a utilization review program. This allows the utilization review to be prospective, retrospective or concurrent to the treatment. Although treatment of injured workers in California may only be provided by physicians and other providers licensed in California, the regulations implementing the utilization review law only require that the reviewer be a “licensed” physician. This means that out-of-state licensed physicians may conduct utilization reviews. It is important that the law be clarified and made consistent with law regarding treatment. Utilization reviews should only be conducted by physicians licensed in California. This will ensure that the Medical Board will have jurisdiction over the reviewing physicians, so that appropriate oversight (and quality assurance and disciplinary enforcement) may be exercised over these physicians.

The amendments made on May 1, 2007 deleted the requirement to have all reviewers be licensed physicians in California. Although that is a major loss from this bill, the exemption from the limitation of visits is still worthy of the Board’s support.

**FISCAL:**               None

**POSITION:**           Support

July 17, 2007

AMENDED IN ASSEMBLY MAY 1, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1073**

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**Introduced by Assembly Member Nava**

February 23, 2007

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An act to amend ~~Sections 4604.5 and 4610~~ *Section 4604.5* of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 1073, as amended, Nava. Workers' compensation: medical treatment utilization schedule.

Existing law establishes a workers' compensation system to compensate an employee for injuries sustained in the course of his or her employment. Existing law requires that the Administrative Director of the Division of Workers' Compensation, on or before January 1, 2004, adopt, after public hearings, a medical treatment utilization schedule, as specified. Existing law provides that, notwithstanding the medical treatment utilization schedule or guidelines set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury, but specifies that this limit shall not apply when an employer authorizes, in writing, additional visits to a health care practitioner for physical medicine services.

This bill would also prohibit the limit on the number of chiropractic, occupational therapy, and physical therapy visits from applying to visits for postsurgical physical medicine and rehabilitative services.

Existing law requires every employer to establish a medical treatment utilization review process, either directly or through its insurer or an entity with which an employer or insurer contracts for these services to review the provision of medical services provided to an injured worker, as specified. Existing law prohibits any person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, as specified, from modifying, delaying, or denying requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

This bill would, instead, prohibit any person other than a physician licensed in California from conducting those medical treatment evaluations.

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

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

- 1 SECTION 1. Section 4604.5 of the Labor Code is amended to
- 2 read:
- 3 4604.5. (a) Upon adoption by the administrative director of a
- 4 medical treatment utilization schedule pursuant to Section 5307.27,
- 5 the recommended guidelines set forth in the schedule shall be
- 6 presumptively correct on the issue of extent and scope of medical
- 7 treatment. The presumption is rebuttable and may be controverted
- 8 by a preponderance of the scientific medical evidence establishing
- 9 that a variance from the guidelines is reasonably required to cure
- 10 or relieve the injured worker from the effects of his or her injury.
- 11 The presumption created is one affecting the burden of proof.
- 12 (b) The recommended guidelines set forth in the schedule
- 13 adopted pursuant to subdivision (a) shall reflect practices that are
- 14 evidence and scientifically based, nationally recognized, and
- 15 peer-reviewed. The guidelines shall be designed to assist providers
- 16 by offering an analytical framework for the evaluation and
- 17 treatment of injured workers, and shall constitute care in
- 18 accordance with Section 4600 for all injured workers diagnosed
- 19 with industrial conditions.
- 20 (c) Three months after the publication date of the updated
- 21 American College of Occupational and Environmental Medicine's
- 22 Occupational Medicine Practice Guidelines, and continuing until
- 23 the effective date of a medical treatment utilization schedule,

1 pursuant to Section 5307.27, the recommended guidelines set forth  
2 in the American College of Occupational and Environmental  
3 Medicine's Occupational Medicine Practice Guidelines shall be  
4 presumptively correct on the issue of extent and scope of medical  
5 treatment, regardless of date of injury. The presumption is  
6 rebuttable and may be controverted by a preponderance of the  
7 evidence establishing that a variance from the guidelines is  
8 reasonably required to cure and relieve the employee from the  
9 effects of his or her injury, in accordance with Section 4600. The  
10 presumption created is one affecting the burden of proof.

11 (d) (1) Notwithstanding the medical treatment utilization  
12 schedule or the guidelines set forth in the American College of  
13 Occupational and Environmental Medicine's Occupational  
14 Medicine Practice Guidelines, for injuries occurring on and after  
15 January 1, 2004, an employee shall be entitled to no more than 24  
16 chiropractic, 24 occupational therapy, and 24 physical therapy  
17 visits per industrial injury.

18 (2) Paragraph (1) shall not apply when an employer authorizes,  
19 in writing, additional visits to a health care practitioner for physical  
20 medicine services.

21 (3) Paragraph (1) shall not apply to visits for postsurgical  
22 physical medicine and rehabilitation services.

23 (e) For all injuries not covered by the American College of  
24 Occupational and Environmental Medicine's Occupational  
25 Medicine Practice Guidelines or official utilization schedule after  
26 adoption pursuant to Section 5307.27, authorized treatment shall  
27 be in accordance with other evidence based medical treatment  
28 guidelines generally recognized by the national medical community  
29 and that are scientifically based.

30 ~~SEC. 2. Section 4610 of the Labor Code is amended to read:~~

31 ~~4610. (a) For purposes of this section, "utilization review"~~  
32 ~~means utilization review or utilization management functions that~~  
33 ~~prospectively, retrospectively, or concurrently review and approve,~~  
34 ~~modify, delay, or deny, based in whole or in part on medical~~  
35 ~~necessity to cure and relieve, treatment recommendations by~~  
36 ~~physicians, as defined in Section 3209.3, prior to, retrospectively,~~  
37 ~~or concurrent with the provision of medical treatment services~~  
38 ~~pursuant to Section 4600.~~

39 ~~(b) Every employer shall establish a utilization review process~~  
40 ~~in compliance with this section, either directly or through its insurer~~



1 or an entity with which an employer or insurer contracts for these  
2 services.

3 (c) Each utilization review process shall be governed by written  
4 policies and procedures. These policies and procedures shall ensure  
5 that decisions based on the medical necessity to cure and relieve  
6 of proposed medical treatment services are consistent with the  
7 schedule for medical treatment utilization adopted pursuant to  
8 Section 5307.27. Prior to adoption of the schedule, these policies  
9 and procedures shall be consistent with the recommended standards  
10 set forth in the American College of Occupational and  
11 Environmental Medicine Occupational Medical Practice  
12 Guidelines. These policies and procedures, and a description of  
13 the utilization process, shall be filed with the administrative director  
14 and shall be disclosed by the employer to employees, physicians,  
15 and the public upon request.

16 (d) If an employer, insurer, or other entity subject to this section  
17 requests medical information from a physician in order to  
18 determine whether to approve, modify, delay, or deny requests for  
19 authorization, the employer shall request only the information  
20 reasonably necessary to make the determination. The employer,  
21 insurer, or other entity shall employ or designate a medical director  
22 who holds an unrestricted license to practice medicine in this state  
23 issued pursuant to Section 2050 or Section 2450 of the Business  
24 and Professions Code. The medical director shall ensure that the  
25 process by which the employer or other entity reviews and  
26 approves, modifies, delays, or denies requests by physicians prior  
27 to, retrospectively, or concurrent with the provision of medical  
28 treatment services, complies with the requirements of this section.  
29 Nothing in this section shall be construed as restricting the existing  
30 authority of the Medical Board of California.

31 (e) No person other than a physician licensed in California who  
32 is competent to evaluate the specific clinical issues involved in the  
33 medical treatment services, and where these services are within  
34 the scope of the physician's practice, requested by the physician  
35 may modify, delay, or deny requests for authorization of medical  
36 treatment for reasons of medical necessity to cure and relieve.

37 (f) The criteria or guidelines used in the utilization review  
38 process to determine whether to approve, modify, delay, or deny  
39 medical treatment services shall be all of the following:

1 ~~(1) Developed with involvement from actively practicing~~  
2 ~~physicians.~~

3 ~~(2) Consistent with the schedule for medical treatment utilization~~  
4 ~~adopted pursuant to Section 5307.27. Prior to adoption of the~~  
5 ~~schedule, these policies and procedures shall be consistent with~~  
6 ~~the recommended standards set forth in the American College of~~  
7 ~~Occupational and Environmental Medicine Occupational Medical~~  
8 ~~Practice Guidelines.~~

9 ~~(3) Evaluated at least annually, and updated if necessary.~~

10 ~~(4) Disclosed to the physician and the employee, if used as the~~  
11 ~~basis of a decision to modify, delay, or deny services in a specified~~  
12 ~~case under review.~~

13 ~~(5) Available to the public upon request. An employer shall~~  
14 ~~only be required to disclose the criteria or guidelines for the~~  
15 ~~specific procedures or conditions requested. An employer may~~  
16 ~~charge members of the public reasonable copying and postage~~  
17 ~~expenses related to disclosing criteria or guidelines pursuant to~~  
18 ~~this paragraph. Criteria or guidelines may also be made available~~  
19 ~~through electronic means. No charge shall be required for an~~  
20 ~~employee whose physician's request for medical treatment services~~  
21 ~~is under review.~~

22 ~~(g) In determining whether to approve, modify, delay, or deny~~  
23 ~~requests by physicians prior to, retrospectively, or concurrent with~~  
24 ~~the provisions of medical treatment services to employees all of~~  
25 ~~the following requirements must be met:~~

26 ~~(1) Prospective or concurrent decisions shall be made in a timely~~  
27 ~~fashion that is appropriate for the nature of the employee's~~  
28 ~~condition, not to exceed five working days from the receipt of the~~  
29 ~~information reasonably necessary to make the determination, but~~  
30 ~~in no event more than 14 days from the date of the medical~~  
31 ~~treatment recommendation by the physician. In cases where the~~  
32 ~~review is retrospective, the decision shall be communicated to the~~  
33 ~~individual who received services, or to the individual's designee,~~  
34 ~~within 30 days of receipt of information that is reasonably~~  
35 ~~necessary to make this determination.~~

36 ~~(2) When the employee's condition is such that the employee~~  
37 ~~faces an imminent and serious threat to his or her health, including,~~  
38 ~~but not limited to, the potential loss of life, limb, or other major~~  
39 ~~bodily function, or the normal timeframe for the decisionmaking~~  
40 ~~process, as described in paragraph (1), would be detrimental to the~~

1 employee's life or health or could jeopardize the employee's ability  
2 to regain maximum function, decisions to approve, modify, delay,  
3 or deny requests by physicians prior to, or concurrent with, the  
4 provision of medical treatment services to employees shall be made  
5 in a timely fashion that is appropriate for the nature of the  
6 employee's condition, but not to exceed 72 hours after the receipt  
7 of the information reasonably necessary to make the determination.

8 (3) (A) Decisions to approve, modify, delay, or deny requests  
9 by physicians for authorization prior to, or concurrent with, the  
10 provision of medical treatment services to employees shall be  
11 communicated to the requesting physician within 24 hours of the  
12 decision. Decisions resulting in modification, delay, or denial of  
13 all or part of the requested health care service shall be  
14 communicated to physicians initially by telephone or facsimile,  
15 and to the physician and employee in writing within 24 hours for  
16 concurrent review, or within two business days of the decision for  
17 prospective review, as prescribed by the administrative director.  
18 If the request is not approved in full, disputes shall be resolved in  
19 accordance with Section 4062. If a request to perform spinal  
20 surgery is denied, disputes shall be resolved in accordance with  
21 subdivision (b) of Section 4062.

22 (B) In the case of concurrent review, medical care shall not be  
23 discontinued until the employee's physician has been notified of  
24 the decision and a care plan has been agreed upon by the physician  
25 that is appropriate for the medical needs of the employee. Medical  
26 care provided during a concurrent review shall be care that is  
27 medically necessary to cure and relieve, and an insurer or  
28 self-insured employer shall only be liable for those services  
29 determined medically necessary to cure and relieve. If the insurer  
30 or self-insured employer disputes whether or not one or more  
31 services offered concurrently with a utilization review were  
32 medically necessary to cure and relieve, the dispute shall be  
33 resolved pursuant to Section 4062, except in cases involving  
34 recommendations for the performance of spinal surgery, which  
35 shall be governed by the provisions of subdivision (b) of Section  
36 4062. Any compromise between the parties that an insurer or  
37 self-insured employer believes may result in payment for services  
38 that were not medically necessary to cure and relieve shall be  
39 reported by the insurer or the self-insured employer to the licensing  
40 board of the provider or providers who received the payments, in

1 a manner set forth by the respective board and in such a way as to  
2 minimize reporting costs both to the board and to the insurer or  
3 self-insured employer, for evaluation as to possible violations of  
4 the statutes governing appropriate professional practices. No fees  
5 shall be levied upon insurers or self-insured employers making  
6 reports required by this section.

7 (4) Communications regarding decisions to approve requests  
8 by physicians shall specify the specific medical treatment service  
9 approved. Responses regarding decisions to modify, delay, or deny  
10 medical treatment services requested by physicians shall include  
11 a clear and concise explanation of the reasons for the employer's  
12 decision, a description of the criteria or guidelines used, and the  
13 clinical reasons for the decisions regarding medical necessity.

14 (5) If the employer, insurer, or other entity cannot make a  
15 decision within the timeframes specified in paragraph (1) or (2)  
16 because the employer or other entity is not in receipt of all of the  
17 information reasonably necessary and requested, because the  
18 employer requires consultation by an expert reviewer, or because  
19 the employer has asked that an additional examination or test be  
20 performed upon the employee that is reasonable and consistent  
21 with good medical practice, the employer shall immediately notify  
22 the physician and the employee, in writing, that the employer  
23 cannot make a decision within the required timeframe, and specify  
24 the information requested but not received, the expert reviewer to  
25 be consulted, or the additional examinations or tests required. The  
26 employer shall also notify the physician and employee of the  
27 anticipated date on which a decision may be rendered. Upon receipt  
28 of all information reasonably necessary and requested by the  
29 employer, the employer shall approve, modify, or deny the request  
30 for authorization within the timeframes specified in paragraph (1)  
31 or (2).

32 (h) Every employer, insurer, or other entity subject to this section  
33 shall maintain telephone access for physicians to request  
34 authorization for health care services.

35 (i) If the administrative director determines that the employer,  
36 insurer, or other entity subject to this section has failed to meet  
37 any of the timeframes in this section, or has failed to meet any  
38 other requirement of this section, the administrative director may  
39 assess, by order, administrative penalties for each failure. A  
40 proceeding for the issuance of an order assessing administrative

1 ~~penalties shall be subject to appropriate notice to, and an~~  
2 ~~opportunity for a hearing with regard to, the person affected. The~~  
3 ~~administrative penalties shall not be deemed to be an exclusive~~  
4 ~~remedy for the administrative director. These penalties shall be~~  
5 ~~deposited in the Workers' Compensation Administration Revolving~~  
6 ~~Fund.~~

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MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1224  
**Author:** Hernandez  
**Bill Date:** June 26, 2007, amended  
**Subject:** Telemedicine: Optometrists  
**Sponsor:** California Optometric Association

**STATUS OF BILL:**

This bill was referred to the Senate Appropriations Committee and has not been set for hearing.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill, as introduced, would add optometrists to the list of health care professionals who are allowed to practice via telemedicine.

As amended, this bill defines collaborating optometrist for purposes of his or her participation in treating primary open angle glaucoma.

**ANALYSIS:**

The term “telemedicine” generally refers to the use of communications and information technologies for the delivery of clinical care. While traditional clinical care entails a face-to-face meeting between the health care provider and the patient, telemedicine allows long-distance meetings, especially with patients in underserved areas, increasing access to care. Telemedicine may be as simple as two health professionals discussing a case over the telephone (usually considered a consultation), or as complex as using satellite technology and video-conferencing equipment to conduct a real-time consultation between medical specialists and patients in two different countries.

Under current law, the health care providers who are allowed to practice telemedicine are physicians; dentists; podiatrists; psychologists; marriage and family therapists; and clinical social workers. This bill would add optometrists to the health care professionals allowed to practice via telemedicine.

The sponsor states that optometrists are now the first line of defense against debilitating eye disease; data show that seven out of 10 eye care patients visit an optometrist first, where threats to visual health and eyesight are first diagnosed. Advances in retinal photography and digital technology have made it possible to store retinal images and forward them electronically for remote diagnosis.

UC-Berkeley, through grants from the California Endowment, California Telemedicine and eHealth Center (CTEC), and California Health Care Foundation, has built a 13-clinic network that brings crucial diagnostic resources to at-risk Central Valley residents. AB 354/Cogdill (Stats. 2005, Chap. 449) amended California's Medi-Cal law to permit reimbursement for remote interpretation of images under this program. Nonetheless, these diagnoses by optometrists would not be eligible for payment from conventional coverage sources, because optometrists as a class are not included as defined "health care providers."

Chronic diseases, such as diabetes, have become a major health care issue and can cause significant complications, only one of which is eye disease. The goal of this bill is to increase access to care through implementation of new models to reach underserved populations.

The amendments to this bill define *collaborating ophthalmologist*, for purposes of the optometrist's participation in treating primary open angle glaucoma, as a physician who is licensed by the state and in the active practice of ophthalmology in the state..

**FISCAL:**                    There would be no fiscal impact to the Medical Board.

**POSITION:**                Support

July 16, 2007

AMENDED IN SENATE JUNE 26, 2007

AMENDED IN ASSEMBLY APRIL 10, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1224**

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**Introduced by Assembly Member Hernandez**

February 23, 2007

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An act to amend Sections ~~805~~ 2290.5 and 3041 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1224, as amended, Hernandez. Optometrists: ~~peer review process~~: telemedicine.

Existing law ~~provides for the professional review of specified healing arts licentiates, as defined, through a peer review process, the Optometry Practice Act, creates the State Board of Optometry that licenses optometrists and regulates their practice. The act defines the practice of optometry as including the treatment of primary open angle glaucoma with the participation, as specified, of a collaborating ophthalmologist.~~ Existing law, the Medical Practice Act, regulates the practice of telemedicine, defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. ~~Existing law requires that, prior to the delivery of health care via telemedicine, the, by a health care practitioner, as defined as a licentiate subject to the peer review process, who has ultimate authority over the care or primary diagnosis of the patient shall obtain verbal and written informed consent from the patient or the patient's legal representative. A violation of the provisions governing telemedicine is unprofessional conduct.~~



This bill would include *make* a licensed optometrist in the definition of licentiate, subject to the peer review process, and would make him or her a health care practitioner for purposes of the *subject to these* telemedicine provisions and would define collaborating ophthalmologist for purposes of his or her participation in treating primary open angle glaucoma.

