MEDICAL BOARD OF CALIFORNIA - 2018 TRACKER LIST
April 18, 2018

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 505	Caballero	Physicians and Surgeons: Probation	2-Year Bill	Oppose	3/27/17
AB 710	Wood	Cannabidiol	Sen. Rules	Reco: Neutral	4/2/18
AB 1368	Calderon	Medi-Cal: Authorization Requests	2-Year Bill	Neutral	6/29/17
AB 1560	Friedman	Nurse Practitioners: Supervision	2-Year Bill	Oppose Unless Amended	7/3/17
AB 1751	Low	Controlled Substances: CURES Database	Asm. Public Safety	Support	1/3/18
AB 1752	Low	Controlled Substances: CURES Database	Asm. Public Safety	Support	4/5/18
AB 1791	Waldron and Gipson	Physicians and Surgeons: Continuing Education	Assembly	Reco: Neutral	4/2/18
AB 1795	Gipson	Emergency Medical Services: Behavioral Health Facilities and Sobering Centers	Asm. Health	Reco: Support	4/2/18
AB 1802	Salas	Optometry: Scope of Practice	Spot Bill		
AB 1998	Rodriguez	Opioids: Safe Prescribing Protocol	Asm. Health	Reco: Neutral	4/11/18
AB 2086	Gallagher	Controlled Substances: CURES Database	Asm. Approps	Reco: Support	4/3/18
AB 2138	Chiu	Licensing Boards: Denial of Application: Criminal Conviction	Asm. B&P	Reco: Oppose	4/2/18
AB 2174	Waldron	Heroin and Opioid Public Education (HOPE) Act	Asm. Approps	Reco: Neutral	3/15/18
AB 2193	Maienschein	Maternal Mental Health	Asm. Health	Reco: Oppose	
AB 2311	Arambula	Medicine: Trainees: International Medical Graduates	Assembly	Sponsor/Support	

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

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AB 2409	Kiley	Professions and Vocations: Occupational Regulations	Asm. B&P	Reco: Oppose	4/16/18
AB 2461	Flora and Obernolte	Criminal History Information: Subsequent Arrest Notification	Asm. Approps	Reco: Support	
AB 2483	Voepel	Indemnification of Public Officers and Employees: Antitrust Awards	Asm. Approps	Reco: Support	4/9/18
AB 2487	McCarty	Physicians: Education: Opiate-Dependent Patient Treatment and Management	Asm. Approps	Reco: Oppose	4/16/18
AB 2539	Mathis	California Physician Corps Program: Practice Setting	Asm. Approps	Reco: Neutral	4/5/18
AB 2682	Burke	Nurse-Midwives	Asm. B&P	Reco: Oppose Unless Amended	
AB 2741	Burke	Prescription Drugs: Opioid Medications: Minors	Asm. Health	Reco: Oppose Unless Amended	4/2/18
AB 2760	Wood	Prescription Drugs: Naloxone Hydrochloride	Asm. Health	Reco: Support	4/3/18
AB 2783	O'Donnell	Controlled Substances: Schedules	Asm. Public Safety	Amended, Board no longer needs to take a position, T2	4/11/18
AB 2789	Wood	Health Care Practitioners: Prescriptions: Electronic Data Transmission	Asm. Approps		4/3/18
AB 2968	Levine	Psychotherapist-Client Relationship: Informational Brochure	Asm. B&P	Reco: Support	3/23/18
SB 641	Lara	CURES: Privacy	2-Year Bill	Neutral	4/20/17
SB 790	McGuire	Health Care Providers: Gifts and Benefits	2-Year Bill	Support	7/6/17
SB 944	Hertzberg	Community Paramedicine Act of 2018	Sen. Health	Reco: Oppose	3/21/18

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

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SB 1109	Bates	Controlled Substances: Schedule II Drugs: Opioids	Sen. Health	Reco: Neutral	4/4/18
SB 1114	Fuller	Health Care Professionals	Spot Bill		
SB 1163	Galgiani	Postmortem Examination or Autopsy	Sen. Public Safety	Reco: Support	4/16/18
SB 1238	Roth	Patient Records: Maintenance and Storage	Sen. Judiciary	Reco: Support	4/9/18
SB 1240	Stone	Prescription Drugs: CURES Database	Sen. B&P	Reco: Oppose	4/9/18
SB 1336	Morrell	Public Health: End of Life Option Act	Sen. Health	Reco: Neutral	4/2/18
SB 1426	Stone	Pharmacists: Authority to Prescribe and Dispense Dangerous Drugs and Devices	Sen. B&P	Reco: Oppose	3/22/18
SB 1448	Hill	Healing Arts Licensees: Probation Status: Disclosure	Sen. B&P		4/9/18
SB 1495	Comm. on Health	Health	Sen. Health	Reco: Neutral	4/10/18

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 710
Author: Wood
Bill Date: April 2, 2018, Amended
Subject: Cannabidiol
Sponsor: Epilepsy Foundation of Greater Los Angeles

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physician, pharmacist, or other authorized healing arts licensee acting within his or her scope of practice, to prescribe, furnish, or dispense cannabidiol, if it is excluded from Schedule 1 of the federal Controlled Substances Act (Act) and placed on a schedule other than Schedule I, or if a product composed of cannabidiol is approved by the federal Food and Drug Administration (FDA) and either placed on a schedule of the Act other than Schedule I or is exempted from the Act. If a physician, pharmacist, or other authorized healing arts licensee who prescribes, furnishes, or dispenses cannabidiol in accordance with federal law, they shall be deemed to be in compliance with state law. This bill is an urgency statute and will take effect immediately upon being signed into law.

BACKGROUND (taken from the fact sheet for AB 845):

Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into five designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I. Existing law places marijuana in Schedule I and cannabidiol is a compound found in marijuana.

Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 Americans will develop epilepsy at some point in their lifetime. There is no "one size fits all" treatment option and about one million people live with uncontrolled or intractable seizures. Access to new treatment is particularly important for these individuals, who live with the continual risk of serious injuries and loss of life.

