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

BILL	AUTHOR	TITLE	STATUS	POSITION	VER. OF BILL POS. BASED	LAST AMENDED	LETTERS
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

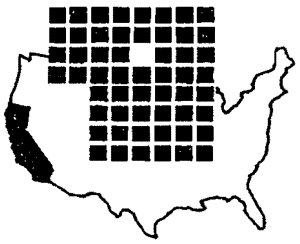
The "oppose unless amended" letter comes from:

- Union of American Physicians and Dentists

FISCAL: None

POSITION: Recommendation: Support

July 18, 2007



CAL/ACEP

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

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS

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

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.

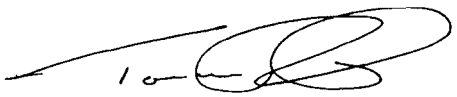
- ***Standardizing the Formulary and Advanced Approval Process for All Drug Orders by Physician Assistants:*** Existing law permits PAs to issue drug orders, similar to prescriptions, for all medications, including controlled substances. PA drug orders are written based on a formulary and protocols established 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

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.

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.

Legal & Government Relations
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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,

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

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secretary
PETER A. STATTI, M.D.
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

Introduced by Assembly Member Bass

December 4, 2006

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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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 pulbic) 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.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

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,

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

Introduced by Assembly Member Eng

February 5, 2007

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:

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

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

~~The~~

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

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

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

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

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

~~This~~

(d) 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. The repeal of this section renders the board subject to the review required by Division 1.2 (commencing with Section 473).

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

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

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

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

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

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

(b) The administration and hearing of disciplinary actions.

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

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

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

(f) Approving undergraduate and graduate medical education programs.

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

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

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

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

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

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

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

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

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

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

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

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

(b) Four members of a panel of the board shall constitute a quorum for the transaction of business at any meeting of the panel. ~~Ten~~ *8* members shall constitute a quorum for the transaction of business at any board meeting.

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

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

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

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

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

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

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

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

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

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

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

2041. The term "licensee" as used in this chapter means the holder of a physician's and surgeon's certificate or doctor of podiatric medicine's certificate, as the case may be, who is engaged in the professional practice authorized by the certificate under the jurisdiction of the appropriate board.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2540.1. Any reference to the "Division of Medical Quality" or to the "Division of Licensing" in this chapter shall be deemed to refer to the Medical Board of California.

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

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

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

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

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

February 13, 2007

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:

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

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

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

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

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

(d) The board shall make a report with its 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.* The report shall include an evaluation of the improvement and affordability of health care services and the reduction in the number of complications achieved by the pilot program.

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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 16th 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 5th 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

Introduced by Assembly Member Bass

February 22, 2007

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:

SECTION 1. Section 480 of the Business and Professions Code is amended to read:

480. (a) A board may deny a license regulated by this code on the grounds that the applicant has done one of the following:

(1) Been convicted of a crime. A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. Any action which a board is permitted to take following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence.

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

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

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

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

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

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

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

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

~~(A)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

490. *(a)* A board may suspend or revoke a license on the ground 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. A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. Any action which a board is permitted to take following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence. ~~No~~

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

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

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

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

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

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

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

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

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

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

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

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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 to 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

Introduced by Assembly Member Nava

February 23, 2007

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:

SECTION 1. Section 4604.5 of the Labor Code is amended to read:

4604.5. (a) Upon adoption by the administrative director of a medical treatment utilization schedule pursuant to Section 5307.27, the recommended guidelines set forth in the schedule shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.

(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are evidence and scientifically based, nationally recognized, and peer-reviewed. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.

(c) Three months after the publication date of the updated American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, and continuing until the effective date of a medical treatment utilization schedule,

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

(d) (1) Notwithstanding the medical treatment utilization schedule or the 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Introduced by Assembly Member Hernandez

February 23, 2007

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:

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

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

~~(1) "Peer review body" includes:~~

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

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

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

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

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

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

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

~~(4) "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.~~

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

~~(6) "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.~~

~~(7) "805 report" means the written report required under subdivision (b).~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Prior to the delivery of health care via telemedicine, the health care practitioner 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. The informed consent procedure shall ensure that at least all of the following information is given to the patient or the patient's legal representative verbally and in writing:

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

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

(3) All existing confidentiality protections apply.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) Corneal surface disease and dry eyes.

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

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

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

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

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

(2) Topical lubricants.

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

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

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

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

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

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

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

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

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

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

(5) Topical antibiotic agents.

(6) Topical hyperosmotics.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) Oral analgesics that are not controlled substances.

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

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

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

(1) Mechanical epilation.

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

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

(4) The prescription of therapeutic contact lenses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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 provides 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

Introduced by Senator Corbett

February 21, 2007

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:

SECTION 1. This act shall be known and may be cited as the California Patient Medication Safety Act.