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

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

1 SECTION 1. Section 805 of the Business and Professions Code  
2 is amended to read:

3 805. (a) As used in this section, the following terms have the  
4 following definitions:

5 (1) "Peer review body" includes:

6 (A) A medical or professional staff of any health care facility  
7 or clinic licensed under Division 2 (commencing with Section  
8 1200) of the Health and Safety Code or of a facility certified to  
9 participate in the federal Medicare Program as an ambulatory  
10 surgical center.

11 (B) A health care service plan registered under Chapter 2.2  
12 (commencing with Section 1340) of Division 2 of the Health and  
13 Safety Code or a disability insurer that contracts with licentiates  
14 to provide services at alternative rates of payment pursuant to  
15 Section 10133 of the Insurance Code.

16 (C) Any medical, psychological, marriage and family therapy,  
17 social work, dental, podiatric, or optometric professional society  
18 having as members at least 25 percent of the eligible licentiates in  
19 the area in which it functions (which must include at least one  
20 county), that is not organized for profit and that has been  
21 determined to be exempt from taxes pursuant to Section 23701 of  
22 the Revenue and Taxation Code.

23 (D) A committee organized by any entity consisting of or  
24 employing more than 25 licentiates of the same class that functions  
25 for the purpose of reviewing the quality of professional care  
26 provided by members or employees of that entity.

27 (2) "Licentiate" means a physician and surgeon, doctor of  
28 podiatric medicine, clinical psychologist, marriage and family  
29 therapist, clinical social worker, dentist, or optometrist. "Licentiate"

1 also includes a person authorized to practice medicine pursuant to  
2 Section 2113.

3 (3) “Agency” means the relevant state licensing agency having  
4 regulatory jurisdiction over the licentiates listed in paragraph (2).

5 (4) “Staff privileges” means any arrangement under which a  
6 licentiate is allowed to practice in or provide care for patients in  
7 a health facility. Those arrangements shall include, but are not  
8 limited to, full staff privileges, active staff privileges, limited staff  
9 privileges, auxiliary staff privileges, provisional staff privileges,  
10 temporary staff privileges, courtesy staff privileges, locum tenens  
11 arrangements, and contractual arrangements to provide professional  
12 services, including, but not limited to, arrangements to provide  
13 outpatient services.

14 (5) “Denial or termination of staff privileges, membership, or  
15 employment” includes failure or refusal to renew a contract or to  
16 renew, extend, or reestablish any staff privileges, if the action is  
17 based on medical disciplinary cause or reason.

18 (6) “Medical disciplinary cause or reason” means that aspect  
19 of a licentiate’s competence or professional conduct that is  
20 reasonably likely to be detrimental to patient safety or to the  
21 delivery of patient care.

22 (7) “805 report” means the written report required under  
23 subdivision (b).

24 (b) The chief of staff of a medical or professional staff or other  
25 chief executive officer, medical director, or administrator of any  
26 peer review body and the chief executive officer or administrator  
27 of any licensed health care facility or clinic shall file an 805 report  
28 with the relevant agency within 15 days after the effective date of  
29 any of the following that occur as a result of an action of a peer  
30 review body:

31 (1) A licentiate’s application for staff privileges or membership  
32 is denied or rejected for a medical disciplinary cause or reason.

33 (2) A licentiate’s membership, staff privileges, or employment  
34 is terminated or revoked for a medical disciplinary cause or reason.

35 (3) Restrictions are imposed, or voluntarily accepted, on staff  
36 privileges, membership, or employment for a cumulative total of  
37 30 days or more for any 12-month period, for a medical disciplinary  
38 cause or reason.

39 (c) The chief of staff of a medical or professional staff or other  
40 chief executive officer, medical director, or administrator of any

1 peer review body and the chief executive officer or administrator  
2 of any licensed health care facility or clinic shall file an 805 report  
3 with the relevant agency within 15 days after any of the following  
4 occur after notice of either an impending investigation or the denial  
5 or rejection of the application for a medical disciplinary cause or  
6 reason:

7 (1) Resignation or leave of absence from membership, staff, or  
8 employment.

9 (2) The withdrawal or abandonment of a licentiate's application  
10 for staff privileges or membership.

11 (3) The request for renewal of those privileges or membership  
12 is withdrawn or abandoned.

13 (d) For purposes of filing an 805 report, the signature of at least  
14 one of the individuals indicated in subdivision (b) or (c) on the  
15 completed form shall constitute compliance with the requirement  
16 to file the report.

17 (e) An 805 report shall also be filed within 15 days following  
18 the imposition of summary suspension of staff privileges;  
19 membership, or employment, if the summary suspension remains  
20 in effect for a period in excess of 14 days.

21 (f) A copy of the 805 report, and a notice advising the licentiate  
22 of his or her right to submit additional statements or other  
23 information pursuant to Section 800, shall be sent by the peer  
24 review body to the licentiate named in the report.

25 The information to be reported in an 805 report shall include the  
26 name and license number of the licentiate involved, a description  
27 of the facts and circumstances of the medical disciplinary cause  
28 or reason, and any other relevant information deemed appropriate  
29 by the reporter.

30 A supplemental report shall also be made within 30 days  
31 following the date the licentiate is deemed to have satisfied any  
32 terms, conditions, or sanctions imposed as disciplinary action by  
33 the reporting peer review body. In performing its dissemination  
34 functions required by Section 805.5, the agency shall include a  
35 copy of a supplemental report, if any, whenever it furnishes a copy  
36 of the original 805 report.

37 If another peer review body is required to file an 805 report, a  
38 health care service plan is not required to file a separate report  
39 with respect to action attributable to the same medical disciplinary  
40 cause or reason. If the Medical Board of California or a licensing

1 agency of another state revokes or suspends, without a stay, the  
2 license of a physician and surgeon, a peer review body is not  
3 required to file an 805 report when it takes an action as a result of  
4 the revocation or suspension.

5 (g) The reporting required by this section shall not act as a  
6 waiver of confidentiality of medical records and committee reports.  
7 The information reported or disclosed shall be kept confidential  
8 except as provided in subdivision (e) of Section 800 and Sections  
9 803.1 and 2027, provided that a copy of the report containing the  
10 information required by this section may be disclosed as required  
11 by Section 805.5 with respect to reports received on or after  
12 January 1, 1976.

13 (h) The Medical Board of California, the Osteopathic Medical  
14 Board of California, and the Dental Board of California shall  
15 disclose reports as required by Section 805.5.

16 (i) An 805 report shall be maintained by an agency for  
17 dissemination purposes for a period of three years after receipt.

18 (j) No person shall incur any civil or criminal liability as the  
19 result of making any report required by this section.

20 (k) A willful failure to file an 805 report by any person who is  
21 designated or otherwise required by law to file an 805 report is  
22 punishable by a fine not to exceed one hundred thousand dollars  
23 (\$100,000) per violation. The fine may be imposed in any civil or  
24 administrative action or proceeding brought by or on behalf of any  
25 agency having regulatory jurisdiction over the person regarding  
26 whom the report was or should have been filed. If the person who  
27 is designated or otherwise required to file an 805 report is a  
28 licensed physician and surgeon, the action or proceeding shall be  
29 brought by the Medical Board of California. The fine shall be paid  
30 to that agency but not expended until appropriated by the  
31 Legislature. A violation of this subdivision may constitute  
32 unprofessional conduct by the licensee. A person who is alleged  
33 to have violated this subdivision may assert any defense available  
34 at law. As used in this subdivision, "willful" means a voluntary  
35 and intentional violation of a known legal duty.

36 (l) Except as otherwise provided in subdivision (k), any failure  
37 by the administrator of any peer review body, the chief executive  
38 officer or administrator of any health care facility, or any person  
39 who is designated or otherwise required by law to file an 805  
40 report, shall be punishable by a fine that under no circumstances

1 shall exceed fifty thousand dollars (\$50,000) per violation. The  
2 fine may be imposed in any civil or administrative action or  
3 proceeding brought by or on behalf of any agency having  
4 regulatory jurisdiction over the person regarding whom the report  
5 was or should have been filed. If the person who is designated or  
6 otherwise required to file an 805 report is a licensed physician and  
7 surgeon, the action or proceeding shall be brought by the Medical  
8 Board of California. The fine shall be paid to that agency but not  
9 expended until appropriated by the Legislature. The amount of the  
10 fine imposed, not exceeding fifty thousand dollars (\$50,000) per  
11 violation, shall be proportional to the severity of the failure to  
12 report and shall differ based upon written findings, including  
13 whether the failure to file caused harm to a patient or created a  
14 risk to patient safety; whether the administrator of any peer review  
15 body, the chief executive officer or administrator of any health  
16 care facility, or any person who is designated or otherwise required  
17 by law to file an 805 report exercised due diligence despite the  
18 failure to file or whether they knew or should have known that an  
19 805 report would not be filed; and whether there has been a prior  
20 failure to file an 805 report. The amount of the fine imposed may  
21 also differ based on whether a health care facility is a small or  
22 rural hospital as defined in Section 124840 of the Health and Safety  
23 Code.

24 (m) A health care service plan registered under Chapter 2.2  
25 (commencing with Section 1340) of Division 2 of the Health and  
26 Safety Code or a disability insurer that negotiates and enters into  
27 a contract with licentiates to provide services at alternative rates  
28 of payment pursuant to Section 10133 of the Insurance Code, when  
29 determining participation with the plan or insurer, shall evaluate,  
30 on a case-by-case basis, licentiates who are the subject of an 805  
31 report, and not automatically exclude or deselect these licentiates.

32 *SECTION 1. Section 2290.5 of the Business and Professions*  
33 *Code is amended to read:*

34 2290.5. (a) (1) For the purposes of this section, “telemedicine”  
35 means the practice of health care delivery, diagnosis, consultation,  
36 treatment, transfer of medical data, and education using interactive  
37 audio, video, or data communications. Neither a telephone  
38 conversation nor an electronic mail message between a health care  
39 practitioner and patient constitutes “telemedicine” for purposes of  
40 this section.

1 (2) For purposes of this section, “interactive” means an audio,  
2 video, or data communication involving a real time (synchronous)  
3 or near real time (asynchronous) two-way transfer of medical data  
4 and information.

5 (b) For the purposes of this section, “health care practitioner”  
6 has the same meaning as “licentiate” as defined in paragraph (2)  
7 of subdivision (a) of Section 805 *and also includes a person*  
8 *licensed as an optometrist pursuant to Chapter 7 (commencing*  
9 *with Section 3000).*

10 (c) Prior to the delivery of health care via telemedicine, the  
11 health care practitioner who has ultimate authority over the care  
12 or primary diagnosis of the patient shall obtain verbal and written  
13 informed consent from the patient or the patient’s legal  
14 representative. The informed consent procedure shall ensure that  
15 at least all of the following information is given to the patient or  
16 the patient’s legal representative verbally and in writing:

17 (1) The patient or the patient’s legal representative retains the  
18 option to withhold or withdraw consent at any time without  
19 affecting the right to future care or treatment nor risking the loss  
20 or withdrawal of any program benefits to which the patient or the  
21 patient’s legal representative would otherwise be entitled.

22 (2) A description of the potential risks, consequences, and  
23 benefits of telemedicine.

24 (3) All existing confidentiality protections apply.

25 (4) All existing laws regarding patient access to medical  
26 information and copies of medical records apply.

27 (5) Dissemination of any patient identifiable images or  
28 information from the telemedicine interaction to researchers or  
29 other entities shall not occur without the consent of the patient.

30 (d) A patient or the patient’s legal representative shall sign a  
31 written statement prior to the delivery of health care via  
32 telemedicine, indicating that the patient or the patient’s legal  
33 representative understands the written information provided  
34 pursuant to subdivision (a), and that this information has been  
35 discussed with the health care practitioner, or his or her designee.

36 (e) The written consent statement signed by the patient or the  
37 patient’s legal representative shall become part of the patient’s  
38 medical record.

1 (f) The failure of a health care practitioner to comply with this  
2 section shall constitute unprofessional conduct. Section 2314 shall  
3 not apply to this section.

4 (g) All existing laws regarding surrogate decisionmaking shall  
5 apply. For purposes of this section, “surrogate decisionmaking”  
6 means any decision made in the practice of medicine by a parent  
7 or legal representative for a minor or an incapacitated or  
8 incompetent individual.

9 (h) Except as provided in paragraph (3) of subdivision (c), this  
10 section shall not apply when the patient is not directly involved in  
11 the telemedicine interaction, for example when one health care  
12 practitioner consults with another health care practitioner.

13 (i) This section shall not apply in an emergency situation in  
14 which a patient is unable to give informed consent and the  
15 representative of that patient is not available in a timely manner.

16 (j) This section shall not apply to a patient under the jurisdiction  
17 of the Department of Corrections or any other correctional facility.

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

22 SEC. 2. Section 3041 of the Business and Professions Code is  
23 amended to read:

24 3041. (a) The practice of optometry includes the prevention  
25 and diagnosis of disorders and dysfunctions of the visual system,  
26 and the treatment and management of certain disorders and  
27 dysfunctions of the visual system, as well as the provision of  
28 rehabilitative optometric services, and is the doing of any or all of  
29 the following:

30 (1) The examination of the human eye or eyes, or its or their  
31 appendages, and the analysis of the human vision system, either  
32 subjectively or objectively.

33 (2) The determination of the powers or range of human vision  
34 and the accommodative and refractive states of the human eye or  
35 eyes, including the scope of its or their functions and general  
36 condition.

37 (3) The prescribing or directing the use of, or using, any optical  
38 device in connection with ocular exercises, visual training, vision  
39 training, or orthoptics.

1 (4) The prescribing of contact and spectacle lenses for, or the  
2 fitting or adaptation of contact and spectacle lenses to, the human  
3 eye, including lenses which may be classified as drugs or devices  
4 by any law of the United States or of this state.

5 (5) The use of topical pharmaceutical agents for the sole purpose  
6 of the examination of the human eye or eyes for any disease or  
7 pathological condition. The topical pharmaceutical agents shall  
8 include mydriatics, cycloplegics, anesthetics, and agents for the  
9 reversal of mydriasis.

10 (b) (1) An optometrist who is certified to use therapeutic  
11 pharmaceutical agents, pursuant to Section 3041.3, may also  
12 diagnose and exclusively treat the human eye or eyes, or any of  
13 its appendages, for all of the following conditions:

14 (A) Through medical treatment, infections of the anterior  
15 segment and adnexa, excluding the lacrimal gland, the lacrimal  
16 drainage system and the sclera. Nothing in this section shall  
17 authorize any optometrist to treat a person with AIDS for ocular  
18 infections.

19 (B) Ocular allergies of the anterior segment and adnexa.

20 (C) Ocular inflammation, nonsurgical in cause, limited to  
21 inflammation resulting from traumatic iritis, peripheral corneal  
22 inflammatory keratitis, episcleritis, and unilateral nonrecurrent  
23 nongranulomatous idiopathic iritis in patients ~~over the age of 18~~  
24 *18 years of age*. Unilateral nongranulomatous idiopathic iritis  
25 recurring within one year of the initial occurrence shall be referred  
26 to an ophthalmologist. An optometrist shall consult with an  
27 ophthalmologist if a patient has a recurrent case of episcleritis  
28 within one year of the initial occurrence. An optometrist shall  
29 consult with an ophthalmologist if a patient has a recurrent case  
30 of peripheral corneal inflammatory keratitis within one year of the  
31 initial occurrence.

32 (D) Traumatic or recurrent conjunctival or corneal abrasions  
33 and erosions.

34 (E) Corneal surface disease and dry eyes.

35 (F) Ocular pain, not related to surgery, associated with  
36 conditions optometrists are authorized to treat.

37 (G) Pursuant to subdivision (f), primary open angle glaucoma  
38 in patients ~~over the age of 18~~ *18 years of age*.



1 (2) For purposes of this section, “treat” means the use of  
2 therapeutic pharmaceutical agents, as described in subdivision (c),  
3 and the procedures described in subdivision (e).

4 (c) In diagnosing and treating the conditions listed in subdivision  
5 (b), an optometrist certified to use therapeutic pharmaceutical  
6 agents pursuant to Section 3041.3, may use all of the following  
7 therapeutic pharmaceutical agents exclusively:

8 (1) All of the topical pharmaceutical agents listed in paragraph  
9 (5) of subdivision (a) as well as topical miotics for diagnostic  
10 purposes.

11 (2) Topical lubricants.

12 (3) Topical antiallergy agents. In using topical steroid  
13 medication for the treatment of ocular allergies, an optometrist  
14 shall do the following:

15 (A) Consult with an ophthalmologist if the patient’s condition  
16 worsens 72 hours after diagnosis.

17 (B) Consult with an ophthalmologist if the inflammation is still  
18 present three weeks after diagnosis.

19 (C) Refer the patient to an ophthalmologist if the patient is still  
20 on the medication six weeks after diagnosis.

21 (D) Refer the patient to an ophthalmologist if the patient’s  
22 condition recurs within three months.

23 (4) Topical antiinflammatories. In using topical steroid  
24 medication for:

25 (A) Unilateral nonrecurrent nongranulomatous idiopathic iritis  
26 or episcleritis, an optometrist shall consult with an ophthalmologist  
27 if the patient’s condition worsens 72 hours after the diagnosis, or  
28 if the patient’s condition has not resolved three weeks after  
29 diagnosis. If the patient is still receiving medication for these  
30 conditions six weeks after diagnosis, the optometrist shall refer  
31 the patient to an ophthalmologist.

32 (B) Peripheral corneal inflammatory keratitis, excluding  
33 Moorens and Terriens diseases, an optometrist shall consult with  
34 an ophthalmologist if the patient’s condition worsens 48 hours  
35 after diagnosis. If the patient is still receiving the medication two  
36 weeks after diagnosis, the optometrist shall refer the patient to an  
37 ophthalmologist.