The FDA is currently reviewing at least one cannabidiol or CBD derived therapy (Epidiolex) that shows promise for the treatment of Dravet and Lennox Gastaut syndromes (LGS), tuberous sclerosis complex (TSC) and potentially other rare epilepsies. This potential treatment option has both Orphan Drug Designation from the FDA for Dravet syndrome and also Orphan Drug Designation for LGS and TSC, other rare types of epilepsy. Given the fast track designation, this potential treatment option could be available as soon as early 2018.

ANALYSIS

This bill would allow a physician, pharmacist, or other authorized healing arts licensee acting within his or her scope of practice, to prescribe, furnish, or dispense cannabidiol, if it is excluded from Schedule 1 of the federal Act and placed on a schedule other than Schedule I, or if a product composed of cannabidiol is approved by the federal Food and Drug Administration (FDA) and either placed on a schedule of the Act other than Schedule I or is exempted from the Act. If a physician, pharmacist, or other authorized healing arts licensee who prescribes, furnishes, or dispenses cannabidiol in accordance with federal law, they shall be deemed to be in compliance with state law.

This bill would specify that the provisions in this bill do not apply to any product containing cannabidiol that has been approved by the federal Food and Drug Administration that has either been placed on a schedule of the federal Controlled Substances Act other than Schedule 1 or has been exempted from one or more provisions of that act, and that is intended for prescribed use for the treatment of a medical condition.

This bill would state that upon the effective date of one of the federal changes specified in this bill, notwithstanding any other state law, a product composed of cannabidiol may be prescribed, furnished, dispensed, transferred, possessed, or used in accordance with federal law and is authorized pursuant to state law. This bill would specify that this section does not apply to any product containing cannabidiol that is made or derived from industrial hemp, and regulated accordingly. This bill is an urgency statute and will take effect immediately upon being signed into law.

Per the author's office, currently any product that contains any quantity of marijuana is considered a Schedule I controlled substance, unless specifically exempted. Under current law, should a product be derived from cannabidiol, it would still be considered a Schedule I controlled substance and therefore could not be prescribed in California. According to the author, the purpose of this bill is to ensure Californians with uncontrolled seizures will have continued access to FDA approved epilepsy treatments derived from cannabidiol.

This bill would ensure that if the federal government approves cannabidiol treatment, then cannabidiol can be prescribed, furnished and dispensed in California, in accordance with federal law. This bill merely aligns state law with federal law to allow treatments authorized by the federal government in the future. This bill essentially mirrors AB 845 (Wood) from 2017, and just adds an exception. The Board took a neutral position on AB 845, so staff is suggesting the Board also take a neutral position on this bill.

FISCAL: None

SUPPORT: Epilepsy Foundation of Greater Los Angeles (Sponsor)

OPPOSITION: None on file

AMENDED IN SENATE APRIL 2, 2018

AMENDED IN SENATE JANUARY 18, 2018

AMENDED IN ASSEMBLY APRIL 27, 2017

AMENDED IN ASSEMBLY MARCH 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 710

Introduced by Assembly Member Wood

February 15, 2017

An act to add Section 26002 to the Business and Professions Code, and to add Section 11150.2 to the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 710, as amended, Wood. Cannabidiol.

Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into 5 designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I, and the least restrictive limitations generally placed on controlled substances classified in Schedule V. Existing law designates cannabis in Schedule I. Cannabidiol is a compound contained in cannabis.

Existing law restricts the prescription, furnishing, possession, sale, and use of controlled substances, including cannabis and synthetic cannabinoid compounds, and makes a violation of those laws a crime, except as specified.

This bill, if one of specified changes in federal law regarding the controlled substance cannabidiol occurs, would deem a physician, pharmacist, or other authorized healing arts licensee who prescribes, furnishes, or dispenses a product composed of cannabidiol, in accordance with federal law, to be in compliance with state law governing those acts. The bill would also provide that upon the effective date of one of those changes in federal law regarding cannabidiol, the prescription, furnishing, dispensing, transfer, transportation, possession, or use of that product in accordance with federal law is for a legitimate medical purpose and is authorized pursuant to state law.

Existing law, the Medicinal and Adult-Use Cannabis Regulation and Safety Act, regulates the cultivation, processing, and sale of medicinal and adult-use cannabis within the state.

This bill would expressly exclude from regulation under that act, any medicinal product composed of cannabidiol approved by the federal Food and Drug Administration and either placed on a schedule of the federal Controlled Substances Act other than Schedule I, or exempted from one or more provisions of that act.

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

Vote: $^2/_3$. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares that both children and adults with epilepsy are in desperate need of new treatment options and that cannabidiol has shown potential as an effective ~~treatments~~ *treatment* option. If federal laws prohibiting the prescription of medications composed of cannabidiol are repealed or if an exception from the general prohibition is enacted permitting the prescription of drugs composed of cannabidiol, patients should have rapid access to this treatment option. The availability of this new prescription medication is intended to augment, not to restrict or otherwise amend, other cannabinoid treatment modalities *including, but not limited to, industrial hemp products and derivatives containing cannabidiol,* currently available under state law.

SEC. 2. Section 26002 is added to the Business and Professions Code, to read:

26002. This division shall not apply to any product containing cannabidiol that has been approved by the federal Food and Drug Administration that has either been placed on a schedule of the federal Controlled Substances Act other than Schedule I or has been exempted from one or more provisions of that act, and that is intended for prescribed use for the treatment of a medical condition.

SEC. 3. Section 11150.2 is added to the Health and Safety Code, to read:

11150.2. (a) Notwithstanding any other law, if cannabidiol is excluded from Schedule I of the federal Controlled Substances Act and placed on a schedule of the act other than Schedule I, or if a product composed of cannabidiol is approved by the federal Food and Drug Administration and either placed on a schedule of the act other than Schedule I, or exempted from one or more provisions of the act, so as to permit a physician, pharmacist, or other authorized healing arts licensee acting within his or her scope of practice, to prescribe, furnish, or dispense that product, the physician, pharmacist, or other authorized healing arts licensee who prescribes, furnishes, or dispenses that product in accordance with federal law shall be deemed to be in compliance with state law governing those acts.

(b) For purposes of this chapter, upon the effective date of one of the changes in federal law described in subdivision (a), notwithstanding any other state law, a product composed of cannabidiol may be prescribed, furnished, dispensed, transferred, transported, possessed, or used in accordance with federal law and is authorized pursuant to state law.