SEC. 2. The Legislature hereby finds and declares all of the following:

(a) Health care costs and spending in California are rising dramatically and are expected to continue to increase.

(b) In California, prescription drug spending totaled over $188 billion in 2004, a $14 billion dollar per year spending increase from 1984.

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

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

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

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

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

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

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

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

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

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

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

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

~~shall include equal membership among groups representing consumers, such as seniors, and groups representing those with special issues regarding language and cultural competency in the use of prescription drugs, as well as pharmacy and medical professionals. The panel may include, but is not limited to, representatives of all of the following:~~

~~(1) Health plans or their representative association.~~

~~(2) Pharmacy representatives.~~

~~(3) Health care providers or their representative association.~~

~~(4) Faculty representatives from a school of pharmacy.~~

~~(5) Associations related to research, manufacturers, or distributors of pharmaceutical drugs.~~

~~(6) Medical associations.~~

~~(7) Consumer groups, such as senior citizens groups.~~

~~(8) Health advocacy groups.~~

~~(9) The board.~~

~~(10) Language accessibility experts.~~

~~(c) The panel may secure private contributions to fund its responsibilities pursuant to this section.~~

~~(d) The panel's review shall include a study and recommendations of best practices for prescription drug labels, including all of the following topics:~~

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

~~(2) Improved directions for use.~~

~~(3) Improved font types and sizes.~~

~~(4) Placement of information that is patient centered.~~

~~(5) Standards for implementation by pharmacies, including both of the following:~~

~~(A) Technology requirements to implement the standards.~~

~~(B) Affordability to pharmacies of implementing the standards. The panel shall ensure that its recommendation for implementation of a standardized label is affordable for pharmacies.~~

~~(e) On the recommendation of the panel, the board shall, by regulation, adopt a standardized label for prescription drug containers. The label shall be developed so that it meets all of the following requirements:~~

~~(1) It is understandable for prescription drug users.~~

~~(2) It describes the contents of the container so that prescription drug users with low medical literacy levels can understand it.~~

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

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

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

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

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

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

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

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

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

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

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

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

(2) Improved directions for use.
(3) Improved font types and sizes.
(4) Placement of information that is patient-centered.
(5) The needs of those patients with limited English proficiency.
(6) The needs of seniors.
(7) Technology requirements necessary to implement the standards.
(d) (1) On or before January 1, 2010, the board shall report to the Legislature on its progress under this section as of the time of the report.
(2) On or before January 1, 2013, the board shall report to the Legislature the status of implementation of the prescription drug label requirements adopted pursuant to this section.

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

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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

SENATE BILL No. 620

Introduced by Senator Correa
(Coauthor: Assembly Member Horton)

February 22, 2007

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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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

AMENDED IN ASSEMBLY JULY 18, 2007

AMENDED IN SENATE MARCH 27, 2007

SENATE BILL No. 761

Introduced by Senator Ridley-Thomas

February 23, 2007

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:

SECTION 1. Section 2006 of the Business and Professions 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:

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

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

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

~~SEC. 3.~~

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

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

~~SEC. 4.~~

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

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

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

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

most complex and varied types of disciplinary actions against the licensees of the 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 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. 5.~~

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

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

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

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

~~SEC. 7.~~

SEC. 8. Section 12529.5 of the Government Code, as added by Section 27 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 assist the division and the boards in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.

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

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards, 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 operative July 1, 2010.

~~SEC. 8.~~

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

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

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

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

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

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

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

O

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

Introduced by Senator Migden

February 23, 2007

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:

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

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

Information provided to the office pursuant to this section shall 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 upon the questionnaire so as to allow the office to track the geographical movements of physicians for planning purposes.

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

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

(2) Immigration trends.

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

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

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

(6) Population growth.

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

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

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

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

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

(1) Family practice.

(2) General internal medicine.

(3) General pediatrics.

(4) General practice.

(5) Gynecology.

(6) Obstetrics.

O

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 opiod 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

Introduced by Senator Ridley-Thomas

February 23, 2007

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:

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

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

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

(c) Prosecute those who sell controlled substances.

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

(e) Enact legislation to authorize any county in the state 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, recordkeeping, and reporting.

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

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

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

(3) Data on utilization of prehospital services.

(4) Suggestions improvements in data collection.

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

~~1714.22. (a) Notwithstanding any other provision of law, 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, obtained through a licensed health care provider who is working in conjunction with an opioid prevention and treatment training program, as defined in subdivision (d), to the person experiencing a drug overdose without being subject to civil liability for damages or criminal penalties as a result of this act.~~

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

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

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

1714.22. (a) For purposes of this section:

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

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

(A) The causes of an opiate overdose.

(B) Mouth to mouth resuscitation.

(C) How to contact appropriate emergency medical services.

(D) How to administer an opioid antagonist.