38 (C) Traumatic iritis, an optometrist shall consult with an  
39 ophthalmologist if the patient’s condition worsens 72 hours after

1 diagnosis and shall refer the patient to an ophthalmologist if the  
2 patient's condition has not resolved one week after diagnosis.

3 (5) Topical antibiotic agents.

4 (6) Topical hyperosmotics.

5 (7) Topical antiglaucoma agents pursuant to the certification  
6 process defined in subdivision (f).

7 (A) The optometrist shall not use more than two concurrent  
8 topical medications in treating the patient for primary open angle  
9 glaucoma. A single combination medication that contains two  
10 pharmacological agents shall be considered as two medications.

11 (B) The optometrist shall refer the patient to an ophthalmologist  
12 if requested by the patient, if treatment goals are not achieved with  
13 the use of two topical medications or if indications of narrow angle  
14 or secondary glaucoma develop.

15 (C) If the glaucoma patient also has diabetes, the optometrist  
16 shall consult in writing with the physician treating the patient's  
17 diabetes in developing the glaucoma treatment plan and shall notify  
18 the physician in writing of any changes in the patient's glaucoma  
19 medication. The physician shall provide written confirmation of  
20 those consultations and notifications.

21 (8) Nonprescription medications used for the rational treatment  
22 of an ocular disorder.

23 (9) Oral antihistamines. In using oral antihistamines for the  
24 treatment of ocular allergies, the optometrist shall refer the patient  
25 to an ophthalmologist if the patient's condition has not resolved  
26 two weeks after diagnosis.

27 (10) Prescription oral nonsteroidal antiinflammatory agents.  
28 The agents shall be limited to three days' use. If the patient's  
29 condition has not resolved three days after diagnosis, the  
30 optometrist shall refer the patient to an ophthalmologist.

31 (11) The following oral antibiotics for medical treatment as set  
32 forth in subparagraph (A) of paragraph (1) of subdivision (b):  
33 tetracyclines, dicloxacillin, amoxicillin, amoxicillin with  
34 clavulanate, erythromycin, clarythromycin, cephalexin,  
35 cephadroxil, cefaclor, trimethoprim with sulfamethoxazole,  
36 ciprofloxacin, and azithromycin. The use of azithromycin shall be  
37 limited to the treatment of eyelid infections and chlamydial disease  
38 manifesting in the eyes.

39 (A) If the patient has been diagnosed with a central corneal ulcer  
40 and the condition has not improved 24 hours after diagnosis, the

1 optometrist shall consult with an ophthalmologist. If the central  
2 corneal ulcer has not improved 48 hours after diagnosis, the  
3 optometrist shall refer the patient to an ophthalmologist. If the  
4 patient is still receiving antibiotics 10 days after diagnosis, the  
5 optometrist shall refer the patient to an ophthalmologist.

6 (B) If the patient has been diagnosed with preseptal cellulitis  
7 or dacryocystitis and the condition has not improved 72 hours after  
8 diagnosis, the optometrist shall refer the patient to an  
9 ophthalmologist. If a patient with preseptal cellulitis or  
10 dacryocystitis is still receiving oral antibiotics 10 days after  
11 diagnosis, the optometrist shall refer the patient to an  
12 ophthalmologist.

13 (C) If the patient has been diagnosed with blepharitis and the  
14 patient's condition does not improve after six weeks of treatment,  
15 the optometrist shall consult with an ophthalmologist.

16 (D) For the medical treatment of all other medical conditions  
17 as set forth in subparagraph (A) of paragraph (1) of subdivision  
18 (b), if the patient's condition worsens 72 hours after diagnosis, the  
19 optometrist shall consult with an ophthalmologist. If the patient's  
20 condition has not resolved 10 days after diagnosis, the optometrist  
21 shall refer the patient to an ophthalmologist.

22 (12) Topical antiviral medication and oral acyclovir for the  
23 medical treatment of the following: herpes simplex viral keratitis,  
24 herpes simplex viral conjunctivitis, and periocular herpes simplex  
25 viral dermatitis; and varicella zoster viral keratitis, varicella zoster  
26 viral conjunctivitis, and periocular varicella zoster viral dermatitis.

27 (A) If the patient has been diagnosed with herpes simplex  
28 keratitis or varicella zoster viral keratitis and the patient's condition  
29 has not improved seven days after diagnosis, the optometrist shall  
30 refer the patient to an ophthalmologist. If a patient's condition has  
31 not resolved three weeks after diagnosis, the optometrist shall refer  
32 the patient to an ophthalmologist.

33 (B) If the patient has been diagnosed with herpes simplex viral  
34 conjunctivitis, herpes simplex viral dermatitis, varicella zoster  
35 viral conjunctivitis, or varicella zoster viral dermatitis, and if the  
36 patient's condition worsens seven days after diagnosis, the  
37 optometrist shall consult with an ophthalmologist. If the patient's  
38 condition has not resolved three weeks after diagnosis, the  
39 optometrist shall refer the patient to an ophthalmologist.

1 (C) In all cases, the use of topical antiviral medication shall be  
2 limited to three weeks, and the use of oral acyclovir shall be limited  
3 to 10 days.

4 (13) Oral analgesics that are not controlled substances.

5 (14) Codeine with compounds and hydrocodone with  
6 compounds as listed in the California Uniform Controlled  
7 Substances Act (Section 11000 of the Health and Safety Code et  
8 seq.) and the United States Uniform Controlled Substances Act  
9 (21 U.S.C. Sec. 801 et seq.). The use of these agents shall be  
10 limited to three days, with a referral to an ophthalmologist if the  
11 pain persists.

12 (d) In any case where this chapter requires that an optometrist  
13 consult with an ophthalmologist, the optometrist shall maintain a  
14 written record in the patient's file of the information provided to  
15 the ophthalmologist, the ophthalmologist's response and any other  
16 relevant information. Upon the consulting ophthalmologist's  
17 request, the optometrist shall furnish a copy of the record to the  
18 ophthalmologist.

19 (e) An optometrist who is certified to use therapeutic  
20 pharmaceutical agents pursuant to Section 3041.3 may also perform  
21 all of the following:

22 (1) Mechanical epilation.

23 (2) Ordering of smears, cultures, sensitivities, complete blood  
24 count, mycobacterial culture, acid fast stain, and urinalysis.

25 (3) Punctal occlusion by plugs, excluding laser, cautery,  
26 diathermy, cryotherapy, or other means constituting surgery as  
27 defined in this chapter.

28 (4) The prescription of therapeutic contact lenses.

29 (5) Removal of foreign bodies ~~of~~ from the cornea, eyelid, and  
30 conjunctiva. Corneal foreign bodies shall be nonperforating, be  
31 no deeper than the anterior stroma, and require no surgical repair  
32 upon removal. Within the central three millimeters of the cornea,  
33 the use of sharp instruments is prohibited.

34 (6) For patients ~~over the age of 12 years~~ 12 years of age, lacrimal  
35 irrigation and dilation, excluding probing of the nasal lacrimal  
36 tract. The State Board of Optometry shall certify an optometrist  
37 to perform this procedure after completing 10 of the procedures  
38 under the supervision of an ophthalmologist as confirmed by the  
39 ophthalmologist.

1 (7) No injections other than the use of an auto-injector to counter  
2 anaphylaxis.

3 (f) The State Board of Optometry shall grant a certificate to an  
4 optometrist certified pursuant to Section 3041.3 for the treatment  
5 of primary open angle glaucoma in patients ~~over the age of 18~~ 18  
6 *years of age* only after the optometrist meets the following  
7 requirements:

8 (1) Satisfactory completion of a didactic course of not less than  
9 24 hours in the diagnosis, pharmacological and other treatment  
10 and management of glaucoma. The 24-hour glaucoma curriculum  
11 shall be developed by an accredited California school of optometry.  
12 Any applicant who graduated from an accredited California school  
13 of optometry on or after May 1, 2000, shall be exempt from the  
14 24-hour didactic course requirement contained in this paragraph.

15 (2) After completion of the requirement contained in paragraph  
16 (1), collaborative treatment of 50 glaucoma patients for a period  
17 of two years for each patient under the following terms:

18 (A) After the optometrist makes a provisional diagnosis of  
19 glaucoma, the optometrist and the patient shall identify a  
20 collaborating ophthalmologist.

21 (B) The optometrist shall develop a treatment plan that considers  
22 for each patient target intraocular pressures, optic nerve appearance  
23 and visual field testing for each eye, and an initial proposal for  
24 therapy.

25 (C) The optometrist shall transmit relevant information from  
26 the examination and history taken of the patient along with the  
27 treatment plan to the collaborating ophthalmologist. The  
28 collaborating ophthalmologist shall confirm or refute the glaucoma  
29 diagnosis within 30 days. To accomplish this, the collaborating  
30 ophthalmologist shall perform a physical examination of the  
31 patient.

32 (D) Once the collaborating ophthalmologist confirms the  
33 diagnosis and approves the treatment plan in writing, the  
34 optometrist may begin treatment.

35 (E) The optometrist shall use no more than two concurrent  
36 topical medications in treating the patient for glaucoma. A single  
37 combination medication that contains two pharmacologic agents  
38 shall be considered as two medications. The optometrist shall  
39 notify the collaborating ophthalmologist in writing if there is any  
40 change in the medication used to treat the patient for glaucoma.

1 (F) Annually after commencing treatment, the optometrist shall  
2 provide a written report to the collaborating ophthalmologist about  
3 the achievement of goals contained in the treatment plan. The  
4 collaborating ophthalmologist shall acknowledge receipt of the  
5 report in writing to the optometrist within 10 days.

6 (G) The optometrist shall refer the patient to an ophthalmologist  
7 if requested by the patient, if treatment goals are not achieved with  
8 the use of two topical medications, or if indications of secondary  
9 glaucoma develop. At his or her discretion, the collaborating  
10 ophthalmologist may periodically examine the patient.

11 (H) If the glaucoma patient also has diabetes, the optometrist  
12 shall consult in writing with the physician treating the patient's  
13 diabetes in preparation of the treatment plan and shall notify the  
14 physician in writing if there is any change in the patient's glaucoma  
15 medication. The physician shall provide written confirmation of  
16 the consultations and notifications.

17 (I) The optometrist shall provide the following information to  
18 the patient in writing: nature of the working or suspected diagnosis,  
19 consultation evaluation by a collaborating ophthalmologist,  
20 treatment plan goals, expected followup care, and a description of  
21 the referral requirements. The document containing the information  
22 shall be signed and dated by both the optometrist and the  
23 ophthalmologist and maintained in their files.

24 (3) When the requirements contained in paragraphs (1) and (2)  
25 have been satisfied, the optometrist shall submit proof of  
26 completion to the State Board of Optometry and apply for a  
27 certificate to treat primary open angle glaucoma. That proof shall  
28 include corroborating information from the collaborating  
29 ophthalmologist. If the ophthalmologist fails to respond within 60  
30 days of a request for information from the State Board of  
31 Optometry, the board may act on the optometrist's application  
32 without that corroborating information.

33 (4) After an optometrist has treated a total of 50 patients for a  
34 period of two years each and has received certification from the  
35 State Board of Optometry, the optometrist may treat the original  
36 50 collaboratively treated patients independently, with the written  
37 consent of the patient. However, any glaucoma patients seen by  
38 the optometrist before the two-year period has expired for each of  
39 the 50 patients shall be treated under the collaboration protocols  
40 described in this section.

1 (5) For purposes of this subdivision, "collaborating  
2 ophthalmologist" means a physician and surgeon who is licensed  
3 by the state and in the active practice of ophthalmology in this  
4 state.

5 (g) Notwithstanding any other provision of law, an optometrist  
6 shall not treat children under one year of age with therapeutic  
7 pharmaceutical agents.

8 (h) Any dispensing of a therapeutic pharmaceutical agent by an  
9 optometrist shall be without charge.

10 (i) Notwithstanding any other provision of law, the practice of  
11 optometry does not include performing surgery. "Surgery" means  
12 any procedure in which human tissue is cut, altered, or otherwise  
13 infiltrated by mechanical or laser means in a manner not  
14 specifically authorized by this chapter. Nothing in the act amending  
15 this section shall limit an optometrist's authority, as it existed prior  
16 to the effective date of the act amending this section, to utilize  
17 diagnostic laser and ultrasound technology.

18 (j) All collaborations, consultations, and referrals made by an  
19 optometrist pursuant to this section shall be to an ophthalmologist  
20 located geographically appropriate to the patient.

21 (k) An optometrist licensed under this chapter is ~~a licentiate for~~  
22 ~~purposes of paragraph (2) of subdivision (a) of Section 805, and,~~  
23 ~~thus, is a health care practitioner subject to the provisions of~~  
24 ~~Section 2290.5 pursuant to subdivision (b) of that section. subject~~  
25 ~~to the provisions of Section 2290.5 for purposes of practicing~~  
26 ~~telemedicine.~~

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 102  
**Author:** Migden  
**Bill Date:** June 7, 2007, as amended  
**Subject:** Blood Transfusions  
**Sponsor:** Author

**STATUS OF BILL:**

This bill was referred to the Senate Special Consent Calendar for concurrence with Assembly amendments and was enrolled to the Governor on July 12, 2007.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would allow a registered nurse or physician's assistant acting under the supervision of a physician to provide a patient with the written summary of the risks associated with blood transfusions, prior to the performance of a blood transfusion. The registered nurse or physician's assistant would be required to make that notation on the medical record that this information had been provided and by whom.

This bill has been amended to include a doctor of podiatric medicine as a professional who may have standardized written procedures allowing a registered nurse or a physician assistant to provide the written summary.

**ANALYSIS:**

Under the Paul Gann Blood Safety Act, when a physician determines that a blood transfusion may be necessary as a result of a medical procedure, the physician is required to inform the patient of the risks associated with receiving a blood transfusion. The physician is required to provide the patient with a document, developed by the Department of Health Services and distributed by the California Medical Board, summarizing those risks.

The Gann Act, which became law in 1990, was proposed in response to patients contracting HIV from blood transfusions in the late 1980's. The law was designed to ensure that patients knew of the infectious risks associated with receiving blood from volunteers. As a result of dramatic advances in the effectiveness of blood screening technology in recent years, the likelihood of a patient contracting HIV or other infectious diseases from a blood transfusion is very small. Some in the medical community have expressed concern that restricting a physician to those authorized to provide the required blood transfusion risk information to patients is not conducive to current medical practices, and is unnecessary considering the reduced risks. Expanding



the individuals authorized to obtain patient consent to include medical professionals such as registered nurses and physician's assistants, whom according to the nursing board, are already authorized to perform a blood transfusion, brings the Gann Act more in line with modern medical practices while still ensuring patients are informed about the risks and benefits associated with blood transfusions. The author intends to amend this bill to include nursing practitioners and nursing midwives.

As amended on March 29, 2007, the bill expands the list of health care providers who may provide the written summary about the positive and negative aspects of receiving blood transfusions; in addition to the physician and surgeon (as allowed by current law), other licensed health care providers who could inform the patient would include nurse practitioners, certified nurse midwives, and physician assistants. The bill also makes conforming changes in other sections. There was concern that these amendments were too broad in giving authority to non-physicians.

Under current law, the Medical Board of California shall publish the standardized written summary about blood transfusions as prepared by the State Department of Public Health and shall distribute copies thereof, upon request, to physicians and surgeons. The March 29, 2007 amendments require, in conjunction with the Board of Registered Nursing, distribution to the health care professionals being added to the law, as described in the previous paragraph.

The amendments of April 12, 2007 again place the responsibility of informing patients about the positive and negative aspects of receiving blood transfusions back on the physician; however, this may now be done directly by the physician or through the nurse practitioners, certified nurse midwives, and physician assistants. The amendment ensures consumer protection oversight. Other conforming changes are made. In regards to the standardized written summary about transfusions, the amendments only require distribution to physicians, but also allow the Medical Board to place the document on its web site. This will allow physicians or the health care extenders to obtain the summary off the web instead of placing an order and paying for the summary.

The amendments of June 7, 2007 include a doctor of podiatric medicine as a professional who may have standardized written procedures allowing a registered nurse or a physician assistant to provide the written summary.

**FISCAL:**               None

**POSITION:**           Support

July 6, 2007

## CHAPTER \_\_\_\_\_

An act to amend Section 1645 of the Health and Safety Code, relating to blood transfusions.

## LEGISLATIVE COUNSEL'S DIGEST

SB 102, Migden. Blood transfusions.

Existing law requires, whenever there is a reasonable possibility, as determined by a physician, that a blood transfusion may be necessary as a result of a medical procedure, that the physician, by means of a standardized written summary that is published by the Medical Board of California and distributed upon request, inform the patient of the positive and negative aspects of receiving autologous blood and directed and nondirected homologous blood from volunteers.

This bill would also include a doctor of podiatric medicine within the scope of these requirements. It would require the information to be given by the physician or doctor of podiatric medicine, directly or through a nurse practitioner, certified nurse midwife, or physician assistant, authorized to order a blood transfusion.

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

SECTION 1. Section 1645 of the Health and Safety Code is amended to read:

1645. (a) Whenever there is a reasonable possibility, as determined by a physician and surgeon or doctor of podiatric medicine, that a blood transfusion may be necessary as a result of a medical or surgical procedure, the physician and surgeon or doctor of podiatric medicine, by means of a standardized written summary as most recently developed or revised by the State Department of Public Health pursuant to subdivision (e), shall inform, either directly or through a nurse practitioner, certified nurse midwife, or a physician assistant, who is licensed in the state and authorized to order a blood transfusion, the patient of the positive and negative aspects of receiving autologous blood and directed and nondirected homologous blood from volunteers. For purposes of this section, the term "autologous blood" includes, but

is not limited to, predonation, intraoperative autologous transfusion, plasmapheresis, and hemodilution.

(b) The person who provided the patient with the standardized written summary pursuant to subdivision (a) shall note on the patient's medical record that the standardized written summary was given to the patient.

(c) Subdivisions (a) and (b) shall not apply when medical contraindications or a life-threatening emergency exists.

(d) When there is no life-threatening emergency and there are no medical contraindications, the physician and surgeon or doctor of podiatric medicine shall allow adequate time prior to the procedure for predonation to occur. Notwithstanding this chapter, if a patient waives allowing adequate time prior to the procedure for predonation to occur, a physician and surgeon or doctor of podiatric medicine shall not incur any liability for his or her failure to allow adequate time prior to the procedure for predonation to occur.