(c) This section does not apply to any product containing cannabidiol that is made or derived from industrial hemp, as defined in Section 11018.5 and regulated pursuant to that section.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure that patients are able to obtain access to a new treatment modality as soon as federal law makes it available, it is necessary that this act take effect immediately.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1752
Author: Low
Bill Date: April 5, 2018, Amended
Subject: Controlled Substances: CURES Database
Sponsor: California State Board of Pharmacy
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

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

BACKGROUND:

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

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

ANALYSIS

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

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

This bill will not add Schedule V drugs to the section of law that requires physicians to check the CURES database. Therefore, adding Schedule V drugs to CURES will have a significant impact on dispensers, not prescribers. In addition, changing the reporting deadline for dispensers will result in up-to-date information in CURES and will make it even more of an effective aid for physicians to use to prevent doctor shopping. This bill would also expand the controlled substances information included in CURES. The Board is supportive of these provisions. The Board did take a support if amended position on this bill at the last Board Meeting because it had a concern with the provision that would allow the California State Board of Pharmacy to add additional medications to CURES. This bill was amended to remove this provision. As such, the Board now is supportive of AB 1752.

FISCAL: None to the Board

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

OPPOSITION: American Civil Liberties Union

AMENDED IN ASSEMBLY APRIL 5, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1752

Introduced by Assembly Member Low

January 3, 2018

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

This bill would add Schedule V controlled substances to the CURES database. ~~The bill would additionally authorize the California State Board of Pharmacy, through regulation, to add additional medications to be tracked in the CURES database.~~ The bill would require a dispensing pharmacy, clinic, or other dispenser to report the information required by the CURES database no more than one working day after a controlled substance is dispensed. The bill would change what

information is required to be reported by deleting references to classification codes and adding the date of sale of the prescription.

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

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

SECTION 1. Section 11165 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

(5) Quantity of the controlled substance dispensed.

(6) Number of refills ordered.

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

(8) Date of origin of the prescription.

(9) Date of dispensing of the prescription.

(10) Date of sale of the prescription.

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

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

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

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

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II,

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

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

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

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

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

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

(iv) Violating a law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

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

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

(D) Commencing no later than October 1, 2018, an approved health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist pursuant to subdivision (b) of Section 209 of the Business and Professions

Code may use the department's online portal or a health information technology system that meets the criteria required in subparagraph (E) to access information in the CURES database pursuant to this section. A subscriber who uses a health information technology system that meets the criteria required in subparagraph (E) to access the CURES database may submit automated queries to the CURES database that are triggered by predetermined criteria.

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

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

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

(I) The date of the query.

(II) The time of the query.

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

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

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

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

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

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

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

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

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

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

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

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

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, Schedule IV, or Schedule V controlled substances, the department may initiate the referral of the history of controlled substances dispensed to an individual

based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the department pursuant to this section is medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a practitioner or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, 1308.14, and 1308.15 of Title 21 of the Code of Federal Regulations.

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

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

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

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

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

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

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1791
Author: Waldron and Gipson
Bill Date: April 2, 2018, Amended
Subject: Physicians and Surgeons: Continuing Education
Sponsor: Authors

DESCRIPTION OF LEGISLATION:

This bill would allow for an optional continuing medical education (CME) course in integrating HIV/AIDS pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medication maintenance and counseling in primary care settings.

BACKGROUND

Existing law requires physicians and surgeons to complete at least 50 hours of approved CME during each two-year license renewal cycle. Currently, physicians and surgeons only have a mandatory one-time CME requirement of 12 hours in the subject of pain management and the treatment of the terminally ill. There is also a mandate in existing law that requires general internists and family physicians who have a patient population of which over 25 percent are 65 years of age or older to complete at least 20 percent of all mandatory CME in a course in the field of geriatric medicine or the care of older patients.

Existing CME courses approved by the Medical Board of California's (Board) Licensing Program include:

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

ANALYSIS

This bill requires the Board, in determining its CME requirements, to consider including a course in integrating HIV/AIDS PrEP and PEP medication maintenance and counseling in primary care settings, especially as it pertains to HIV testing, access to care, counseling, high-risk communities, patient concerns, exposure to HIV/AIDS, and the appropriate care and treatment referrals. This bill would specify that the course shall be consistent with the most recent guidelines on PrEP and PEP, as published by the United States Public Health Service and the Centers for Disease Control and Prevention.

According to the authors, ample research shows that PrEP and PEP awareness among primary care providers is inadequate. As a result, these lifesaving treatments are under-prescribed at the expense of patient care, especially for prevention treatment and counseling in high-risk communities.

Although the Board has historically opposed mandated CME, this bill would not mandate particular CME for physicians. This bill only requires the Board to consider a course on integrating HIV/AIDS PrEP and PEP medication maintenance and counseling in primary care settings. The Board does not track employment information for physicians, so the Board would not know which physicians practice in primary care settings. However, if the Board decides that it is important to get out information to physicians on this particular type of CME to encourage attendance in these CME courses, it could include an article in its Newsletter or put information on the Board's website. Board staff suggests that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: APLA Health
Desert AIDS Project
Los Angeles LGBT Center
North County LGBTQ Resource Center
San Diego LGBT Community Center
San Francisco AIDS Foundation

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 2, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1791

Introduced by Assembly Members Waldron and Gipson
(Coauthors: Assembly Members Gallagher, Maienschein, and Voepel)
~~(Coauthor: Senator Wiener)~~
(Coauthors: Senators Atkins and Wiener)

January 8, 2018

An act to add Section 2191.4 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1791, as amended, Waldron. Physicians and surgeons: continuing education.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under that act, the board is required to adopt and administer standards for the continuing education of physicians and surgeons.