(b) A licensed health care provider who is permitted by law to prescribe an opioid antagonist may, if acting with reasonable care, prescribe and subsequently dispense or distribute an opioid antagonist in conjunction with an opioid overdose prevention and treatment training program, without being subject to civil liability or criminal prosecution. This immunity shall apply to the licensed health care provider even when the opioid antagonist is administered by and to someone other than the person to whom it is prescribed.

(c) Each local health jurisdiction that operates or registers an opioid overdose prevention and treatment training program shall, by September 1, 2009, collect, and report to the State Department of Public Health, all of the following data on programs within the jurisdiction:

(1) Number of training programs operating in the local health jurisdiction.

(2) Number of individuals who have received a prescription and training to administer naloxone hydrochloride.

(3) Number of naloxone hydrochloride doses prescribed.

(4) Number of naloxone hydrochloride doses administered.

(5) Number of individuals who received naloxone hydrochloride injections who were properly revived.

(6) Number of individuals who received naloxone hydrochloride injections who were not revived.

(7) Number of adverse events associated with a naloxone hydrochloride dose that was distributed as part of an opioid overdose prevention and treatment training program, including a description of the adverse events.

(d) On or before January 1, 2010, the State Department of Public Health shall compile the reports received by the local health jurisdictions pursuant to this section and forward the full report on opioid overdose prevention and treatment training programs to the Legislature.

(e) This section shall remain in effect only until January 1, 2011, and as of that date is repealed, unless a later enacted statute, that

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

O

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

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

March 22, 2007

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The total number of reports received pursuant to Section 805 by the type of peer review body reporting and, where applicable, the type of health care facility involved and the total number and type of administrative or disciplinary actions taken by the Medical Board of California with respect to the reports.

(e) The number of malpractice settlements in excess of thirty thousand dollars ($30,000) reported pursuant to Section 801.01. This information shall be grouped by specialty practice and shall include the total number of physicians and surgeons practicing in each specialty. For the purpose of this subdivision, "specialty" includes all specialties and subspecialties considered in determining the risk categories described in Section 803.1.

SEC. 28. Section 2335 of the Business and Professions Code is amended to read:

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

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

(c) A proposed decision shall be acted upon by a panel of the Division of Medical Quality or the California Board of Podiatric Medicine, as the case may be, in accordance with Section 11517 of the Government Code, except that all of the following shall apply to proceedings against licensees under this chapter:

(1) When considering a proposed decision, the division panel and the California Board of Podiatric Medicine shall give great weight to the findings of fact of the administrative law judge, except to the extent those findings of fact are controverted by new evidence.

(2) The Division of Medical Quality or the California Board of Podiatric Medicine shall poll the members of the division panel or California Board of Podiatric Medicine by written mail ballot concerning the proposed decision. The mail ballot shall be sent within 10 calendar days of receipt of the proposed decision, and shall poll each member on whether the member votes to approve the decision, to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of additional evidence, to defer final decision pending discussion of the case by the panel or board as a whole, or to nonadopt the decision. No party to the proceeding, including employees of the agency that filed the accusation, and no person who has a direct or indirect interest in the outcome of the proceeding or who presided at a previous stage of the decision, may communicate directly or indirectly, upon the merits of a contested matter while the proceeding is pending, with any member of the panel or board, without notice and opportunity for all parties to participate in the communication. The votes of four members of a division panel, and a majority of the California Board of Podiatric Medicine, are required to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of further evidence, or to nonadopt the decision. The votes of two members of the panel or board are required to defer final decision pending discussion of the case by the panel or board as a whole. If there is a vote by the specified number to defer final decision pending discussion of the case by the panel or board as a whole, provision shall be made for that discussion before the 100-day period specified in paragraph (3) expires, but in no event shall that 100-day period be extended.

(3) If four members of a division panel, or a majority of the California Board of Podiatric Medicine vote to do so, the panel of the division and the California Board of Podiatric Medicine shall issue an order of nonadoption of a proposed decision within 100 calendar days of the date it is received by the board. If a panel of the division or the California Board of Podiatric Medicine does

not refer the case back to the administrative law judge for the taking of additional evidence or issue an order of nonadoption within 100 days, the decision shall be final and subject to review under Section 2337. Members of a panel of the division or the California Board of Podiatric Medicine who review a proposed decision or other matter and vote by mail as provided in paragraph (2) shall return their votes by mail to the board within 30 days from receipt of the proposed decision or other matter.

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

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

SEC. 29. Section 2397 of the Business and Professions Code is amended to read:

2397. (a) A licensee shall not be liable for civil damages for injury or death caused in an emergency situation occurring in the licensee's office or in a hospital on account of a failure to inform a patient of the possible consequences of a medical procedure where the failure to inform is caused by any of the following:

(1) The patient was unconscious.