(e) The State Department of Public Health shall develop and annually review, and if necessary revise, a standardized written summary which explains the advantages, disadvantages, risks, and descriptions of autologous blood, and directed and nondirected homologous blood from volunteer donors. These blood options shall include, but not be limited to, the blood options described in subdivision (a). The summary shall be written so as to be easily understood by a layperson.

(f) The Medical Board of California shall publish the standardized written summary prepared pursuant to subdivision (e) by the State Department of Public Health and shall distribute copies thereof, upon request, to physicians and surgeons and doctors of podiatric medicine. The Medical Board of California shall make the summary available for a fee not exceeding in the aggregate the actual costs to the State Department of Public Health and the Medical Board of California for developing, updating, publishing and distributing the summary. Physicians and surgeons and doctors of podiatric medicine shall purchase the written summary from the Medical Board of California for, or purchase or otherwise receive the written summary from the Web site of the board or any other entity for, distribution to their patients as specified in subdivision (a). Clinics, health facilities, and blood collection centers may purchase the summary if they desire.

(g) Any entity may reproduce the written summary prepared pursuant to subdivision (e) by the State Department of Public Health and distribute the written summary to physicians and surgeons and doctors of podiatric medicine.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 472  
**Author:** Corbett  
**Bill Date:** June 20, 2007, as amended  
**Subject:** Prescription drug labeling requirements  
**Sponsor:** Author

**STATUS OF BILL:**

This bill has been referred to the Senate Appropriations Committee and has not been set for hearing.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill, as amended, would require the State Board of Pharmacy to promulgate regulations that require a standardized, patient-centered, prescription drug label on all prescription medication dispensed to patients in California. The board would be required to hold special statewide public meetings in order to seek information from certain groups, and would be required to consider specified factors in developing the label requirements.

The bill would require the Board of Pharmacy to report to the Legislature on or before January 1, 2010, on its progress at the time of the report, and to report to the Legislature on or before January 1, 2013, on the status of implementation of the requirements.

**ANALYSIS:**

Under current law, pharmacists must dispense a prescription in a container that meets certain labeling requirements. This bill would require the Board of Pharmacy to promulgate regulations that require a standardized, patient-centered, prescription drug label on all prescription medication dispensed to patients in California. The Board would be required to hold special public meetings statewide in order to seek information from certain groups, and would be required to consider specified factors in developing the label requirements.

This bill would require the Board to report to the Legislature on or before January 1, 2010, on its progress at the time of the report, and to report to the Legislature on or before January 1, 2013, on the status of implementation of the requirements.

This bill may be one step behind AB 1276 which requires that the prescriber ask the patient if he or she wants the purpose of the prescription on the label. The regulations

could include a requirement for a space for the purpose of the drug, but this bill does not require the prescriber to include the purpose.

**FISCAL:**           None

**POSITION:**           Support

July 16, 2007

AMENDED IN ASSEMBLY JUNE 20, 2007

AMENDED IN SENATE MAY 21, 2007

AMENDED IN SENATE APRIL 30, 2007

AMENDED IN SENATE APRIL 16, 2007

AMENDED IN SENATE APRIL 9, 2007

## SENATE BILL

No. 472

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Introduced by Senator Corbett

February 21, 2007

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An act to add Section 4076.5 to the Business and Professions Code, relating to pharmacy.

### LEGISLATIVE COUNSEL'S DIGEST

SB 472, as amended, Corbett. Prescription drugs: labeling ~~requirements and panel requirements.~~

Existing law, the Pharmacy Law, provides for the licensure and regulation of the practice of pharmacy by the California State Board of Pharmacy in the Department of Consumer Affairs. Existing law prohibits a pharmacist from dispensing a prescription, except in a container that meets certain labeling requirements.

This bill would require the board to ~~convene a prescription drug label panel, with specified membership, for purposes of reviewing and making recommendations on a standard format for the labeling of prescription drug containers dispensed in the state that is affordable for pharmacies. The bill would require the panel to make a recommendation for a standardized prescription drug container label to the board on or before October 31, 2008, would require the board to promulgate regulations establishing requirements for a mandatory standardized label for~~

~~prescription drug containers within 90 days of receiving the panel's recommendation, and would require specified pharmacies in the state to begin using the standardized labels within 90 days of the effective date of the regulations. The bill would require that pharmacy consultations by a telephonic translation service be available to patients with limited English language proficiency, and that pharmacies be authorized to issue translated prescription drug labels, as specified promulgate regulations that require, on or before January 1, 2011, a standardized, patient-centered, prescription drug label on all prescription medication dispensed to patients in California. The bill would require the board to hold special public meetings statewide in order to seek information from certain groups, and would require the board to consider specified factors in developing the label requirements. The bill would require the board to report to the Legislature on or before January 1, 2010, on its progress at the time of the report, and to report to the Legislature on or before January 1, 2013, on the status of implementation of the requirements.~~

Because a knowing violation of the Pharmacy Law constitutes a crime, and because the above-described provisions would impose additional duties under that law, this bill would impose a state-mandated local program.

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

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

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

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

- 1 SECTION 1. This act shall be known and may be cited as the
- 2 California Patient Medication Safety Act.
- 3 SEC. 2. The Legislature hereby finds and declares all of the
- 4 following:
- 5 (a) Health care costs and spending in California are rising
- 6 dramatically and are expected to continue to increase.
- 7 (b) In California, prescription drug spending totaled over \$188
- 8 billion in 2004, a \$14 billion dollar per year spending increase
- 9 from 1984.



1 (c) Prescription drug cost continues to be among the most  
2 significant cost factors in California's overall spending on health  
3 care.

4 (d) According to the Institution of Medicine of the National  
5 Academies, medication errors are among the most common medical  
6 errors, harming at least 1.5 million people every year.

7 (e) Up to one-half of all medications are taken incorrectly or  
8 mixed with other medications that cause dangerous reactions that  
9 can lead to injury and death.

10 (f) Approximately 46 percent of American adults cannot  
11 understand the label on their prescription medications.

12 (g) Ninety percent of Medicare patients take medications for  
13 chronic conditions and nearly one-half of them take five or more  
14 different medications.

15 (h) Nearly six out of 10 adults in the United States have taken  
16 prescription medications incorrectly.

17 (i) The people of California recognize the importance of  
18 reducing medication-related errors and increasing health care  
19 literacy regarding prescription drugs and prescription container  
20 labeling, which can increase consumer protection and improve the  
21 health, safety, and well-being of consumers.

22 (j) The Legislature affirms the importance of identifying  
23 deficiencies in, and opportunities for improving, patient medication  
24 safety systems in order to identify and encourage the adoption of  
25 structural safeguards related to prescription drug container labels.

26 (k) It is the intent of the Legislature to adopt a standardized  
27 prescription drug label that will be designed by a panel appointed  
28 to work with the California State Board of Pharmacy and that will  
29 be implemented in all California outpatient community and mail  
30 service pharmacies providing prescriptions to patients. *the*  
31 *California State Board of Pharmacy for use on any prescription*  
32 *drug dispensed to a patient in California.*

33 SEC. 3. Section 4076.5 is added to the Business and Professions  
34 Code, to read:

35 ~~4076.5.—(a) The board, in consultation with professionals in~~  
36 ~~the field, shall convene a prescription drug label panel to review~~  
37 ~~and make recommendations regarding the standardization of~~  
38 ~~prescription drug labels. The panel shall work with the board.~~

39 ~~(b) The board shall delegate board members to work with the~~  
40 ~~panel as it sees fit, and shall staff the panel. Members of the panel~~

- 1 shall include equal membership among groups representing  
2 consumers, such as seniors, and groups representing those with  
3 special issues regarding language and cultural competency in the  
4 use of prescription drugs, as well as pharmacy and medical  
5 professionals. The panel may include, but is not limited to,  
6 representatives of all of the following:
- 7 (1) Health plans or their representative association.
  - 8 (2) Pharmacy representatives.
  - 9 (3) Health care providers or their representative association.
  - 10 (4) Faculty representatives from a school of pharmacy.
  - 11 (5) Associations related to research, manufacturers, or
  - 12 distributors of pharmaceutical drugs.
  - 13 (6) Medical associations.
  - 14 (7) Consumer groups, such as senior citizens groups.
  - 15 (8) Health advocacy groups.
  - 16 (9) The board.
  - 17 (10) Language accessibility experts.
- 18 (c) The panel may secure private contributions to fund its  
19 responsibilities pursuant to this section:
- 20 (d) The panel's review shall include a study and
  - 21 recommendations of best practices for prescription drug labels,
  - 22 including all of the following topics:
- 23 (1) Medical literacy research that points to increased
  - 24 understandability of labels.
  - 25 (2) Improved directions for use.
  - 26 (3) Improved font types and sizes.
  - 27 (4) Placement of information that is patient centered.
  - 28 (5) Standards for implementation by pharmacies, including both
  - 29 of the following:
- 30 (A) Technology requirements to implement the standards.
  - 31 (B) Affordability to pharmacies of implementing the standards.
- 32 The panel shall ensure that its recommendation for implementation  
33 of a standardized label is affordable for pharmacies.
- 34 (e) On the recommendation of the panel, the board shall, by  
35 regulation, adopt a standardized label for prescription drug  
36 containers. The label shall be developed so that it meets all of the  
37 following requirements:
- 38 (1) It is understandable for prescription drug users.
  - 39 (2) It describes the contents of the container so that prescription
  - 40 drug users with low medical literacy levels can understand it.

1     ~~(3) It displays necessary information about properly taking the~~  
2     ~~container's contents so that prescription drug users with low~~  
3     ~~medical literacy levels can understand it.~~

4     ~~(4) It displays mandated warnings about the container's contents~~  
5     ~~so that prescription drug users with low medical literacy levels~~  
6     ~~can understand it.~~

7     ~~(5) Implementation of the standardized label is affordable for~~  
8     ~~pharmacies.~~

9     ~~(f) Pharmacy consultations by a telephonic translation service~~  
10    ~~shall be available to patients with limited English language~~  
11    ~~proficiency. A pharmacy shall be permitted to issue translated~~  
12    ~~labels for prescriptions, provided that those labels are found to be~~  
13    ~~safe and reliable.~~

14    ~~(g) (1) The panel shall be established and begin meeting as~~  
15    ~~soon as possible after January 1, 2008.~~

16    ~~(2) The panel shall make a recommendation for a standardized~~  
17    ~~label to the board on or before October 31, 2008.~~

18    ~~(3) Within 90 days of receiving the panel's recommendation,~~  
19    ~~the board shall promulgate regulations to establish requirements~~  
20    ~~for a standardized label for prescription drug containers, pursuant~~  
21    ~~to subdivision (c), which shall be required to be used by all~~  
22    ~~California outpatient community and mail service pharmacies~~  
23    ~~providing prescriptions to patients.~~

24    ~~(4) Within 90 days of the effective date of the adopted~~  
25    ~~regulations, each pharmacy described in paragraph (3) shall begin~~  
26    ~~using the standardized labels for prescription drug containers.~~

27    ~~4076.5. (a) The board shall promulgate regulations that~~  
28    ~~require, on or before January 1, 2011, a standardized,~~  
29    ~~patient-centered, prescription drug label on all prescription~~  
30    ~~medicine dispensed to patients in California.~~

31    ~~(b) To ensure maximum public comment, the board shall hold~~  
32    ~~public meetings statewide that are separate from its normally~~  
33    ~~scheduled hearings in order to seek information from groups~~  
34    ~~representing consumers, seniors, pharmacists or the practice of~~  
35    ~~pharmacy, other health care professionals, and other interested~~  
36    ~~parties.~~

37    ~~(c) When developing the requirements for prescription drug~~  
38    ~~labels, the board shall consider all of the following factors:~~

39    ~~(1) Medical literacy research that points to increased~~  
40    ~~understandability of labels.~~

- 1     (2) *Improved directions for use.*
- 2     (3) *Improved font types and sizes.*
- 3     (4) *Placement of information that is patient-centered.*
- 4     (5) *The needs of those patients with limited English proficiency.*
- 5     (6) *The needs of seniors.*
- 6     (7) *Technology requirements necessary to implement the*
- 7     *standards.*

8     (d) (1) *On or before January 1, 2010, the board shall report*  
9     *to the Legislature on its progress under this section as of the time*  
10    *of the report.*

11    (2) *On or before January 1, 2013, the board shall report to the*  
12    *Legislature the status of implementation of the prescription drug*  
13    *label requirements adopted pursuant to this section.*

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

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 620  
**Author:** Correa (Coauthor: Assembly Member Horton)  
**Bill Date:** February 22, 2007, introduced  
**Subject:** Dentistry: general anesthesia.  
**Sponsor:** The California Dental Association

**STATUS OF BILL:**

This bill passed out of the Assembly Appropriations Committee and is on the Assembly Floor consent calendar.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would remove the January 1, 2008 sunset date on the permitting process for physicians who administer general anesthesia for dental patients.

**ANALYSIS:**

Under current law a physician is permitted to administer general anesthesia in the office of a licensed dentist, for dental patients, whether or not the dentist has been certified to perform general anesthesia, if the physician holds a valid general anesthesia permit issued by the Board of Dental Examiners of California. The use of physicians for the administration of anesthesiology in dental offices is done primarily for pediatrics. If this bill is not passed or the permit program is not extended to a new sunset date, physicians will no longer be allowed to administer anesthesia in dental offices.

**FISCAL:** None

**POSITION:** Support

July 16, 2007

**Introduced by Senator Correa**  
(Coauthor: Assembly Member Horton)

February 22, 2007

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An act to amend Sections 1646.9 and 2079 of the Business and Professions Code, relating to dentistry, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 620, as introduced, Correa. Dentistry: general anesthesia.

Existing law, the Dental Practice Act, authorizes a physician and surgeon, until January 1, 2008, to administer general anesthesia to a dental patient in the office of a dentist who does not possess a general anesthesia permit if, among other things, the physician and surgeon holds a valid general anesthesia permit issued by the Dental Board of California. In order to obtain that permit, existing law requires the physician and surgeon, among other things, to pay specified fees, which are deposited in the State Dentistry Fund and the Contingent Fund of the Medical Board of California, continuously appropriated funds, and to submit his or her application to the Medical Board of California for review, as specified.

This bill would delete the January 1, 2008, repeal date, thereby extending the operation of these provisions indefinitely. By extending the operation of the provisions dealing with the payment of fees into continuously appropriated funds, the bill would make an appropriation.

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

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

1     SECTION 1. Section 1646.9 of the Business and Professions  
2     Code is amended to read:

3     1646.9. (a) Notwithstanding any other provision of law,  
4     including, but not limited to, Section 1646.1, a physician and  
5     surgeon licensed pursuant to Chapter 5 (commencing with Section  
6     2000) may administer general anesthesia in the office of a licensed  
7     dentist for dental patients, without regard to whether the dentist  
8     possesses a permit issued pursuant to this article, if ~~all~~ *both* of the  
9     following conditions are met:

10    (1) The physician and surgeon possesses a current license in  
11    good standing to practice medicine in this state.

12    (2) The physician and surgeon holds a valid general anesthesia  
13    permit issued by the Dental Board of California pursuant to  
14    subdivision (b).

15    (b) (1) A physician and surgeon who desires to administer  
16    general anesthesia as set forth in subdivision (a) shall apply to the  
17    Dental Board of California on an application form prescribed by  
18    the board and shall submit all of the following:

19    (A) The payment of an application fee prescribed by this article.

20    (B) Evidence satisfactory to the Medical Board of California  
21    showing that the applicant has successfully completed a  
22    postgraduate residency training program in anesthesiology that is  
23    recognized by the American Council on Graduate Medical  
24    Education, as set forth in Section 2079.

25    (C) Documentation demonstrating that all equipment and drugs  
26    required by the Dental Board of California are possessed by the  
27    applicant and shall be available for use in any dental office in  
28    which he or she administers general anesthesia.

29    (D) Information relative to the current membership of the  
30    applicant on hospital medical staffs.

31    (2) Prior to issuance or renewal of a permit pursuant to this  
32    section, the Dental Board of California may, at its discretion,  
33    require an onsite inspection and evaluation of the facility,  
34    equipment, personnel, including, but not limited to, the physician  
35    and surgeon, and procedures utilized. At least one of the persons  
36    evaluating the procedures utilized by the physician and surgeon  
37    shall be a licensed physician and surgeon expert in outpatient

1 general anesthesia who has been authorized or retained under  
2 contract by the Dental Board of California for this purpose.

3 (3) The permit of ~~any~~ a physician and surgeon who has failed  
4 an onsite inspection and evaluation shall be automatically  
5 suspended 30 days after the date on which the board notifies the  
6 physician and surgeon of the failure unless within that time period  
7 the physician and surgeon has retaken and passed an onsite  
8 inspection and evaluation. Every physician and surgeon issued a  
9 permit under this article shall have an onsite inspection and  
10 evaluation at least once every six years. Refusal to submit to an  
11 inspection shall result in automatic denial or revocation of the  
12 permit.

13 ~~(c) This section shall remain in effect until January 1, 2008, and~~  
14 ~~as of that date is repealed, unless a later enacted statute, which is~~  
15 ~~enacted on or before January 1, 2008, deletes or extends that date.~~

16 SEC. 2. Section 2079 of the Business and Professions Code is  
17 amended to read:

18 2079. (a) A physician and surgeon who desires to administer  
19 general anesthesia in the office of a dentist pursuant to Section  
20 1646.9, shall provide the Medical Board of California with a copy  
21 of the application submitted to the Dental Board of California  
22 pursuant to subdivision (b) of Section 1646.9 and a fee established  
23 by the board not to exceed the costs of processing the application  
24 as provided in this section.

25 (b) The Medical Board of California shall review the information  
26 submitted and take action as follows:

27 (1) Inform the Dental Board of California whether the physician  
28 and surgeon has a current license in good standing to practice  
29 medicine in this state.

30 (2) Verify whether the applicant has successfully completed a  
31 postgraduate residency training program in anesthesiology and  
32 whether the program has been recognized by the American Council  
33 on Graduate Medical Education.

34 (3) Inform the Dental Board of California whether the Medical  
35 Board of California has determined that the applicant has  
36 successfully completed the postgraduate residency training program  
37 in anesthesiology recognized by the American Council on Graduate  
38 Medicine.