This bill would require the board, in determining continuing education requirements, to consider including a course in integrating HIV/AIDS pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medication maintenance and counseling in primary care settings, 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 2191.4 is added to the Business and Professions Code, to read:

2191.4. The board, in determining its continuing education requirements, shall consider including a course in integrating HIV/AIDS pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medication maintenance and counseling in primary care settings, especially as it pertains to HIV testing, access to care, counseling, high-risk communities, patient concerns, exposure to HIV/AIDS, and the appropriate care and treatment referrals. *That course shall be consistent with the most recent guidelines on PrEP and PEP as published by the United States Public Health Service and the Centers for Disease Control and Prevention.*

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1795
Author:	Gipson
Bill Date:	April 2, 2018, Amended
Subject:	Emergency Medical Services: Behavioral Health Facilities and Sobering Centers
Sponsor	Los Angeles County and California Hospital Association

DESCRIPTION OF LEGISLATION:

This bill would allow an emergency medical technician-paramedic (EMT-P), at the scene of an emergency, to transport the patient to a behavioral health facility, sobering center or a general acute care hospital (GACH), pursuant to an approved local emergency medical services (EMS) agencies' plan.

BACKGROUND

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

ANALYSIS

This bill would include in the definition of advanced life support, which an EMT-P is authorized to provide, allowing transport at the scene of an emergency to a behavioral health facility, sobering center, or GACH. If transport occurs to a behavioral health facility or sobering center, the approved local EMS plan must be followed.

This bill would define a behavioral health facility as a designated facility set forth in subdivision (n) of Section 5008 of the Welfare and Institutions Code, as follows:
(n) "Designated facility" or "facility designated by the county for evaluation and treatment" means a facility that is licensed or certified as a mental health treatment facility or a hospital, as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code, by the State Department of Public Health, and may include, but is not limited to, a licensed psychiatric hospital, a licensed psychiatric health facility, and a certified crisis stabilization unit.

This bill would define a sobering center as a non-correctional facility designated by a city county, or city and county, to provide a safe, supportive environment for intoxicated

individuals to become sober. This bill would specify that a city, county, or city and county may designate and contract with one or more sobering centers for the receipt of intoxicated individuals for the purposes of providing a safe environment for the individuals to regain their sobriety, and shall enter into a written agreement with the center to monitor safety.

This bill would require the sobering center to develop a plan to access emergency medical services at one or more facilities providing emergency-level care. This bill would require a sobering center to do the following:

- Provide one bed or mat per individual.
- Be equipped with, and maintain, an automated external defibrillator.
- Be adequately staffed, and have at least one registered nurse.
- Be equipped to monitor and treat intoxicated persons who do not require emergency medical care at a general acute care hospital.
- Establish medical and nursing standardized procedures for its nursing staff.
- Have sufficient bathroom and shower facilities to serve the projected caseload, including at least one ADA-accessible option.

This bill would allow a local EMS agency to submit, as part of its EMS plan, a plan to transport patients, who meet triage criteria, to a behavioral health facility or to a sobering center. This bill would require the plan to include all of the following:

- Standardized triage criteria and assessment procedures based on peer-reviewed data to be used by EMT-Ps to identify patients to be transported to a behavioral health facility or to a sobering center. The local EMS agency shall revise the triage criteria and the assessment procedures to adhere to guidelines developed by the Emergency Medical Services Authority (EMSA).
- One or more policies for the treatment of patients being transported to a behavioral health facility or to a sobering center.
- One or more policies for the prompt transfer of patient care between prehospital care personnel and medical personnel at a behavioral health facility or at a sobering center, including, but not limited to, an assessment to determine if the patient's condition requires transport to an emergency department of a GACH.
- A list of behavioral health facilities and of sobering centers that have agreed to participate and their hours of operation, including the hours when they are available to receive patients.
- A quality improvement plan that includes the submission of service data to the local EMS agency and EMSA by participating behavioral health facilities and sobering centers, as necessary to ensure the quality of the EMS services being provided.
- A policy requiring that a patient who meets the triage criteria for transport to a behavioral health facility or to a sobering center, but who requests to be transported to the emergency department of a GACH, shall be transported to the emergency department of a GACH.
- A provision setting forth the recommendations of the appropriate county agency or director, including the county mental health director, for the transport of persons to a behavioral health facility, in support of the plan to transport patients meeting triage

criteria to a behavioral health facility or to a sobering center.
- Provisions setting forth procedures for notification of next of kin and for the protection of the confidentiality of patient records consistent with applicable law.

This bill would require training for EMT-P's transporting to behavioral health facilities and sobering centers. For transport to a behavioral health facility, a participating EMT-P must complete at least 32 hours of instruction on all of the following:

- Behavioral health crisis intervention, provided by a licensed physician and surgeon with experience in the emergency department of a GACH.
- Assessment and treatment of intoxicated patients.
- Local EMS agency policies for the triage, treatment, transport, and transfer of care, of patients to a behavioral health facility.

In addition, this bill would require the local EMS agency to verify that the participating EMT-P participating in transfers to behavioral health facilities has completed training in all of the following topics meeting the standards of the United States Department of Transportation National Highway Traffic Safety Administration National Emergency Medical Services Education Standards:

- Psychiatric disorders.
- Neuropharmacology.
- Alcohol and substance abuse.
- Patient consent.
- Patient documentation.
- Medical quality improvement.

For sobering centers, this bill would require a participating EMT-P to complete at least 8 hours of instruction, with a 4-hour online didactic portion and a 4-hour classroom portion, on all of the following:

- The impact of alcohol intoxication on the local public health and emergency medical services system.
- Alcohol and substance use disorders.
- Triage and transport parameters.
- Health risks and interventions in stabilizing acutely intoxicated persons.
- Common conditions with presentations similar to intoxication.
- Disease process, behavioral emergencies, and injury patterns common to those with chronic alcohol use disorders.

This bill would require EMSA, by July 1, 2020, to develop and, after approval by the commission, adopt guidelines for the triage criteria and assessment procedures for local EMS agencies to use when they submit their EMS plans. This bill would also require EMSA to develop and, after approval by the commission, adopt guidelines for the collection and reporting of data.

This bill would require EMSA to do the following on an annual basis:

- Work in partnership with the local EMS agencies to review and analyze the data reported by the local EMS agencies as part of their EMS plans.
- Analyze the EMT-P training required, including, but not limited to, a statewide analysis of the data to provide feedback to local EMS agencies.
- Issue a report that includes at least all of the following:
    - EMSA's analysis of the EMS agencies data and training.
    - Detailed findings on the past and current status of local EMS agency plans.
    - An assessment of patient outcomes in the aggregate resulting from services provided under approved EMS plans.
    - Policy recommendations for improvement of administration of local plans and for the improvement of patient outcomes.