(2) The medical procedure was undertaken without the consent of the patient because the licensee reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient.

(3) A medical procedure was performed on a person legally incapable of giving consent, and the licensee reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of a person authorized to give such consent for the patient.

(b) This section is applicable only to actions for damages for injuries or death arising because of a licensee's failure to inform,

and not to actions for damages arising because of a licensee's negligence in rendering or failing to render treatment.

(c) As used in this section:

(1) "Hospital" means a licensed general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

(2) "Emergency situation occurring in the licensee's office" means a situation occurring in an office, other than a hospital, used by a licensee for the examination or treatment of patients, requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.

(3) "Emergency situation occurring in a hospital" means a situation occurring in a hospital, whether or not it occurs in an emergency room, requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.

SEC. 30. Section 2416 of the Business and Professions Code is amended to read:

2416. Physicians and surgeons and doctors of podiatric medicine may conduct their professional practices in a partnership or group of physician and surgeons or a partnership or group of doctors of podiatric medicine, respectively. Physician and surgeons and doctors of podiatric medicine may establish a professional partnership that includes both physician and surgeons and doctors of podiatric medicine, if both of the following conditions are satisfied:

(a) A majority of the partners and partnership interests in the professional partnership are physician and surgeons or osteopathic physician and surgeons.

(b) Notwithstanding Chapter 2 (commencing with Section 15001) of Title 1 of the Corporations Code, a partner who is not a physician and surgeon shall not practice in the partnership or vote on partnership matters related to the practice of medicine that are outside his or her scope of practice. All partners may vote on general administrative, management, and business matters.

SEC. 31. Section 2471 is added to the Business and Professions Code, to read:

SEC. 85. Section 4997 of the Business and Professions Code is repealed.

SEC. 86. Section 4997 is added to the Business and Professions Code, to read:

4997. (a) A licensee may apply to the board to request that his or her license be placed on inactive status.

(b) A licensee on inactive status shall be subject to this chapter and shall not engage in the practice of clinical social work in this state.

(c) A licensee who holds an inactive license shall pay a biennial fee in the amount of one-half of the standard renewal fee and shall be exempt from continuing education requirements.

(d) A licensee on inactive status who has not committed an act or crime constituting grounds for denial of licensure may, upon request, restore his or her license to practice clinical social work to active status.

(1) A licensee requesting his or her license be restored to active status between renewal cycles shall pay the remaining one-half of his or her renewal fee.

(2) A licensee requesting to restore his or her license to active status whose license will expire less than one year from the date of the request shall complete 18 hours of continuing education as specified in Section 4996.22.

(3) A licensee requesting to restore his or her license to active status whose license will expire more than one year from the date of the request shall complete 36 hours of continuing education as specified in Section 4996.22.

SEC. 87. Section 11372 of the Government Code is amended to read:

11372. (a) Except as provided in subdivision (b), all adjudicative hearings and proceedings relating to the discipline or reinstatement of licensees of the Medical Board of California, including licensees of affiliated health agencies within the jurisdiction of the Medical Board of California, that are heard pursuant to the Administrative Procedure Act, shall be conducted by an administrative law judge as designated in Section 11371, sitting alone if the case is so assigned by the agency filing the charging pleading.

(b) Proceedings relating to interim orders shall be heard in accordance with Section 11529.

SEC. 88. Section 12529 of the Government Code, as amended by Section 24 of Chapter 674 of the Statutes of 2005, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of the Medical Board of California or a division of the board.

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

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the 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, the Board of Psychology, and the committees under the jurisdiction of the Medical Board of California or a division of the board, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 89. Section 12529 of the Government Code, as added by Section 25 of Chapter 674 of the Statutes of 2005, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the

section is to prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of the Medical Board of California or a division of the board, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision (b) of Section 12529.5.

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

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the 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, the Board of Psychology, and the committees under the jurisdiction of the Medical Board of California or a division of the board, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become operative July 1, 2008.

SEC. 90. 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, the California Board of Podiatric Medicine, or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section

12529 to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints.

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

(d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, boards, or committees as appropriate in consultation with the senior assistant.

(e) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 91. Section 12529.5 of the Government Code, as added by Section 27 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, the California Board of Podiatric Medicine, or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

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

A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate

with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases.

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

(d) The determination to bring a disciplinary proceeding against a licensee of the division or the boards shall be made by the executive officer of the division, boards, or committees as appropriate in consultation with the senior assistant.

(e) This section shall become operative July 1, 2008.

SEC. 92. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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Medical Board of California
2007 Tracker II - Legislative Bills
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BILL	AUTHOR	TITLE	STATUS	AMENDED
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	Electonic 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 reivew	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	

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BILL	AUTHOR	TITLE	STATUS	AMENDED
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 Papillonavirus 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
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BILL	AUTHOR	TITLE	STATUS	AMENDED
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