- 1     ~~(e) This section shall remain in effect until January 1, 2008, and~~
- 2     ~~as of that date is repealed, unless a later enacted statute, which is~~
- 3     ~~enacted on or before January 1, 2008, deletes or extends that date.~~

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 761  
**Author:** Ridley-Thomas  
**Bill Date:** July 18, 2007, as amended  
**Subject:** Healing arts: diversion and investigations  
**Sponsor:** Medical Board of California

**STATUS OF BILL:**

This bill was referred to the Assembly Appropriations Committee and has not been set for hearing.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would extend the dates on which the provisions for the diversion program are repealed from January 1, 2009 to January 1, 2011.

As amended on March 27, 2007, the bill requires the board to create and appoint a Diversion Advisory Council (DAC). The council would be required to make recommendations and provide clinical quality improvement advice on matters specified by the board or a committee of the board. Another amendment extends the sunset date of the Vertical Enforcement Prosecution (E/P) model. This would extend the dates on which the provisions for the vertical (E/P) model are repealed from January 1, 2009 to January 1, 2011.

The July 18, 2007 amendments authorize the board to employ special agents and would require the board to transition investigators who are peace officers to a special agents classification. The first reclassification would need to be completed on or before June 30, 2009. The amendments also delete the requirement that an investigator be under the direction of the deputy attorney general who is simultaneously assigned a complaint, and instead, require that investigator assist the deputy attorney general, who would be responsible for the legal direction of the case.

**ANALYSIS:**

SB 231 (2005) stated that it is the intent of the Legislature, through a request to the Joint Legislative Audit Committee, that a thorough performance audit of the diversion program be conducted. In addition, this legislation sunset the diversion program on July 1, 2008 in anticipation of the audit results being made available in time to make an informed decision as to whether or not the diversion program should be modified and/or extended.

On June 7, 2007 the Bureau of State Audits (BSA) released its audit of the diversion program. That report has been discussed by the board's Executive Committee and

the DAC (established by the board at its May meeting). This report will be discussed by the Diversion Committee on July 26, 2007. (Report in packet)

The Enforcement Monitor's report that lead to the need for an audit, recommended that the liaison committee to the diversion program be abolished. This bill creates a Diversion Advisory Council (DAC) that functions differently from the liaison committee. This council shall make recommendations and provide clinical quality improvement advice on matters specified by the Board. This counsel will provide to the Board expertise on addiction and mental health issues.

SB 231 also created the vertical prosecution pilot project that was implemented January 1, 2006 and will sunset July 1, 2008. Under this pilot, investigations are referred simultaneously and jointly assigned to an investigator in MBC and a deputy attorney general who is responsible for prosecuting the case. The joint assignment exists for the duration of the disciplinary matter and the investigation is under the direction of the deputy attorney general.

SB 231 requires the board, in consultation with the Department of Justice, the Department of Consumer Affairs, the Department of Finance, and the Department of Personnel Administration to report and make recommendations to the Governor and the Legislature on the vertical prosecution model by July 1, 2007. This report will provide the data necessary to make a determination to implement full vertical prosecution which would transfer investigators to the Attorney General; to continue the pilot for a set amount of time to obtain additional data; or to discontinue the pilot model and return to the hand-off model. Although the bill does not address investigator pay, this item has been discussed in conjunction with the various options.

The report, due July 1, 2007, was discussed at the Executive Committee meeting of June 18, 2007. The members recommended some additions to the report and established a sub committee to assist staff with the final document to be reviewed by the full board at the July 26, 2007 meeting prior to its presentation to the Legislature. (Report in packet)

This bill was amended again on July 18, 2007 to authorize the board to employ special agents and requiring the board to transition investigators who are peace officers into special agent classifications. The bill requires the first reclassification to be completed on or before June 30, 2009. The bill was amended to specify that an investigator would no longer be under the direction of the deputy attorney general who is simultaneously assigned a complaint, and instead, that investigator would be assisting the deputy attorney general, who would be responsible for the legal case direction.

**FISCAL:** Unknown regarding diversion, approximately \$1,859,000 for the special agent upgrade.

**POSITION:** Sponsor/ Support

July 19, 2007

AMENDED IN ASSEMBLY JULY 18, 2007

AMENDED IN SENATE MARCH 27, 2007

**SENATE BILL**

**No. 761**

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**Introduced by Senator Ridley-Thomas**

February 23, 2007

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An act to amend Sections 2006, 2020, and 2358 of, and to add Section 2347 to, the Business and Professions Code, and to amend Sections 12529, 12529.5, and 12529.6 of the Government Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 761, as amended, Ridley-Thomas. Healing arts: diversion: investigations.

*Existing law, the Medical Practice Act, creates the Medical Board of California within the Department of Consumer Affairs. Existing law, until July 1, 2010, authorizes the board to employ an executive director and to employ investigators, legal counsel, medical consultants, and other assistance as it deems necessary.*

*This bill would also authorize the board to employ special agents, and would require the board, commencing on July 1, 2008, to transition investigators who are peace officers and who handle the most complex and varied types of disciplinary investigations into a special agent classification, as specified. The bill would require the first reclassification to be completed on or before June 30, 2009.*

~~Existing law, the~~

*The Medical Practice Act, provides for the Division of Medical Quality of the Medical Board of California to oversee diversion programs for physician and surgeons with impairment due to abuse of drugs or alcohol, or due to mental or physical illness. Under existing*

law, these provisions become inoperative on July 1, 2008, and are repealed on January 1, 2009.

This bill would extend the dates on which the provisions become inoperative to July 1, 2010, and would extend the dates on which the provisions are repealed to January 1, 2011. The bill would also require the board to create and appoint a Diversion Advisory Council. The council would be required to make recommendations and provide clinical quality improvement advice on matters specified by the board or a committee of the board. The council would also be required to elect a chairperson who would be required to report to the board, or a committee of the board, at its regularly scheduled meetings, as specified.

Existing law creates the Health Quality Enforcement Section within the Department of Justice with the primary responsibility of investigating and prosecuting proceedings against licensees and applicants within the jurisdiction of the Medical Board of California and various other boards. Existing law requires that attorneys staff the intake unit of specified regulatory boards to evaluate and screen complaints and develop uniform standards for their processing. Existing law also simultaneously assigns a complaint received by the medical board to an investigator and a deputy attorney general in the Health Quality Enforcement Section, *and provides that, for the duration of the assignment, the investigator is under the direction of the deputy attorney general.* Existing law makes these provisions inoperative on July 1, 2008, and repeals them on January 1, 2009, unless a later enacted statute deletes or extends those dates.

This bill would make those provisions inoperative on July 1, 2010, repeal them on January 1, 2011, unless a later enacted statute deletes or extends those dates, and would make other related changes. *The bill would delete the requirement that an investigator be under the direction of the deputy attorney general simultaneously assigned to a complaint, and would instead require that the investigator assist the deputy attorney general, who would be responsible for legal case direction.*

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

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

- 1 SECTION 1. Section 2006 of the Business and Professions
- 2 Code is amended to read:

2006. (a) On and after January 1, 2006, any reference in this chapter to an investigation by the board, or one of its divisions, shall be deemed to refer to an investigation conducted by employees of the Department of Justice.

(b) This section shall become inoperative on July 1, 2010, and as of January 1, 2011, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. *Section 2020 of the Business and Professions Code is amended to read:*

2020. (a) The board may employ an executive director exempt from the provisions of the Civil Service Act and may also employ *special agents*, investigators, legal counsel, medical consultants, and other assistance as it may deem necessary to carry into effect this chapter. ~~The~~

(b) The board may fix the compensation to be paid for services subject to the provisions of applicable state laws and regulations and may incur other expenses as it may deem necessary. ~~Investigators~~

(c) *Investigators* employed by the board shall be provided special training in investigating medical practice activities.

~~The~~

(d) The Attorney General shall act as legal counsel for the board for any judicial and administrative proceedings and his or her services shall be a charge against it. ~~This~~

(e) *The board shall begin the transition of investigators who are peace officers and who handle the most complex and varied types of disciplinary investigations into the special agent classification used by the Attorney General pursuant to Article 6 (commencing with Section 12570) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code. The first reclassification shall be initiated on or before July 1, 2008, and shall be completed on or before June 30, 2009.*

(f) This section shall become inoperative on July 1, 2010, and, as of January 1, 2011, is repealed, unless a later enacted statute, which becomes effective on or before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed.

~~SEC. 2.~~

SEC. 3. Section 2347 is added to the Business and Professions Code, to read:

1 2347. (a) The board shall create and appoint a Diversion  
2 Advisory Council.

3 (b) The council shall make recommendations and provide  
4 clinical quality improvement advice on matters specified by the  
5 board or a committee of the board. The council shall elect from  
6 its membership a chairperson. The chairperson, or his or her  
7 designee, shall report to the board, or a committee of the board, at  
8 its regularly scheduled meetings.

9 (c) For purposes of this section, "committee" means a committee  
10 created by the board.

11 ~~SEC. 3.~~

12 *SEC. 4.* Section 2358 of the Business and Professions Code is  
13 amended to read:

14 2358. This article shall become inoperative on July 1, 2010,  
15 and, as of January 1, 2011, is repealed, unless a later enacted statute  
16 that is enacted before January 1, 2011, deletes or extends the dates  
17 on which it becomes inoperative and is repealed.

18 ~~SEC. 4.~~

19 *SEC. 5.* Section 12529 of the Government Code, as amended  
20 by Section 24 of Chapter 674 of the Statutes of 2005, is amended  
21 to read:

22 12529. (a) There is in the Department of Justice the Health  
23 Quality Enforcement Section. The primary responsibility of the  
24 section is to investigate and prosecute proceedings against licensees  
25 and applicants within the jurisdiction of the Medical Board of  
26 California including all committees under the jurisdiction of the  
27 board or a division of the board, including the Board of Podiatric  
28 Medicine, and the Board of Psychology.

29 (b) The Attorney General shall appoint a Senior Assistant  
30 Attorney General of the Health Quality Enforcement Section. The  
31 Senior Assistant Attorney General of the Health Quality  
32 Enforcement Section shall be an attorney in good standing licensed  
33 to practice in the State of California, experienced in prosecutorial  
34 or administrative disciplinary proceedings and competent in the  
35 management and supervision of attorneys performing those  
36 functions.

37 (c) The Attorney General shall ensure that the Health Quality  
38 Enforcement Section is staffed with a sufficient number of  
39 experienced and able employees that are capable of handling the

1 most complex and varied types of disciplinary actions against the  
2 licensees of the division or board.

3 (d) Funding for the Health Quality Enforcement Section shall  
4 be budgeted in consultation with the Attorney General from the  
5 special funds financing the operations of the Medical Board of  
6 California, the California Board of Podiatric Medicine, and the  
7 committees under the jurisdiction of the Medical Board of  
8 California or a division of the board, and the Board of Psychology,  
9 with the intent that the expenses be proportionally shared as to  
10 services rendered.

11 (e) This section shall become inoperative on July 1, 2010, and,  
12 as of January 1, 2011, is repealed, unless a later enacted statute,  
13 that becomes operative on or before January 1, 2011, deletes or  
14 extends the dates on which it becomes inoperative and is repealed.

15 ~~SEC. 5.~~

16 *SEC. 6.* Section 12529 of the Government Code, as added by  
17 Section 25 of Chapter 674 of the Statutes of 2005, is amended to  
18 read:

19 12529. (a) There is in the Department of Justice the Health  
20 Quality Enforcement Section. The primary responsibility of the  
21 section is to prosecute proceedings against licensees and applicants  
22 within the jurisdiction of the Medical Board of California including  
23 all committees under the jurisdiction of the board or a division of  
24 the board, including the Board of Podiatric Medicine, and the  
25 Board of Psychology, and to provide ongoing review of the  
26 investigative activities conducted in support of those prosecutions,  
27 as provided in subdivision (b) of Section 12529.5.

28 (b) The Attorney General shall appoint a Senior Assistant  
29 Attorney General of the Health Quality Enforcement Section. The  
30 Senior Assistant Attorney General of the Health Quality  
31 Enforcement Section shall be an attorney in good standing licensed  
32 to practice in the State of California, experienced in prosecutorial  
33 or administrative disciplinary proceedings and competent in the  
34 management and supervision of attorneys performing those  
35 functions.

36 (c) The Attorney General shall ensure that the Health Quality  
37 Enforcement Section is staffed with a sufficient number of  
38 experienced and able employees that are capable of handling the  
39 most complex and varied types of disciplinary actions against the  
40 licensees of the division or board.



(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, and the committees under the jurisdiction of the Medical Board of California or a division of the board, and the Board of Psychology, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become operative July 1, 2010.

~~SEC. 6.~~

*SEC. 7.* Section 12529.5 of the Government Code, as amended by Section 26 of Chapter 674 of the Statutes of 2005, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section 12529 to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, division, or allied health committees, including the Board of Podiatric Medicine, in designing and providing initial and in-service training programs for staff of the division, boards, or allied health committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, the board, or allied health committee, including the Board of Podiatric Medicine, or the Board of Psychology, as appropriate in consultation with the senior assistant.

(e) This section shall become inoperative on July 1, 2010, and, as of January 1, 2011, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed.

1     ~~SEC. 7.~~

2     *SEC. 8.* Section 12529.5 of the Government Code, as added  
3 by Section 27 of Chapter 674 of the Statutes of 2005, is amended  
4 to read:

5     12529.5. (a) All complaints or relevant information concerning  
6 licensees that are within the jurisdiction of the Medical Board of  
7 California or the Board of Psychology shall be made available to  
8 the Health Quality Enforcement Section.

9     (b) The Senior Assistant Attorney General of the Health Quality  
10 Enforcement Section shall assign attorneys to assist the division  
11 and the boards in intake and investigations and to direct  
12 discipline-related prosecutions. Attorneys shall be assigned to  
13 work closely with each major intake and investigatory unit of the  
14 boards, to assist in the evaluation and screening of complaints from  
15 receipt through disposition and to assist in developing uniform  
16 standards and procedures for the handling of complaints and  
17 investigations.

18     A deputy attorney general of the Health Quality Enforcement  
19 Section shall frequently be available on location at each of the  
20 working offices at the major investigation centers of the boards,  
21 to provide consultation and related services and engage in case  
22 review with the boards' investigative, medical advisory, and intake  
23 staff. The Senior Assistant Attorney General and deputy attorneys  
24 general working at his or her direction shall consult as appropriate  
25 with the investigators of the boards, medical advisors, and  
26 executive staff in the investigation and prosecution of disciplinary  
27 cases.

28     (c) The Senior Assistant Attorney General or his or her deputy  
29 attorneys general shall assist the boards, division, or allied health  
30 committees, including the Board of Podiatric Medicine, in  
31 designing and providing initial and in-service training programs  
32 for staff of the division, boards, or allied health committees,  
33 including, but not limited to, information collection and  
34 investigation.

35     (d) The determination to bring a disciplinary proceeding against  
36 a licensee of the division or the boards shall be made by the  
37 executive officer of the division, the board, or allied health  
38 committee, including the Board of Podiatric Medicine, or the Board  
39 of Psychology, as appropriate in consultation with the senior  
40 assistant.

1 (e) This section shall become operative July 1, 2010.

2 ~~SEC. 8.~~

3 *SEC. 9.* Section 12529.6 of the Government Code is amended  
4 to read:

5 12529.6. (a) The Legislature finds and declares that the  
6 Medical Board of California, by ensuring the quality and safety  
7 of medical care, performs one of the most critical functions of state  
8 government. Because of the critical importance of the board's  
9 public health and safety function, the complexity of cases involving  
10 alleged misconduct by physicians and surgeons, and the evidentiary  
11 burden in the board's disciplinary cases, the Legislature finds and  
12 declares that using a vertical prosecution model for those  
13 investigations is in the best interests of the people of California.

14 (b) Notwithstanding any other provision of law, as of January  
15 1, 2006, each complaint that is referred to a district office of the  
16 board for investigation shall be simultaneously and jointly assigned  
17 to an investigator and to the deputy attorney general in the Health  
18 Quality Enforcement Section responsible for prosecuting the case  
19 if the investigation results in the filing of an accusation. The joint  
20 assignment of the investigator and the deputy attorney general  
21 shall exist for the duration of the disciplinary matter. During the  
22 assignment, the investigator so assigned shall, ~~under the direction~~  
23 ~~of the deputy attorney general, assist the deputy attorney general,~~  
24 *who shall provide legal case direction, and shall be responsible*  
25 *for obtaining the evidence required to permit the Attorney General*  
26 *to advise the board on legal matters such as whether the board*  
27 *should file a formal accusation, dismiss the complaint for a lack*  
28 *of evidence required to meet the applicable burden of proof, or*  
29 *take other appropriate legal action.*

30 (c) The Medical Board of California, the Department of  
31 Consumer Affairs, and the Office of the Attorney General shall,  
32 if necessary, enter into an interagency agreement to implement  
33 this section.

34 (d) This section does not affect the requirements of Section  
35 12529.5 as applied to the Medical Board of California where  
36 complaints that have not been assigned to a field office for  
37 investigation are concerned.

38 (e) This section shall become inoperative on July 1, 2010, and,  
39 as of January 1, 2011, is repealed, unless a later enacted statute,

1 that is enacted before January 1, 2011, deletes or extends the dates  
2 on which it becomes inoperative and is repealed.

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MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 764  
**Author:** Migden  
**Bill Date:** June 19, 2007, as amended  
**Subject:** Health Care Providers  
**Sponsor:** California Association of Physician Groups

**STATUS OF BILL:**

This bill was referred to the Assembly Appropriations Suspense file.

**DESCRIPTION OF CURRENT LEGISLATION:**

The Medical Board must report licensee information to OSHPD so that OSHPD can run projections and statistical data regarding primary care physicians in California. OSHPD must then prepare a report projecting the workforce of physicians in California.

**ANALYSIS:**

Under current law, OSHPD may receive, and the Medical Board may provide, data about physicians in California. This data is to be used to address the use of physicians under the Health Care Professional Disaster Response Act.

This bill would require that the Medical Board provide data about California physicians to OSHPD. However, instead of a disaster preparedness study, OSHPD shall use this data to study the number of primary care physicians in the state and make a five-year projection about trends for this number.