This bill would require EMSA to issue its first annual report by January 1, 2021. This bill would specify that the annual reports are public records within the meaning of the California Public Records Act. This bill would require EMSA to retain the reports and to make them available to the public by posting on EMSA's internet website.

The Board took a support in concept position on the previous language of this bill and on AB 820 at the last Board Meeting in January. At that time the Board believed that language needed to be included in this bill that set specific criteria for EMS plans that must be approved. The Board also had concerns regarding expanding the scope of EMT-Ps to include all types of treatment. This bill no longer includes any changes to an EMT-P's scope regarding treatment. This bill has added a significant amount of criteria that the EMS plans must include, including triage criteria and assessment procedures, which must be approved by EMSA. This bill now also includes specified training that must be completed by participating EMT-Ps. With these changes, based upon the Board's previous position, the Board should take a support position on this bill.

FISCAL: None

SUPPORT: California Hospital Association (Co-Sponsor)
Los Angeles County (Co-Sponsor)

OPPOSITION: American College of Emergency Physicians
California Nurses Association

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 2, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1795

Introduced by Assembly Member Gipson
(Principal coauthor: Assembly Member Ting)
(Coauthors: Assembly Members Acosta, Burke, Chiu, and Gallagher)
(Coauthor: Senator Wiener)

January 9, 2018

An act to amend Sections ~~1797.52, 1797.172,~~ *1797.52* and 1797.218 of, and to add Sections ~~1797.98~~ *1797.98, 1797.119, 1797.205,* and 1797.260 to, the Health and Safety Code, relating to emergency medical services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1795, as amended, Gipson. Emergency medical services: ~~community care facilities.~~ *behavioral health facilities and sobering centers.*

Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of all state agencies concerning emergency medical services. Among other duties, the authority is required to develop planning and implementation guidelines for emergency medical services systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of emergency medical services systems, and receive plans for the implementation of emergency medical services and trauma care systems from local EMS agencies.

The act also authorizes each county to develop an emergency medical services program and requires local EMS agencies to plan, implement, and evaluate an emergency medical services system. Existing law requires local EMS agencies to be responsible for the implementation of advanced life support systems, limited advanced life support systems, and for the monitoring of specified training programs for emergency personnel. Existing law defines advanced life support as special services designed to provide definitive prehospital emergency medical care, as specified, at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by that hospital. *Existing law makes it a crime to violate the act, or the rules or regulations adopted under the act.*

This bill would authorize a local emergency medical services agency to submit, as part of its emergency *medical* services plan, a plan to transport specified patients *who meet triage criteria* to a ~~community care facility,~~ *behavioral health facility or a sobering center,* as ~~defined, in lieu of transportation to a general acute care hospital.~~ *defined.* The bill would make conforming changes to the definition of advanced life support to include prehospital emergency care provided before and during, transport to a ~~community care facility, as specified. The bill would also direct the Emergency Medical Services Authority to authorize a local EMS agency to add to its scope of practice for specified emergency personnel those activities necessary for the assessment, treatment, and transport of a patient to a community care facility.~~ *behavioral health facility or a sobering center. The bill would authorize a city, county, or city and county to designate, and contract with, a sobering center to receive patients, and would establish sobering center standards.*

This bill would require the authority to adopt guidelines for the triage criteria and assessment procedures by July 1, 2020, and would require the authority to annually analyze administration of local plans and to report, as specified.

By expanding an existing crime, 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: ~~no~~ *yes*.

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

SECTION 1. Section 1797.52 of the Health and Safety Code is amended to read:

1797.52. "Advanced life support" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that ~~hospital, at the scene of an emergency for the purpose of determining transport to a community care facility or an acute care~~ hospital, and during transport to a ~~community care~~ *behavioral health* facility ~~as part of an approved local EMS agency emergency medical services plan.~~ *or to a sobering center.*

SEC. 2. Section 1797.98 is added to the Health and Safety Code, *immediately following Section 1797.97,* to read:

~~1797.98. "Community care facility" means a mental health urgent care center or sobering center staffed with medical personnel that is designated by a local EMS agency, as part of an approved local emergency medical services plan.~~

1797.98. (a) "Behavioral health facility" means a designated facility as set forth in subdivision (n) of Section 5008 of the Welfare and Institutions Code.

(b) "Sobering center" means a noncorrectional facility designated by a city, county, or city and county, to provide a safe, supportive environment for intoxicated individuals to become sober as set forth in Section 1797.205.

~~SEC. 3. Section 1797.172 of the Health and Safety Code is amended to read:~~

~~1797.172. (a) The authority shall develop and, after approval by the commission pursuant to Section 1799.50, adopt minimum standards for the training and scope of practice for EMT-P.~~

~~(b) The approval of the director, in consultation with a committee of local EMS medical directors named by the EMS Medical Directors Association of California, is required prior to implementation of any addition to a local optional scope of practice for EMT-Ps proposed by the medical director of a local EMS agency.~~

~~(c) Notwithstanding any other law, the authority shall be the agency solely responsible for licensure and licensure renewal of EMT-Ps who meet the standards and are not precluded from licensure because of any of the reasons listed in subdivision (d) of Section 1798.200. Each application for licensure or licensure renewal shall require the applicant's social security number in order to establish the identity of the applicant. The information obtained as a result of a state and federal level criminal offender record information search shall be used in accordance with Section 11105 of the Penal Code, and to determine whether the applicant is subject to denial of licensure or licensure renewal pursuant to this division. Submission of fingerprint images to the Department of Justice may not be required for licensure renewal upon determination by the authority that fingerprint images have previously been submitted to the Department of Justice during initial licensure, or a previous licensure renewal, provided that the license has not lapsed and the applicant has resided continuously in the state since the initial licensure.~~

~~(d) The authority shall charge fees for the licensure and licensure renewal of EMT-Ps in an amount sufficient to support the authority's licensure program at a level that ensures the qualifications of the individuals licensed to provide quality care. The basic fee for licensure or licensure renewal of an EMT-P shall not exceed one hundred twenty-five dollars ($125) until the adoption of regulations that specify a different amount that does not exceed the authority's EMT-P licensure, license renewal, and enforcement programs. The authority shall annually evaluate fees to determine if the fee is sufficient to fund the actual costs of the authority's licensure, licensure renewal, and enforcement programs.~~