The bill requires that the information forwarded by the Medical Board be transmitted in a form so that the name or license number of an individual licensee is not identifiable. However, an encoding procedure shall be used to assign a unique identifying number to the other information provided so as to allow the office to track the geographical movements of physicians for planning purposes.

The Medical Board collects physician data at the time of renewal. This data contains the information that would be required for extraction by this bill and can be provided to OSHPD, using the license number as the identifier.

The April 12, 2007 amendment requires OSHPD to prepare a report that makes a 5-year projection on the full time, practicing primary care physician and surgeon workforce in the state.

**FISCAL:** Minor and absorbable to the Medical Board. While there will be some workload impacted by the implementation of this bill, this can be absorbed within current resources.

**POSITION:** Support with Conditions. Specifically, support is offered so long as the renewal data we receive and process from the questionnaire is satisfactory for the purpose of this bill.

July 16, 2007

AMENDED IN ASSEMBLY JUNE 19, 2007

AMENDED IN ASSEMBLY JUNE 5, 2007

AMENDED IN SENATE APRIL 25, 2007

AMENDED IN SENATE APRIL 12, 2007

## SENATE BILL

**No. 764**

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### Introduced by Senator Migden

February 23, 2007

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An act to amend Section 127775 of the Health and Safety Code, relating to health care providers.

#### LEGISLATIVE COUNSEL'S DIGEST

SB 764, as amended, Migden. Health care providers.

Existing law authorizes the Office of Statewide Health Planning and Development to receive basic data that the Medical Board of California may provide on individual licentiates.

This bill would, instead, require the office to receive, and the Medical Board of California and the Osteopathic Medical Board of California to provide, information respecting individual board licentiates upon request by the office.

The bill would also require, on or before June 1, 2009, the office to prepare and provide to the Legislature *and the State Department of Health Care Services* a report that makes a 5-year projection on the full time, practicing primary care physician and surgeon workforce in the state, as specified.

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

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

1 SECTION 1. Section 127775 of the Health and Safety Code  
2 is amended to read:

3 127775. The office shall receive, and the Medical Board of  
4 California and the Osteopathic Medical Board of California shall  
5 provide, information respecting individual licentiates licensed by  
6 the board upon request by the office.

7 Information provided to the office pursuant to this section shall  
8 be transmitted in a form so that the name or license number of an  
9 individual licensee is not identifiable. However, an encoding  
10 procedure shall be used to assign a unique identifying number to  
11 the other information provided upon the questionnaire so as to  
12 allow the office to track the geographical movements of physicians  
13 for planning purposes.

14 SEC. 2. (a) The Office of Statewide Health Planning and  
15 Development shall, on or before June 1, 2009, prepare and provide  
16 to the Legislature *and the State Department of Health Care*  
17 *Services, for the department's consideration in setting Medi-Cal*  
18 *provider reimbursement rates*, a report that makes a five-year  
19 projection on the full time, practicing primary care physician and  
20 surgeon workforce in the state for use in addressing geographic  
21 gaps in health care provided by these physicians and surgeons.  
22 The office shall request and use licentiate information provided  
23 by the Medical Board of California and the Osteopathic Medical  
24 Board of California and use publicly available information from  
25 any other public or private source necessary to make its projection.  
26 In preparing the report, the office shall consider all of the  
27 following:

28 (1) Demographic changes within the state's population.

29 (2) Immigration trends.

30 (3) Actual and potential impacts of health care reforms on the  
31 physician and surgeon workforce.

32 (4) The ages of practicing primary care physicians and surgeons.

33 (5) The expected number of primary care physicians and  
34 surgeons medical school graduates.

35 (6) Population growth.

36 (7) The current and recommended ratio of the number of primary  
37 physicians and surgeons to the state population.



1 (8) Geographic gaps in health care ~~provided by~~ *based on the*  
2 *location of* primary care physicians and surgeons *as compared to*  
3 *the locations of underserved populations.*

4 (9) The number of physicians and surgeons enrolled as Medi-Cal  
5 providers.

6 (10) Cultural and linguistic proficiency of physicians and  
7 surgeons.

8 (b) For purposes of this section, “primary care physician and  
9 surgeon” means a physician and surgeon who provides medical  
10 services in any of the following specialties:

11 (1) Family practice.

12 (2) General internal medicine.

13 (3) General pediatrics.

14 (4) General practice.

15 (5) Gynecology.

16 (6) Obstetrics.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 767  
**Author:** Ridley-Thomas  
**Bill Date:** May 15, 2007, as amended  
**Subject:** Drug overdose treatment: liability  
**Sponsor:** County of Los Angeles and Harm Reduction Coalition

**STATUS OF BILL:**

This bill was referred to the Assembly Appropriations Committee.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill, as introduced, provides that any person who, in good faith and without compensation, believes that another person is experiencing a drug overdose and who acts with reasonable care may administer an opioid antagonist, provided by specified health care professionals, to the person experiencing a drug overdose without being subject to civil liability for damages or criminal penalties as a result of that act. Other provisions also address avenues to minimize drug overdoses.

This bill was amended to require that local health jurisdictions operating opioid overdose prevention and treatment training programs collect prescribed data and report it to the State Department of Public Health. The Department of Public Health will be required to compile those reports for submission to the Legislature.

**ANALYSIS:**

Current law does not provide civil and criminal liability protection for health care professionals and third parties who are involved in the prescription, distribution, and/or injection/administration of naloxone to someone who is experiencing an opiate overdose.

The sponsor has stated that drug overdose is the second leading cause of accidental death in the United States and the leading cause of death in California's opioid using population. When a person overdoses on opiates (heroin, morphine, methadone, oxycontin, etc.), he/she is rendered unconscious and is in danger of dying because the opiates slow down, and eventually stop, the person's breathing. Opioid antagonists such as naloxone are routinely used in hospitals and in pre-hospital settings (by paramedics in the field) on patients who are suspected to be overdosing on opiates. Naloxone counteracts life-threatening depression of the central nervous and respiratory systems caused by an opiate overdose, allowing an overdose victim to breathe normally. Currently, naloxone can be prescribed only by licensed health care professionals, but it is

not a scheduled drug and has the same level of regulation as prescription ibuprofen. Naloxone is not addictive, it is inexpensive, and it has no pharmacologic effect if a person does not have opiates in their system. Furthermore, there is no data to suggest that distributing naloxone to drug users leads to increased drug use.

Many victims of opiate overdoses never receive proper medical attention because bystanders (who are often drug users themselves) do not call 911, fearing police involvement. In recent years several successful overdose prevention programs have been established around the state and country to provide lay community members (including drug users) with the training and tools (including a naloxone prescription) necessary to intervene effectively when they witness a drug overdose. These programs are providing overdose prevention, recognition, and response training, including training in calling 911, rescue breathing and take-home prescriptions of naloxone, to drug users and to those likely to be overdose bystanders.

This bill would:

- Offer immunity from liability if persons acting in good faith provide naloxone to someone they believe is overdosing.
- Defines an opioid antagonist as naloxone hydrochloride or any other similarly acting and equally safe drug approved by the FDA for the treatment of a drug overdose
- Encourages, but does not mandate, counties to establish standards for approval of any opioid overdose prevention program, which may include, but not be limited to, standards for program directors, appropriate clinical oversight, training, record-keeping, and reporting.
- Encourages, but does not mandate, counties to collect and review overdose death rates and other information to ascertain changes in the cause and rates of fatal opioid overdoses and report the statistic gathered.

The debate for the Board is two-fold. While there is support for this bill based on public health and safety issues, underscored by the potential of saving lives, this bill does allow lay persons to access and administer a prescription drug. As an extension of the arguments against needle exchange programs, it could be claimed that this bill would encourage intravenous drug use.

L.A. County Department of Public Health has heard from local providers that they are having difficulty finding clinicians that are willing to prescribe take-home opioid antagonists, like naloxone, to their patients. The clinicians are afraid of potential civil and criminal liability if a patient uses his or her naloxone on someone else. This bill would remove the liability barriers to a good faith administration of naloxone.

The April 12, 2007 amendments address some of the Board's concerns by specifying that the person administering the opioid antagonist shall not be subject to civil liability if he is acting without compensation and if the opioid is obtained through a licensed health care provider who is working in conjunction with an opioid prevention and treatment training program.

Lastly, the amendments set forth the scope of an opioid overdose prevention and treatment training program and indicate that the person who would administer the opioid antagonist shall have been trained in the following:

- (1) The causes of an opiate overdose.
- (2) Mouth-to-mouth resuscitation.
- (3) How to contact appropriate emergency medical services.
- (4) How to administer an opioid antagonist.

The May 15, 2007 amendments add the requirement that any local health jurisdiction operating a opioid overdose prevention and treatment training program must collect prescribed data and report it to the State Department of Public Health for submissions to the Legislature.

**FISCAL:** None.

**POSITION:** Neutral

July 16, 2007

AMENDED IN SENATE MAY 15, 2007

AMENDED IN SENATE APRIL 12, 2007

**SENATE BILL**

**No. 767**

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**Introduced by Senator Ridley-Thomas**

February 23, 2007

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An act to add ~~Section 1714.22 to~~ *and repeal Section 1714.22 of the Civil Code, relating to drug overdose treatment.*

LEGISLATIVE COUNSEL'S DIGEST

SB 767, as amended, Ridley-Thomas. Drug overdose treatment: liability.

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

This bill would provide, *until January 1, 2011*, that ~~any person who, in good faith, believes that another person is experiencing a drug overdose and who acts with reasonable care and not for compensation, may administer an opioid antagonist, as defined, that is obtained through a licensed health care provider, as specified, to the person experiencing a drug overdose without being subject to civil liability for damages or criminal penalties as a result of that act. The bill would also permit a licensed health care provider, who is already permitted pursuant to existing law to prescribe a~~ *an opioid antagonist, as defined, and who acts with reasonable care to prescribe; and subsequently dispense; or*

distribute an opioid antagonist in conjunction with an opioid overdose prevention and treatment training program, as defined, without being subject to civil liability or criminal prosecution.

*The bill would require a local health jurisdiction that operates or registers an opioid overdose prevention and treatment training program to collect prescribed data and report it to the State Department of Public Health, and the department will be required to compile those reports for submission to the Legislature.*

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

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

1 SECTION 1. The Legislature hereby finds and declares that  
2 because drug overdose deaths are preventable, it is therefore an  
3 appropriate role for the state to do all of the following:

4 (a) Seek to prevent the onset of drug use through preventive  
5 measures.

6 (b) Provide cessation treatment for those addicted to drugs.

7 (c) Prosecute those who sell controlled substances.

8 (d) Seek to prevent needless death and damage caused by drug  
9 overdose by implementing appropriate crisis interventions when  
10 these interventions are needed.

11 (e) Enact legislation to authorize any county in the state to  
12 establish standards for approval of any opioid overdose prevention  
13 program, which may include, but not be limited to, standards for  
14 program directors, appropriate clinical oversight, training,  
15 recordkeeping, and reporting.

16 (f) Enact legislation to authorize any county that establishes an  
17 opioid overdose data that reviews overdose death rates and other  
18 information to ascertain changes in the cause and rates of fatal  
19 opioid overdoses. It is the intent of the Legislature that the report  
20 include the following information:

21 (1) Information on opioid overdose deaths, including age,  
22 gender, ethnicity, and geographic location.

23 (2) Data on emergency room utilization for the treatment of  
24 opioid overdose.

25 (3) Data on utilization of prehospital services.

26 (4) Suggestions improvements in data collection.

27 SEC. 2. Section 1714.22 is added to the Civil Code, to read:

1     ~~1714.22. (a) Notwithstanding any other provision of law, any~~  
2     ~~person who, in good faith, believes that another person is~~  
3     ~~experiencing a drug overdose and who acts with reasonable care~~  
4     ~~and not for compensation may administer an opioid antagonist,~~  
5     ~~obtained through a licensed health care provider who is working~~  
6     ~~in conjunction with an opioid prevention and treatment training~~  
7     ~~program, as defined in subdivision (d), to the person experiencing~~  
8     ~~a drug overdose without being subject to civil liability for damages~~  
9     ~~or criminal penalties as a result of this act.~~

10    ~~(b) A licensed health care provider who is permitted by law to~~  
11    ~~prescribe an opioid antagonist, if acting with reasonable care, may~~  
12    ~~prescribe, dispense, or distribute an opioid antagonist, in~~  
13    ~~conjunction with an opioid overdose prevention and treatment~~  
14    ~~training program, without being subject to civil liability or criminal~~  
15    ~~prosecution.~~

16    ~~(c) For purposes of this section, an opioid antagonist means~~  
17    ~~naloxone hydrochloride or any other similarly acting and equally~~  
18    ~~safe drug approved by the federal Food and Drug Administration~~  
19    ~~for the treatment of a drug overdose.~~

20    ~~(d) For purposes of this section, an opioid overdose prevention~~  
21    ~~and treatment training program means any program that trains~~  
22    ~~individuals to provide first aid or emergency treatment when~~  
23    ~~witnessing an opiate overdose, and that includes, at a minimum,~~  
24    ~~training that teaches a person all of the following:~~

- 25    ~~(1) The causes of an opiate overdose.~~  
26    ~~(2) Mouth-to-mouth resuscitation.~~  
27    ~~(3) How to contact appropriate emergency medical services.~~  
28    ~~(4) How to administer an opioid antagonist.~~

29    ~~1714.22. (a) For purposes of this section:~~

30    ~~(1) "Opioid antagonist" means naloxone hydrochloride that is~~  
31    ~~approved by the federal Food and Drug Administration for the~~  
32    ~~treatment of a drug overdose.~~

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

- 39    ~~(A) The causes of an opiate overdose.~~  
40    ~~(B) Mouth to mouth resuscitation.~~

- 1     (C) How to contact appropriate emergency medical services.  
2     (D) How to administer an opioid antagonist.
- 3     (b) A licensed health care provider who is permitted by law to  
4     prescribe an opioid antagonist may, if acting with reasonable care,  
5     prescribe and subsequently dispense or distribute an opioid  
6     antagonist in conjunction with an opioid overdose prevention and  
7     treatment training program, without being subject to civil liability  
8     or criminal prosecution. This immunity shall apply to the licensed  
9     health care provider even when the opioid antagonist is  
10    administered by and to someone other than the person to whom it  
11    is prescribed.
- 12    (c) Each local health jurisdiction that operates or registers an  
13    opioid overdose prevention and treatment training program shall,  
14    by September 1, 2009, collect, and report to the State Department  
15    of Public Health, all of the following data on programs within the  
16    jurisdiction:
- 17    (1) Number of training programs operating in the local health  
18    jurisdiction.
- 19    (2) Number of individuals who have received a prescription  
20    and training to administer naloxone hydrochloride.
- 21    (3) Number of naloxone hydrochloride doses prescribed.
- 22    (4) Number of naloxone hydrochloride doses administered.
- 23    (5) Number of individuals who received naloxone hydrochloride  
24    injections who were properly revived.
- 25    (6) Number of individuals who received naloxone hydrochloride  
26    injections who were not revived.
- 27    (7) Number of adverse events associated with a naloxone  
28    hydrochloride dose that was distributed as part of an opioid  
29    overdose prevention and treatment training program, including a  
30    description of the adverse events.
- 31    (d) On or before January 1, 2010, the State Department of  
32    Public Health shall compile the reports received by the local health  
33    jurisdictions pursuant to this section and forward the full report  
34    on opioid overdose prevention and treatment training programs  
35    to the Legislature.
- 36    (e) This section shall remain in effect only until January 1, 2011,  
37    and as of that date is repealed, unless a later enacted statute, that



1 *is enacted on or before January 1, 2011, deletes or extends that*  
2 *date.*

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MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 1048  
**Author:** Senate Business and Professions Committee  
**Bill Date:** July 12, 2007, introduced  
**Subject:** Healing Arts: Omnibus  
**Sponsor:** Author

**STATUS OF BILL:**

This bill has been referred to the Assembly Appropriations Committee and has not been set for hearing.

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill is the vehicle by which omnibus legislation is being carried by the Senate Business and Professions Committee. Some provisions, although non-substantive, will impact statutes governing the Medical Practices Act.

There are provisions pertaining to the Medical Board in this bill. The first, amending B&P code section 2177, allows an applicant who obtains a passing score on Part III of the USMLE in more than four attempts and who meets the requirements of Section 2135.5 to be eligible for a physician's license. The second provision, amending B&P code section 2313, makes current the language to reflect changes specified in SB 1438 (2006) making references to B&P Code section 801 to now refer to section 801.1. It also revises language on collecting information on complaint forms as it is no longer practical to report on forms sent out by mail, as many are printed from the Web site. A third provision, amending B&P code section 2335, adds 10 days to the 90-day period by which provisions and proposed decisions must be issued by the Board. This provision will make the requirements consistent with the Administrative Procedures Act so that all time periods will now be 100 days.

**ANALYSIS:**

This bill is proposing non-substantive and non-controversial changes to law, such as making technical and grammatical changes.

The amendment to B&P code section 2177, regarding Part III of the USMLE, is in response to the Governor's signing message on AB 1796 (2006), expressing concern that failing to provide exceptions to the requirement that physicians pass the

USMLE, Step 3, within four attempts may result in unintended consequences and directed the Board to address this issue.

**FISCAL:**           None

**POSITION:**       Support MBC provisions

July 17, 2007

AMENDED IN ASSEMBLY JULY 12, 2007

AMENDED IN ASSEMBLY JUNE 27, 2007

**SENATE BILL**

**No. 1048**

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**Introduced by Committee on Business, Professions and Economic  
Development (Senators Ridley-Thomas (Chair), Aanestad,  
Corbett, Denham, Florez, Harman, Simitian, and Yee)**

March 22, 2007

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An act to amend Sections 337, 1701.1, 1725, 1750, 1750.1, 1750.2, 1750.3, 1750.4, 1751, 1752, 1752.1, 1752.2, 1752.5, 1752.6, 1753, 1753.1, 1754, 1756, 1757, 1770, 2177, 2225, 2313, 2335, 2397, 2416, 2497.5, 2570.7, 2717, 2732.05, 3057, 3527, 3634, 4068, 4084, 4101, 4160, 4161, 4162, 4162.5, 4200, 4200.1, 4200.2, 4208, 4314, 4315, 4980.01, 4980.38, 4980.40, 4980.44, 4980.54, 4980.57, 4980.80, 4980.90, 4982, 4984.1, 4984.4, 4989.36, 4989.42, 4989.54, 4992.3, 4996.4, 4996.6, 4996.18, and 4996.22 of, to add Sections 1672, 2471, 2570.8, 4984.01, 4984.72, 4992.10, and 4996.28 to, and to repeal and add Sections 3530, 4984.7, 4984.8, 4996.3, 4996.14, and 4997 of, the Business and Professions Code, and to amend Sections 11372, 12529, and 12529.5 of the Government Code, relating to healing arts, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 1048, as amended, Committee on Business, Professions and Economic Development. Healing arts.

(1) Existing law, the Dental Practice Act, establishes the Dental Board of California and provides for the licensure and regulation of the practice of dentistry. The act makes the willful practice, attempt to practice, or advertisement to practice without appropriate authorization in circumstances causing harm, as specified, a misdemeanor offense.

The act also provides for the licensure of various types of dental auxiliaries and for their licensure fees to be established by board resolution. The act defines the functions certain dental auxiliaries are authorized to perform and revises the criteria for licensure and the functions certain dental auxiliaries are authorized to perform, on and after January 1, 2008. Under the act, commencing on that date, the board is authorized to issue dental auxiliary licenses for a registered orthodontic, surgery, and restorative assistant, and a dentist is authorized to train and educate employees in those licensure categories pursuant to specified procedures. The act requires the board, commencing January 1, 2008, to adopt regulations governing the procedures that dental auxiliaries are authorized to perform.

This bill would delay from January 1, 2008, to January 1, 2010, the operation of provisions revising the duties and licensure criteria for certain dental auxiliaries and requiring the board to adopt regulations governing the procedures dental auxiliaries are authorized to perform. The bill would similarly delay the board's licensure of the additional dental auxiliary categories and would revise the procedures applicable to a dentist training his or her employees in those categories. The bill would revise the licensure fee provisions for dental auxiliaries and make other related changes to the dental auxiliary provisions of the Dental Practice Act. The bill would also increase the punishment for unauthorized practice under the Dental Practice Act in circumstances causing harm, as specified, by making it a felony offense. *The bill would authorize the board to require a licensee to pay the costs of monitoring probationary terms or conditions imposed on his or her license and would prohibit the board from renewing or reinstating a license if those costs are unpaid.*

(2) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California (the medical board) and for the licensure and regulation of podiatrists by the California Board of Podiatric Medicine (the podiatric board), within the jurisdiction of the medical board. Existing law creates the Health Quality Enforcement Section within the Department of Justice with the primary responsibility of prosecuting proceedings against licensees and applicants within the jurisdiction of the medical board and various other boards. Under existing law, a panel of administrative law judges, the Medical Quality Hearing Panel within the Office of Administrative Hearings, conducts disciplinary proceedings against licensees of the medical board and of boards under its jurisdiction.

Existing law requires the podiatric board and the Division of Medical Quality of the medical board to issue an order of nonadoption of a proposed decision by the Medical Quality Hearing Panel within 90 days of receipt of the decision. Existing law requires that all complaints or relevant information concerning licensees that are within the jurisdiction of the medical board or the Board of Psychology be made available to the Health Quality Enforcement Section and requires the Division of Medical Quality of the medical board to report annually specified information to the Legislature relating to its operations and to the licensees of the medical board.

This bill would specify that an applicant remains eligible for a physician's and surgeon's certificate issued by the medical board after having obtained a passing score on the licensure examination in more than 4 attempts. The bill would authorize the podiatric board to employ, within the limits of the funds received by the podiatric board and subject to specified limitations, all personnel necessary to carry out the licensing and regulatory provisions applicable to podiatrists. The bill also would clarify that the provisions concerning the responsibilities of the Health Quality Enforcement Section within the Department of Justice apply to complaints and proceedings concerning licensees of the podiatric board. The bill would extend to 100 days the time period within which the podiatric board and the Division of Medical Quality are required to issue an order of nonadoption of a proposed decision by the Medical Quality Hearing Panel and would revise the information the division is required to include in its annual report to the Legislature.

(3) Existing law, the Occupational Therapy Act, establishes the California Board of Occupational Therapy and makes it responsible for issuing an occupational therapist's license and an occupational therapist certification. The act requires that licensure and certification examinations be given at least twice each year at a place determined by the board and that the board provide notice of the examinations.

This bill would delete these particular provisions relating to licensure and certification examinations and would specify that the information on the board's Internet Web site is adequate for licensure verification purposes.

(4) Existing law, the Nursing Practice Act, provides for the registration and regulation of nurses by the Board of Registered Nursing in the Department of Consumer Affairs. Existing law requires an employer of, or agent for, a registered nurse to ascertain that the nurse

1 1770. (a) A licensed dentist may simultaneously utilize in his  
2 or her practice no more than two dental auxiliaries in extended  
3 functions licensed pursuant to Sections 1756 and 1768.

4 (b) This section shall remain in effect only until January 1, 2010,  
5 and as of that date is repealed, unless a later enacted statute, that  
6 is enacted before January 1, 2010, deletes or extends that date.

7 SEC. 24. Section 1770 of the Business and Professions Code,  
8 as amended by Section 23 of Chapter 621 of the Statutes of 2005,  
9 is amended to read:

10 1770. (a) A licensed dentist may simultaneously utilize in his  
11 or her practice no more than three dental auxiliaries in extended  
12 functions licensed pursuant to Sections 1753 and 1768.

13 (b) This section shall become operative on January 1, 2010.

14 SEC. 25. Section 2177 of the Business and Professions Code  
15 is amended to read:

16 2177. (a) A passing score is required for an entire examination  
17 or for each part of an examination, as established by resolution of  
18 the Division of Licensing.

19 (b) Applicants may elect to take the written examinations  
20 conducted or accepted by the division in separate parts.

21 (c) (1) An applicant shall have obtained a passing score on Part  
22 III of the United States Medical Licensing Examination within not  
23 more than four attempts in order to be eligible for a physician's  
24 and surgeon's certificate.

25 (2) Notwithstanding paragraph (1), an applicant who obtains  
26 a passing score on Part III of the United States Medical Licensing  
27 Examination in more than four attempts and who meets the  
28 requirements of Section 2135.5 shall be eligible to be considered  
29 for issuance of a physician's and surgeon's certificate.

30 SEC. 26. Section 2225 of the Business and Professions Code  
31 is amended to read:

32 2225. (a) Notwithstanding Section 2263 and any other  
33 provision of law making a communication between a physician  
34 and surgeon or a doctor of podiatric medicine and his or her  
35 patients a privileged communication, those provisions shall not  
36 apply to investigations or proceedings conducted under this chapter.  
37 Members of the board, the Senior Assistant Attorney General of  
38 the Health Quality Enforcement Section, members of the California  
39 Board of Podiatric Medicine, and deputies, employees, agents, and  
40 representatives of the board or the California Board of Podiatric

1 Medicine and the Senior Assistant Attorney General of the Health  
2 Quality Enforcement Section shall keep in confidence during the  
3 course of investigations, the names of any patients whose records  
4 are reviewed and may not disclose or reveal those names, except  
5 as is necessary during the course of an investigation, unless and  
6 until proceedings are instituted. The authority of the board or the  
7 California Board of Podiatric Medicine and the Health Quality  
8 Enforcement Section to examine records of patients in the office  
9 of a physician and surgeon or a doctor of podiatric medicine is  
10 limited to records of patients who have complained to the board  
11 or the California Board of Podiatric Medicine about that licensee.

12 (b) Notwithstanding any other provision of law, the Attorney  
13 General and his or her investigative agents, and investigators and  
14 representatives of the board or the California Board of Podiatric  
15 Medicine, may inquire into any alleged violation of the Medical  
16 Practice Act or any other federal or state law, regulation, or rule  
17 relevant to the practice of medicine or podiatric medicine,  
18 whichever is applicable, and may inspect documents relevant to  
19 those investigations in accordance with the following procedures:

20 (1) Any document relevant to an investigation may be inspected,  
21 and copies may be obtained, where patient consent is given.

22 (2) Any document relevant to the business operations of a  
23 licensee, and not involving medical records attributable to  
24 identifiable patients, may be inspected and copied where relevant  
25 to an investigation of a licensee.

26 (c) In all cases where documents are inspected or copies of those  
27 documents are received, their acquisition or review shall be  
28 arranged so as not to unnecessarily disrupt the medical and business  
29 operations of the licensee or of the facility where the records are  
30 kept or used.

31 (d) Where documents are lawfully requested from licensees in  
32 accordance with this section by the Attorney General or his or her  
33 agents or deputies, or investigators of the board or the California  
34 Board of Podiatric Medicine, they shall be provided within 15  
35 business days of receipt of the request, unless the licensee is unable  
36 to provide the documents within this time period for good cause,  
37 including, but not limited to, physical inability to access the records  
38 in the time allowed due to illness or travel. Failure to produce  
39 requested documents or copies thereof, after being informed of  
40 the required deadline, shall constitute unprofessional conduct. The



1 board may use its authority to cite and fine a physician and surgeon  
2 for any violation of this section. This remedy is in addition to any  
3 other authority of the board to sanction a licensee for a delay in  
4 producing requested records.

5 (e) Searches conducted of the office or medical facility of any  
6 licensee shall not interfere with the recordkeeping format or  
7 preservation needs of any licensee necessary for the lawful care  
8 of patients.

9 SEC. 27. Section 2313 of the Business and Professions Code  
10 is amended to read:

11 2313. The Division of Medical Quality shall report annually  
12 to the Legislature, no later than October 1 of each year, the  
13 following information:

14 (a) The total number of temporary restraining orders or interim  
15 suspension orders sought by the board or the division to enjoin  
16 licensees pursuant to Sections 125.7, 125.8 and 2311, the  
17 circumstances in each case that prompted the board or division to  
18 seek that injunctive relief, and whether a restraining order or  
19 interim suspension order was actually issued.

20 (b) The total number and types of actions for unprofessional  
21 conduct taken by the board or a division against licensees, the  
22 number and types of actions taken against licensees for  
23 unprofessional conduct related to prescribing drugs, narcotics, or  
24 other controlled substances, including those related to the  
25 undertreatment or undermedication of pain.

26 (c) Information relative to the performance of the division,  
27 including the following: number of consumer calls received;  
28 number of consumer calls or letters designated as discipline-related  
29 complaints; number of complaint forms received; number of  
30 Section 805 reports by type; number of Section 801.01 and Section  
31 803 reports; coroner reports received; number of convictions  
32 reported to the division; number of criminal filings reported to the  
33 division; number of complaints and referrals closed, referred out,  
34 or resolved without discipline, respectively, prior to accusation;  
35 number of accusations filed and final disposition of accusations  
36 through the division and court review, respectively; final physician  
37 discipline by category; number of citations issued with fines and  
38 without fines, and number of public reprimands issued; number  
39 of cases in process more than six months from receipt by the  
40 division of information concerning the relevant acts to the filing

1 of an accusation; average and median time in processing complaints  
2 from original receipt of complaint by the division for all cases at  
3 each stage of discipline and court review, respectively; number of  
4 persons in diversion, and number successfully completing diversion  
5 programs and failing to do so, respectively; probation violation  
6 reports and probation revocation filings and dispositions; number  
7 of petitions for reinstatement and their dispositions; and caseloads  
8 of investigators for original cases and for probation cases,  
9 respectively.

10 “Action,” for purposes of this section, includes proceedings  
11 brought by, or on behalf of, the division against licensees for  
12 unprofessional conduct that have not been finally adjudicated, as  
13 well as disciplinary actions taken against licensees.

14 (d) The total number of reports received pursuant to Section  
15 805 by the type of peer review body reporting and, where  
16 applicable, the type of health care facility involved and the total  
17 number and type of administrative or disciplinary actions taken  
18 by the Medical Board of California with respect to the reports.

19 (e) The number of malpractice settlements in excess of thirty  
20 thousand dollars (\$30,000) reported pursuant to Section 801.01.  
21 This information shall be grouped by specialty practice and shall  
22 include the total number of physicians and surgeons practicing in  
23 each specialty. For the purpose of this subdivision, “specialty”  
24 includes all specialties and subspecialties considered in determining  
25 the risk categories described in Section 803.1.

26 SEC. 28. Section 2335 of the Business and Professions Code  
27 is amended to read:

28 2335. (a) All proposed decisions and interim orders of the  
29 Medical Quality Hearing Panel designated in Section 11371 of the  
30 Government Code shall be transmitted to the executive director  
31 of the board, or the Executive Director of the California Board of  
32 Podiatric Medicine as to the licensees of that board, within 48  
33 hours of filing.

34 (b) All interim orders shall be final when filed.

35 (c) A proposed decision shall be acted upon by a panel of the  
36 Division of Medical Quality or the California Board of Podiatric  
37 Medicine, as the case may be, in accordance with Section 11517  
38 of the Government Code, except that all of the following shall  
39 apply to proceedings against licensees under this chapter:

1 (1) When considering a proposed decision, the division panel  
2 and the California Board of Podiatric Medicine shall give great  
3 weight to the findings of fact of the administrative law judge,  
4 except to the extent those findings of fact are controverted by new  
5 evidence.

6 (2) The Division of Medical Quality or the California Board of  
7 Podiatric Medicine shall poll the members of the division panel  
8 or California Board of Podiatric Medicine by written mail ballot  
9 concerning the proposed decision. The mail ballot shall be sent  
10 within 10 calendar days of receipt of the proposed decision, and  
11 shall poll each member on whether the member votes to approve  
12 the decision, to approve the decision with an altered penalty, to  
13 refer the case back to the administrative law judge for the taking  
14 of additional evidence, to defer final decision pending discussion  
15 of the case by the panel or board as a whole, or to nonadopt the  
16 decision. No party to the proceeding, including employees of the  
17 agency that filed the accusation, and no person who has a direct  
18 or indirect interest in the outcome of the proceeding or who  
19 presided at a previous stage of the decision, may communicate  
20 directly or indirectly, upon the merits of a contested matter while  
21 the proceeding is pending, with any member of the panel or board,  
22 without notice and opportunity for all parties to participate in the  
23 communication. The votes of four members of a division panel,  
24 and a majority of the California Board of Podiatric Medicine, are  
25 required to approve the decision with an altered penalty, to refer  
26 the case back to the administrative law judge for the taking of  
27 further evidence, or to nonadopt the decision. The votes of two  
28 members of the panel or board are required to defer final decision  
29 pending discussion of the case by the panel or board as a whole.  
30 If there is a vote by the specified number to defer final decision  
31 pending discussion of the case by the panel or board as a whole,  
32 provision shall be made for that discussion before the 100-day  
33 period specified in paragraph (3) expires, but in no event shall that  
34 100-day period be extended.

35 (3) If four members of a division panel, or a majority of the  
36 California Board of Podiatric Medicine vote to do so, the panel of  
37 the division and the California Board of Podiatric Medicine shall  
38 issue an order of nonadoption of a proposed decision within 100  
39 calendar days of the date it is received by the board. If a panel of  
40 the division or the California Board of Podiatric Medicine does

1 not refer the case back to the administrative law judge for the  
2 taking of additional evidence or issue an order of nonadoption  
3 within 100 days, the decision shall be final and subject to review  
4 under Section 2337. Members of a panel of the division or the  
5 California Board of Podiatric Medicine who review a proposed  
6 decision or other matter and vote by mail as provided in paragraph  
7 (2) shall return their votes by mail to the board within 30 days  
8 from receipt of the proposed decision or other matter.

9 (4) The division panel or California Board of Podiatric Medicine  
10 shall afford the parties the opportunity to present oral argument  
11 before deciding a case after nonadoption of the administrative law  
12 judge's decision.

13 (5) A vote of four members of a division panel, or a majority  
14 of the California Board of Podiatric Medicine, are required to  
15 increase the penalty from that contained in the proposed  
16 administrative law judge's decision. No member of the division  
17 panel or of the California Board of Podiatric Medicine may vote  
18 to increase the penalty except after reading the entire record and  
19 personally hearing any additional oral argument and evidence  
20 presented to the panel or board.

21 SEC. 29. Section 2397 of the Business and Professions Code  
22 is amended to read:

23 2397. (a) A licensee shall not be liable for civil damages for  
24 injury or death caused in an emergency situation occurring in the  
25 licensee's office or in a hospital on account of a failure to inform  
26 a patient of the possible consequences of a medical procedure  
27 where the failure to inform is caused by any of the following:

28 (1) The patient was unconscious.

29 (2) The medical procedure was undertaken without the consent  
30 of the patient because the licensee reasonably believed that a  
31 medical procedure should be undertaken immediately and that  
32 there was insufficient time to fully inform the patient.

33 (3) A medical procedure was performed on a person legally  
34 incapable of giving consent, and the licensee reasonably believed  
35 that a medical procedure should be undertaken immediately and  
36 that there was insufficient time to obtain the informed consent of  
37 a person authorized to give such consent for the patient.

38 (b) This section is applicable only to actions for damages for  
39 injuries or death arising because of a licensee's failure to inform,

1 and not to actions for damages arising because of a licensee's  
2 negligence in rendering or failing to render treatment.

3 (c) As used in this section:

4 (1) "Hospital" means a licensed general acute care hospital as  
5 defined in subdivision (a) of Section 1250 of the Health and Safety  
6 Code.

7 (2) "Emergency situation occurring in the licensee's office"  
8 means a situation occurring in an office, other than a hospital, used  
9 by a licensee for the examination or treatment of patients, requiring  
10 immediate services for alleviation of severe pain, or immediate  
11 diagnosis and treatment of unforeseeable medical conditions,  
12 which, if not immediately diagnosed and treated, would lead to  
13 serious disability or death.

14 (3) "Emergency situation occurring in a hospital" means a  
15 situation occurring in a hospital, whether or not it occurs in an  
16 emergency room, requiring immediate services for alleviation of  
17 severe pain, or immediate diagnosis and treatment of unforeseeable  
18 medical conditions, which, if not immediately diagnosed and  
19 treated, would lead to serious disability or death.