~~If the evaluation shows that the fees are excessive or are insufficient to fund the actual costs of the authority's EMT-P licensure, licensure renewal, and enforcement programs, then the fees shall be adjusted accordingly through the rulemaking process described in the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Separate additional fees may be charged, at the option of the authority, for services that are not shared by all applicants for licensure and licensure renewal, including, but not limited to, any of the following services:~~

~~(1) Initial application for licensure as an EMT-P.~~

~~(2) Competency testing, the fee for which shall not exceed thirty dollars ($30), except that an additional fee may be charged for the cost of any services that provide enhanced availability of the exam for the convenience of the EMT-P, such as on-demand electronic testing.~~

~~(3) Fingerprint and criminal record check. The applicant shall, if applicable according to subdivision (c), submit fingerprint images and related information for criminal offender record information searches with the Department of Justice and the Federal Bureau of Investigation.~~

~~(4) Out-of-state training equivalency determination.~~

~~(5) Verification of continuing education for a lapse in licensure.~~

~~(6) Replacement of a lost licensure card. The fees charged for individual services shall be set so that the total fees charged to EMT-Ps shall not exceed the authority's actual total cost for the EMT-P licensure program.~~

~~(e) The authority may provide nonconfidential, nonpersonal information relating to EMS programs to interested persons upon request, and may establish and assess fees for the provision of this information. These fees shall not exceed the costs of providing the information.~~

~~(f) At the option of the authority, fees may be collected for the authority by an entity that contracts with the authority to provide any of the services associated with the EMT-P program. All fees collected for the authority in a calendar month by any entity designated by the authority pursuant to this section to collect fees for the authority shall be transmitted to the authority for deposit into the Emergency Medical Services Personnel Fund within 30 calendar days following the last day of the calendar month in which~~

~~the fees were received by the designated entity, unless the contract between the entity and the authority specifies a different timeframe.~~

~~(g) Upon approval of a plan to transport patients to a community care facility submitted pursuant to Section 1797.260, the authority shall authorize a local EMS agency to add to its scope of practice for an EMT-P those activities necessary for the assessment, treatment, and transport of a patient to a community care facility.~~

SEC. 3. Section 1797.119 is added to the Health and Safety Code, immediately following Section 1797.118, to read:

1797.119. (a) The authority shall, by July 1, 2020, develop and, after approval by the commission, adopt guidelines for the triage criteria and assessment procedures as set forth in paragraph (1) of subdivision (a) of Section 1797.260, and for the collection and reporting of data as set forth in paragraph (5) of subdivision (a) of Section 1797.260.

(b) The authority shall annually do all of the following:

(1) Work in partnership with the local EMS agencies to review and analyze the data reported pursuant to paragraph (5) of subdivision (a) of Section 1797.260.

(2) Analyze EMT-P training provided pursuant to paragraph (6) of subdivision (a) of Section 1797.260. including, but not limited to a statewide analysis of the data to provide feedback to local EMS agencies.

(3) Issue a report that includes at least all of the following:

(A) A provision setting forth the analyses required pursuant to paragraphs (1) and (2).

(B) Detailed findings on the past and current status of local EMS agency plans submitted pursuant to Section 1797.260.

(C) An assessment of patient outcomes in the aggregate resulting from services provided under approved plans pursuant to Section 1797.260.

(D) Policy recommendations for improvement of administration of local plans and for the improvement of patient outcomes.

(c) The first annual report pursuant to paragraph (3) of subdivision (b) shall be issued by January 1, 2021.

(d) The reports are public records within the meaning of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The reports shall be retained by the authority and made available to the public by posting on the authority's Internet Web site.

SEC. 4. Section 1797.205 is added to the Health and Safety Code, immediately following Section 1797.204, to read:

1797.205. (a) A city, county, or city and county may designate, and contract with, one or more sobering centers for the receipt of intoxicated individuals for the purposes of providing a safe environment for the individuals to regain their sobriety, and shall enter into a written agreement with the center to monitor safety and programmatic implementation pursuant to the agreement.

(b) The sobering center shall, pursuant to the agreement, develop a plan to access emergency medical services at one or more facilities providing emergency-level care.

(c) A sobering center shall comply with all of the following:

(1) It shall provide one bed or mat per individual.

(2) It shall be equipped with, and shall maintain, an automated external defibrillator.

(3) It shall be adequately staffed, and have at least one registered nurse.

(4) It shall be equipped to monitor and treat intoxicated persons who do not require emergency medical care at a general acute care hospital.

(5) It shall establish medical and nursing standardized procedures for its nursing staff.

(6) It shall have sufficient bathroom and shower facilities to serve the projected caseload, including at least one ADA-accessible option.

~~SEC. 4.~~

SEC. 5. Section 1797.218 of the Health and Safety Code is amended to read:

1797.218. *(a)* Any local EMS agency may authorize an advanced life support or limited advanced life support program which provides services utilizing EMT-II or EMT-P, or both, for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital, during interfacility transfer, while in the emergency department of a general acute care hospital until care responsibility is assumed by the regular staff of that hospital, *and* during training within the facilities of a participating general acute care ~~hospital, at the scene of an emergency for the purpose of determining transport to a community care facility or an acute care hospital, and during transport to a community care facility as part of an~~

~~approved local EMS agency emergency medical services plan.~~ *hospital.*

(b) Any local EMS agency may authorize an advanced life support program that provides services utilizing an EMT-P to transport patients to a behavioral health facility or to a sobering center pursuant to Section 1797.260.