20 SEC. 30. Section 2416 of the Business and Professions Code  
21 is amended to read:

22 2416. Physicians and surgeons and doctors of podiatric  
23 medicine may conduct their professional practices in a partnership  
24 or group of physician and surgeons or a partnership or group of  
25 doctors of podiatric medicine, respectively. Physician and surgeons  
26 and doctors of podiatric medicine may establish a professional  
27 partnership that includes both physician and surgeons and doctors  
28 of podiatric medicine, if both of the following conditions are  
29 satisfied:

30 (a) A majority of the partners and partnership interests in the  
31 professional partnership are physician and surgeons or osteopathic  
32 physician and surgeons.

33 (b) Notwithstanding Chapter 2 (commencing with Section  
34 15001) of Title 1 of the Corporations Code, a partner who is not  
35 a physician and surgeon shall not practice in the partnership or  
36 vote on partnership matters related to the practice of medicine that  
37 are outside his or her scope of practice. All partners may vote on  
38 general administrative, management, and business matters.

39 SEC. 31. Section 2471 is added to the Business and Professions  
40 Code, to read:

1 SEC. 85. Section 4997 of the Business and Professions Code  
2 is repealed.

3 SEC. 86. Section 4997 is added to the Business and Professions  
4 Code, to read:

5 4997. (a) A licensee may apply to the board to request that his  
6 or her license be placed on inactive status.

7 (b) A licensee on inactive status shall be subject to this chapter  
8 and shall not engage in the practice of clinical social work in this  
9 state.

10 (c) A licensee who holds an inactive license shall pay a biennial  
11 fee in the amount of one-half of the standard renewal fee and shall  
12 be exempt from continuing education requirements.

13 (d) A licensee on inactive status who has not committed an act  
14 or crime constituting grounds for denial of licensure may, upon  
15 request, restore his or her license to practice clinical social work  
16 to active status.

17 (1) A licensee requesting his or her license be restored to active  
18 status between renewal cycles shall pay the remaining one-half of  
19 his or her renewal fee.

20 (2) A licensee requesting to restore his or her license to active  
21 status whose license will expire less than one year from the date  
22 of the request shall complete 18 hours of continuing education as  
23 specified in Section 4996.22.

24 (3) A licensee requesting to restore his or her license to active  
25 status whose license will expire more than one year from the date  
26 of the request shall complete 36 hours of continuing education as  
27 specified in Section 4996.22.

28 SEC. 87. Section 11372 of the Government Code is amended  
29 to read:

30 11372. (a) Except as provided in subdivision (b), all  
31 adjudicative hearings and proceedings relating to the discipline or  
32 reinstatement of licensees of the Medical Board of California,  
33 including licensees of affiliated health agencies within the  
34 jurisdiction of the Medical Board of California, that are heard  
35 pursuant to the Administrative Procedure Act, shall be conducted  
36 by an administrative law judge as designated in Section 11371,  
37 sitting alone if the case is so assigned by the agency filing the  
38 charging pleading.

39 (b) Proceedings relating to interim orders shall be heard in  
40 accordance with Section 11529.

1 SEC. 88. Section 12529 of the Government Code, as amended  
2 by Section 24 of Chapter 674 of the Statutes of 2005, is amended  
3 to read:

4 12529. (a) There is in the Department of Justice the Health  
5 Quality Enforcement Section. The primary responsibility of the  
6 section is to investigate and prosecute proceedings against licensees  
7 and applicants within the jurisdiction of the Medical Board of  
8 California, the California Board of Podiatric Medicine, the Board  
9 of Psychology, or any committee under the jurisdiction of the  
10 Medical Board of California or a division of the board.

11 (b) The Attorney General shall appoint a Senior Assistant  
12 Attorney General of the Health Quality Enforcement Section. The  
13 Senior Assistant Attorney General of the Health Quality  
14 Enforcement Section shall be an attorney in good standing licensed  
15 to practice in the State of California, experienced in prosecutorial  
16 or administrative disciplinary proceedings and competent in the  
17 management and supervision of attorneys performing those  
18 functions.

19 (c) The Attorney General shall ensure that the Health Quality  
20 Enforcement Section is staffed with a sufficient number of  
21 experienced and able employees that are capable of handling the  
22 most complex and varied types of disciplinary actions against the  
23 licensees of the division or board.

24 (d) Funding for the Health Quality Enforcement Section shall  
25 be budgeted in consultation with the Attorney General from the  
26 special funds financing the operations of the Medical Board of  
27 California, the California Board of Podiatric Medicine, the Board  
28 of Psychology, and the committees under the jurisdiction of the  
29 Medical Board of California or a division of the board, with the  
30 intent that the expenses be proportionally shared as to services  
31 rendered.

32 (e) This section shall become inoperative on July 1, 2008, and,  
33 as of January 1, 2009, is repealed, unless a later enacted statute,  
34 that becomes operative on or before January 1, 2009, deletes or  
35 extends the dates on which it becomes inoperative and is repealed.

36 SEC. 89. Section 12529 of the Government Code, as added by  
37 Section 25 of Chapter 674 of the Statutes of 2005, is amended to  
38 read:

39 12529. (a) There is in the Department of Justice the Health  
40 Quality Enforcement Section. The primary responsibility of the

1 section is to prosecute proceedings against licensees and applicants  
2 within the jurisdiction of the Medical Board of California, the  
3 California Board of Podiatric Medicine, the Board of Psychology,  
4 or any committee under the jurisdiction of the Medical Board of  
5 California or a division of the board, and to provide ongoing review  
6 of the investigative activities conducted in support of those  
7 prosecutions, as provided in subdivision (b) of Section 12529.5.

8 (b) The Attorney General shall appoint a Senior Assistant  
9 Attorney General of the Health Quality Enforcement Section. The  
10 Senior Assistant Attorney General of the Health Quality  
11 Enforcement Section shall be an attorney in good standing licensed  
12 to practice in the State of California, experienced in prosecutorial  
13 or administrative disciplinary proceedings and competent in the  
14 management and supervision of attorneys performing those  
15 functions.

16 (c) The Attorney General shall ensure that the Health Quality  
17 Enforcement Section is staffed with a sufficient number of  
18 experienced and able employees that are capable of handling the  
19 most complex and varied types of disciplinary actions against the  
20 licensees of the division or board.

21 (d) Funding for the Health Quality Enforcement Section shall  
22 be budgeted in consultation with the Attorney General from the  
23 special funds financing the operations of the Medical Board of  
24 California, the California Board of Podiatric Medicine, the Board  
25 of Psychology, and the committees under the jurisdiction of the  
26 Medical Board of California or a division of the board, with the  
27 intent that the expenses be proportionally shared as to services  
28 rendered.

29 (e) This section shall become operative July 1, 2008.

30 SEC. 90. Section 12529.5 of the Government Code, as amended  
31 by Section 26 of Chapter 674 of the Statutes of 2005, is amended  
32 to read:

33 12529.5. (a) All complaints or relevant information concerning  
34 licensees that are within the jurisdiction of the Medical Board of  
35 California, the California Board of Podiatric Medicine, or the  
36 Board of Psychology shall be made available to the Health Quality  
37 Enforcement Section.

38 (b) The Senior Assistant Attorney General of the Health Quality  
39 Enforcement Section shall assign attorneys to work on location at  
40 the intake unit of the boards described in subdivision (d) of Section



1 12529 to assist in evaluating and screening complaints and to assist  
2 in developing uniform standards and procedures for processing  
3 complaints.

4 (c) The Senior Assistant Attorney General or his or her deputy  
5 attorneys general shall assist the boards, division, or committees  
6 in designing and providing initial and in-service training programs  
7 for staff of the division, boards, or committees, including, but not  
8 limited to, information collection and investigation.

9 (d) The determination to bring a disciplinary proceeding against  
10 a licensee of the division or the boards shall be made by the  
11 executive officer of the division, boards, or committees as  
12 appropriate in consultation with the senior assistant.

13 (e) This section shall become inoperative on July 1, 2008, and,  
14 as of January 1, 2009, is repealed, unless a later enacted statute,  
15 that becomes operative on or before January 1, 2009, deletes or  
16 extends the dates on which it becomes inoperative and is repealed.

17 SEC. 91. Section 12529.5 of the Government Code, as added  
18 by Section 27 of Chapter 674 of the Statutes of 2005, is amended  
19 to read:

20 12529.5. (a) All complaints or relevant information concerning  
21 licensees that are within the jurisdiction of the Medical Board of  
22 California, the California Board of Podiatric Medicine, or the  
23 Board of Psychology shall be made available to the Health Quality  
24 Enforcement Section.

25 (b) The Senior Assistant Attorney General of the Health Quality  
26 Enforcement Section shall assign attorneys to assist the division  
27 and the boards in intake and investigations and to direct  
28 discipline-related prosecutions. Attorneys shall be assigned to  
29 work closely with each major intake and investigatory unit of the  
30 boards, to assist in the evaluation and screening of complaints from  
31 receipt through disposition and to assist in developing uniform  
32 standards and procedures for the handling of complaints and  
33 investigations.

34 A deputy attorney general of the Health Quality Enforcement  
35 Section shall frequently be available on location at each of the  
36 working offices at the major investigation centers of the boards,  
37 to provide consultation and related services and engage in case  
38 review with the boards' investigative, medical advisory, and intake  
39 staff. The Senior Assistant Attorney General and deputy attorneys  
40 general working at his or her direction shall consult as appropriate

1 with the investigators of the boards, medical advisors, and  
2 executive staff in the investigation and prosecution of disciplinary  
3 cases.

4 (c) The Senior Assistant Attorney General or his or her deputy  
5 attorneys-general shall assist the boards, division, or committees  
6 in designing and providing initial and in-service training programs  
7 for staff of the division, boards, or committees, including, but not  
8 limited to, information collection and investigation.

9 (d) The determination to bring a disciplinary proceeding against  
10 a licensee of the division or the boards shall be made by the  
11 executive officer of the division, boards, or committees as  
12 appropriate in consultation with the senior assistant.

13 (e) This section shall become operative July 1, 2008.

14 SEC. 92. No reimbursement is required by this act pursuant to  
15 Section 6 of Article XIII B of the California Constitution because  
16 the only costs that may be incurred by a local agency or school  
17 district will be incurred because this act creates a new crime or  
18 infraction, eliminates a crime or infraction, or changes the penalty  
19 for a crime or infraction, within the meaning of Section 17556 of  
20 the Government Code, or changes the definition of a crime within  
21 the meaning of Section 6 of Article XIII B of the California  
22 Constitution.

**Medical Board of California  
2007 Tracker II - Legislative Bills  
7/19/2007**

<u>BILL</u>	<u>AUTHOR</u>	<u>TITLE</u>	<u>STATUS</u>	<u>AMENDED</u>
AB 14	Laird	Discrimination: Civil Rights Act	Senate	07/03/07
AB 34	Portantino	Umbilical Cord Blood Collection Program	Sen. Judiciary	07/17/07
AB 54	Dymally	Health Care Coverage: Acupuncture	Health	03/08/07
AB 64	Berg	Uniform Emergency Volunteer Health Practitioners Act	Sen. Rules	07/11/07
AB 139	Bass	Vehicles: Schoolbus Drivers: Medical Examinations	Asm. Concur.	07/10/07
AB 158	Ma	Public Health	Approps.	05/01/07
AB 249	Eng	Licensees: Healing Arts: Settlement Agreements	Sen. B&P	
AB 269	Eng	Dentists: License Renewal	Sen. Approps.	06/26/07
AB 272	Garcia	HIV Tests	Health	
AB 295	Lieu	State Agencies: Collection of Demographic Data	Sen. Approps.	07/11/07
AB 309	Tran	State Boards and Commissions: Salaries: Suspension	B&P	04/12/07
AB 325	Nava	Peace Officers: Recruitment	App-Susp.	03/19/07
AB 374	Berg	California Compassionate Choices Act	Floor	05/25/07
AB 436	Salas	Medical Records	Health	04/09/07
AB 555	Nakanishi	Electronic Medical Records	Introduced	
AB 611	Nakanishi	Physician Assistants - Education Loan Program	Sen. Approps.	06/19/07
AB 612	Ruskin	Child Custody: Evaluations	Sen. Floor	07/17/07
AB 632	Salas	Health Care Facilities: Whistleblower Protections	Sen. Approps.	07/17/07
AB 636	Levine	Acupuncture	B&P	03/27/07
AB 644	Dymally	Workers' Compensation: medical treatment utilization review	Insurance	04/09/07
AB 682	Berg	HIV/AIDS Testing	Sen. Approps.	07/18/07
AB 865	Davis	State Agencies: Live Customer Service	B&P	04/23/07
AB 871	Davis	Hypertension and Diabetes	Introduced	
AB 961	Hernandez	Diabetes	Appr. Susp.	05/01/07
AB 1009	Benoit	Fetal Pain Prevention	Health	
AB 1039	Parra	Medical Referral Services	Introduced	

**Medical Board of California  
2007 Tracker II - Legislative Bills  
7/19/2007**

<b>BILL</b>	<b>AUTHOR</b>	<b>TITLE</b>	<b>STATUS</b>	<b>AMENDED</b>
AB 1044	Strickland	Optometrists: Regulation	B&P	04/09/07
AB 1057	Beall	Electronic Personal Records Strategic Plan	Senate Health	07/03/07
AB 1102	Nakanishi	Prescription Lenses: fitting of lenses	Introduced	
AB 1137	Eng	Chiropractors	Sen. B&P	07/03/07
AB 1154	Leno	Diabetes: Pilot Program	Health	04/10/07
AB 1178	Hernandez	Medical Information: Disclosures	Sen. Consent	07/03/07
AB 1198	Benoit	Law Enforcement Response Costs: Driving Under the Influence	Judiciary	
AB 1276	Karnette	Prescription Containers: Labels with Purpose	B&P	04/17/07
AB 1298	Jones	Personal Information: Disclosure	Sen. Approps.	07/17/07
AB 1390	Huffman	Health Care Service Plans: Unfair Payment Patterns	Sen. Health	
AB 1393	Leno	Public Records	Senate Approps.	06/26/07
AB 1399	Richardson	Pharmacies: Prescription Labels	Health	
AB 1429	Evans	Human Papillomavirus Vaccination	Sen. Floor	05/01/07
AB 1436	Hernandez	Scope of Practice: Nurse Practitioners & Physician Assistants	B&P	05/30/07
AB 1444	Emmerson	Physical Therapists: Scope of Practice	B&P	04/09/07
AB 1468	Garrick	Hospitals: Patient Data	Health	04/10/07
AB 1480	Mendoza	Physicians and Surgeons: Medical Board of CA	Introduced	
AB 1486	Calderon	Licensed Professional Counselors	Sen. B&P	06/26/07
AB 1531	DeSaulnier	Vehicles: Disabled Parking	Sen. Approps.	07/17/07
AB 1555	Lieber	Health Care Services: Chronic Care Model	Approps.	04/26/07
AB 1587	De La Torre	Personal Information: Pharmacy	Sen. E.,R.,&C.A.	07/16/07
AB 1643	Niello	Supervision of Nurse Practitioners: more than four	B&P	
AB 1725	Comm. on Judiciary	Discrimination: Medical Care	Sen. Consent	04/10/07
SB 136	Cedillo	Acupuncture: Asian Massage	B&P	04/16/07
SB 284	Lowenthal	Athletic Trainers: Registration	Sen. Floor	07/10/07
SB 320	Alquist	CA Health Care Information Infrastructure Program	Appr.-Susp	06/26/07

**Medical Board of California  
2007 Tracker II - Legislative Bills  
7/19/2007**

<b><u>BILL</u></b>	<b><u>AUTHOR</u></b>	<b><u>TITLE</u></b>	<b><u>STATUS</u></b>	<b><u>AMENDED</u></b>
SB 356	Negrete McLeod	List of Reportable Diseases and Conditions	Asm. Approps.	06/04/07
SB 374	Harman	Military Service: Benefits	Appr.-Susp	05/01/07
SB 387	Alquist	Dentists: Death or Incapacity	Asm. Approps.	07/10/07
SB 478	Hollingsworth	Physicians: Loan Repayment	Rules	
SB 519	Comm. on Gov Org	Public Meetings: Special Meetings	Enrolled	07/11/07
SB 533	Yee	Health: Immunizations: Pneumococcus	Asm. Approps.	07/18/07
SB 557	Wiggins	Worker's Comp: Qualified Medical Evaluators: Audiologists	Asm. Approps.	07/09/07
SB 615	Oropeza	Pharmacy Technicians: Scholarship & Loan Repayment Prog	Asm. Approps.	04/16/07
SB 618	Alquist	State Agencies: Electronic Records	Appr.-Susp	
SB 661	Maldonado	Healing Arts: Anatomic Pathology Services	Asm. Approps.	06/28/07
SB 676	Ridley-Thomas	Immunizations	Asm. Approps.	07/18/07
SB 721	Ashburn	State Agencies: Succession Plans	Asm. Approps.	
SB 731	Oropeza	Massage Therapy	Asm. Approps.	07/09/07
SB 743	Kuehl	Hospitals: Medical Errors	Floor	05/16/07
SB 801	Ridley-Thomas	Chiropractors	Asm. Approps.	06/04/07
SB 809	Ashburn	Expanding Scope of Practice for Nurse Practitioners	B&P	03/26/07
SB 822	Aanestad	Immunity: Evaluation of Practitioner of Healing Arts	Chaptered (36)	07/10/07
SB 840	Kuehl	Single-Payer Health Care Coverage	Asm. Approps.	07/10/07
SB 843	Calderon	Medical Information	Judiciary	04/18/07
SB 850	Maldonado	Birth Certificates: Stillborn Births	Asm. Approps.	06/13/07
SB 907	Calderon	Compensation for Referrals	B&P	
SB 962	Migden	Umbilical Cord Blood Collection Program	Asm. Approps.	05/01/07
SB 963	Ridley-Thomas	Regulatory Boards: Regulation	Asm. B&P	06/25/07
SB 971	McClintock	Government Reorganization: Realignment of Closure	G.O.	
SB 993	Aanestad	Psychologists: Scope of Practice: prescribing	B&P	04/18/07
SB 1014	Kuehl	Taxation: Single-Payer Health Care Coverage Tax	Rev.&Tax	04/23/07
SB 1047	B&P Comm.	Professions and Vocations	Asm. Approps.	06/25/07