~~SEC. 5.~~

SEC. 6. Section 1797.260 is added to the Health and Safety Code, *immediately following Section 1797.258,* to read:

1797.260. *(a)* A local EMS agency may submit, as part of its emergency *medical* services plan, a plan to transport ~~patients to a community care facility that is not a general acute care hospital based on a determination that there is no need for emergency health care. This plan shall include, without limitation, all of the following:~~ *patients, who meet the triage criteria, to a behavioral health facility or to a sobering center. The plan shall include at least all of the following:*

~~(a) Criteria for designating a facility as a community care facility, including appropriate medical staffing and administrative medical oversight such as a medical director.~~

~~(b) One or more policies for prompt evaluation and treatment of patients within a facility.~~

~~(c) A communication plan between prehospital medical personnel.~~

~~(d) A secondary transport plan to include criteria for contacting the jurisdictional prehospital provider for transport to an emergency department of an acute care hospital.~~

~~(e) Medical equipment and monitoring protocols.~~

~~(f) Required submission of a quality improvement plan and patient outcome data to the local EMS agency.~~

~~(g) Additional education requirements for paramedics.~~

~~(h) Protocols for handling patient destination considerations including requests by patients.~~

(1) Standardized triage criteria and assessment procedures based on peer-reviewed data to be used by EMT-Ps to identify patients to be transported to a behavioral health facility or to a sobering center. The local EMS agency shall revise the triage criteria and the assessment procedures to adhere to guidelines developed by the authority pursuant to Section 1797.119.

(2) One or more policies for the treatment of patients being transported to a behavioral health facility or to a sobering center.

(3) One or more policies for the prompt transfer of patient care between prehospital care personnel and medical personnel at a behavioral health facility or at a sobering center, including, but not limited to, an assessment to determine if the patient's condition requires transport to an emergency department of a general acute care hospital.

(4) A list of behavioral health facilities and of sobering centers that have agreed to participate and their hours of operation, including the hours when they are available to receive patients.

(5) A quality improvement plan that includes, notwithstanding Sections 4514 and 5328 of the Welfare and institutions Code, the submission of service data to the local EMS agency and the EMS authority by participating behavioral health facilities and sobering centers, as necessary to ensure the quality of the EMS services being provided. The data shall be redacted as necessary to ensure patient confidentiality and shall be reported in aggregate form only, with no personally identifiable patient information.

(6) (A) For transport to a behavioral health facility, a training component as follows:

(i) A requirement that a participating EMT-P complete at least 32 hours of instruction on all of the following:

(I) Behavioral health crisis intervention, provided by a licensed physician and surgeon with experience in the emergency department of a general acute care hospital.

(II) Assessment and treatment of intoxicated patients.

(III) Local EMS agency policies for the triage, treatment, transport, and transfer of care, of patients to a behavioral health facility.

(ii) A requirement that the local EMS agency verify that the participating EMT-P has completed training in all of the following topics meeting the standards of the United States Department of Transportation National Highway Traffic Safety Administration National Emergency Medical Services Education Standards:

(I) Psychiatric disorders.

(II) Neuropharmacology.

(III) Alcohol and substance abuse.

(IV) Patient consent.

(V) Patient documentation.

(VI) Medical quality improvement.

(B) For transport to a sobering center, a training component that requires a participating EMT-P to complete at least 8 hours of instruction, with a 4-hour online didactic portion and a 4-hour classroom portion, on all of the following:

(i) The impact of alcohol intoxication on the local public health and emergency medical services system.

(ii) Alcohol and substance use disorders.

(iii) Triage and transport parameters.

(iv) Health risks and interventions in stabilizing acutely intoxicated persons.

(v) Common conditions with presentations similar to intoxication.

(vi) Disease process, behavioral emergencies, and injury patterns common to those with chronic alcohol use disorders.

(7) A policy requiring that a patient who meets the triage criteria for transport to behavioral health facility or to a sobering center, but who requests to be transported to the emergency department of a general acute care hospital, shall be transported to the emergency department of a general acute care hospital.

(8) A provision setting forth the recommendations of the appropriate county agency or director, including the county mental health director, for the transport of persons to a behavioral health facility, in support of the plan to transport patients meeting triage criteria to a behavioral health facility or to a sobering center.

(9) Provisions setting forth procedures for notification of next of kin and for the protection of the confidentiality of patient records consistent with applicable law, including, but not limited to, the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), Sections 4514 and 5328 of the Welfare and Institutions Code, and the privacy provisions of the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(b) This section does not authorize a local EMS agency to adopt policies authorizing an EMT-P to initiate an involuntary detention or hold of a patient under Division 5 (commencing with Section 5000) of the Welfare and Institutions Code.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school

district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1998
Author: Rodriguez
Bill Date: April 11, 2018, Amended
Subject: Opioids: Safe Prescribing Protocol
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require, by June 1, 2019, every health care practitioner authorized to prescribe opioids to adopt a safe prescribing protocol, as specified.

BACKGROUND:

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

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

In 2014, the Director of the California Department of Public Health (CDPH) launched a state agency Prescription Opioid Misuse and Overdose Prevention Workgroup (Workgroup) to share information and develop collaborative strategies to curb prescription drug misuse, abuse, and overdose deaths in California. The Workgroup started as a multi-sector group consisting of more than 10 state agencies, including CDPH, Department of Justice, Department of Health Care Services, Department of Managed Health Care, Department of Education, Department of Industrial Relations, Department of Corrections and Rehabilitation, Department of Consumer Affairs

(including the Board, Dental Board, Board of Pharmacy, and Board of Registered Nursing), Emergency Medical Services Authority, and others. The Workgroup initially commenced a multi-phase plan involving enhancement of the state's Prescription Drug Monitoring Program (PDMP), promoting the release and adoption of the Board's revised Guidelines for Prescribing Controlled Substances for Pain, and development of a comprehensive public education campaign to increase public awareness about the potential dangers of opioid medications and to create better understanding and expectations among the public regarding proper prescribing, use, storage and disposal of opioids.

ANALYSIS

This bill would state the intent of the Legislature to reduce the number of opioid prescriptions and the quantity of doses in California by January 1, 2022. This bill would require, by June 1, 2019, every health care practitioner authorized to prescribe opioids classified as Schedule II and Schedule III to adopt a safe prescribing protocol (protocol). This bill would allow a group of practitioners to adopt a protocol that applies to all parties as part of a business affiliation or contract with an organized provider group.

This bill would require the protocol to be a written document promoting the appropriate and optimal selection, dosage, and duration of opioid prescriptions for patients, with the goal of reducing the misuse of opioids. This bill would require the protocol to include, but not be limited to, all of the following:

- The maximum dose and duration of prescriptions for adult patients experiencing acute pain.
- The maximum dose and duration of prescriptions for pediatric patients experiencing acute pain.
- Alternatives to opioid treatment, including non-pharmacological treatment options.
- Refill authorization practices.
- Co-prescription of opioid antagonists to at-risk patients, including, but not limited to, patients who meet any of the following criteria:
    - An opioid dosage of 90 morphine milligrams or more per day.
    - Patients who are prescribed benzodiazepines.
    - Patients with a history of substance abuse disorder.
- Referral guidelines and policies between primary care and specialty care, including, but not limited to, pain specialists.
- Mechanisms for prescriber peer-to-peer review and cooperation.
- Procedures for periodic review of the protocol for effectiveness in reducing opioid prescriptions.
- Procedures for updating the protocol, as appropriate.
- Mechanisms for patient education on the side effects of opioids, including the risk of addiction and overdose.

This bill would require the development of the protocol to include review and consideration of evidence-based science, literature, research, and guidelines, including relevant recommendations and research from academia and consideration of existing

guidelines and recommendations from groups including, but not limited to, the federal Centers for Disease Control and Prevention, the federal Centers for Medicare and Medicaid Services, the Board, and the American Society of Addiction Medicine.

This bill would allow a health care practitioner or a group of practitioners to adopt the federal Centers for Medicare and Medicaid Service opioid prescribing guidelines as the protocol.

This bill would specify that if, in the health care practitioner's professional judgment, adherence to the safe prescribing protocol is not appropriate for a patient's condition, the practitioner must note in the patient's record the reason the protocol was not followed. This bill would specify that it does not apply to a health care practitioner whose prescribing of opioids is limited to patients undergoing treatment for chronic pain, cancer, substance use disorder, or hospice or end-of-life care.

This bill would state that failure to develop or adhere to the protocol would constitute unprofessional conduct, which would be enforceable by the health care practitioner's licensing board.

This bill would require the CDPH, utilizing data from the CURES database for the year ending December 31, 2016, to monitor progress toward the goal stated in the legislative intent. This bill would require CDPH to report this information to the Legislature on an annual basis.

The growing opioid abuse epidemic remains a matter of concern for the Board. This bill would require individual physicians and/or physician groups to develop protocols for safe prescribing. However, instead of each individual physician and group developing a new protocol, this bill would allow adoption of the federal Centers for Medicare and Medicaid Service opioid prescribing guidelines as the protocol. This bill does not mandate the standard of care in law, but it does require physicians to have a protocol for prescribing opioids, which may help to promote appropriate prescribing. Board staff suggest that the Board take a neutral position on this bill.

FISCAL: Minimal and absorbable

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 11, 2018

AMENDED IN ASSEMBLY MARCH 12, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 1998

Introduced by Assembly Member Rodriguez

February 1, 2018

An act to ~~amend Section 11190 of, and to add Section 11154.5 to,~~ *add Section 11153.1 to* the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

AB 1998, as amended, Rodriguez. Opioids: ~~prescription limitations.~~ *safe prescribing protocol.*

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

This bill would require, by June 1, 2019, every health care practitioner authorized to prescribe opioids classified as Schedule II and Schedule III to adopt a safe prescribing protocol, as specified. The bill would require the health care practitioner to note the reason the safe prescribing protocol was not followed if, in the health care practitioner's professional judgment, adherence to the safe prescribing protocol is not appropriate for a patient's condition. The bill would make the failure to develop or adhere to the protocol, except as specified, unprofessional conduct and enforceable by the health care practitioner's licensing

board. Because violation of these provisions is also a crime, the bill would create a new crime, thereby imposing a state-mandated local program.

The bill would require the State Department of Public Health, utilizing data from the CURES database for the year ending December 31, 2016, to monitor progress toward stated goals and to report this information to the Legislature annually.

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.

~~This bill would prohibit a prescriber from prescribing an opioid in an amount greater that the patient needs for a 3-day period unless the prescriber believes, in his or her professional judgment, that a larger prescription is needed to treat a medical condition or that a larger prescription is necessary for the treatment of chronic pain. The bill would require a prescriber who writes a prescription for an opioid that is either larger than the 3-day supply or that is the 4th prescription without the dosage decreasing to include in the patient's record why the excess or additional prescription was needed, what other medications were considered, the patient's injury or illness, and the milligram dosage of the prescription. The bill would require the prescriber to take specified actions prior to prescribing an opioid, including informing the patient of the risks and treatment options for opioid addiction. By creating new crimes, this bill would impose a state-mandated local program.~~

~~Existing law imposes reporting requirements on practitioners prescribing Schedule II controlled substances and makes a violation of those reporting requirements a misdemeanor.~~

~~This bill would require, when a prescription is for an amount larger than that needed for 3 days or when the prescription is the 4th prescription without the dosage decreasing, the prescriber to report, in detail, why the excess or additional prescription was needed, what other medications were considered, the patient's injury or illness, and the milligram dosage of the prescription. The bill would also require a prescriber who fails to submit the report required to be referred to the appropriate licensing board for administrative action, as deemed appropriate by that board. By creating a new crime, 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. Section 11153.1 is added to the Health and Safety Code, to read:

11153.1. (a) It is the intent of the Legislature that by January 1, 2022, there shall be a ____% reduction in the number of prescriptions issued in California for opioids classified as Schedule II and Schedule III, as defined in Sections 11055 and 11056, respectively. It is also the intent of the Legislature that by January 1, 2022, there shall be a reduction of ____% in the quantity of doses authorized pursuant to prescriptions for opioids classified as Schedule II and Schedule III.

(b) By June 1, 2019, every health care practitioner authorized to prescribe opioids classified as Schedule II and Schedule III pursuant to Sections 11055 and 11056, respectively, shall adopt a safe prescribing protocol, as described in subdivision (c). A group of practitioners may adopt a safe prescribing protocol that applies to all parties as part of a business affiliation or contract with an organized provider group.

(c) The safe prescribing protocol shall be a written document promoting the appropriate and optimal selection, dosage, and duration of opioid prescriptions for patients, with the goal of reducing the misuse of opioids. The protocol shall include, but is not limited to, all of the following:

(1) The maximum dose and duration of prescriptions for adult patients experiencing acute pain.

(2) The maximum dose and duration of prescriptions for pediatric patients experiencing acute pain.

(3) Alternatives to opioid treatment, including nonpharmacological treatment options.

(4) Refill authorization practices.

(5) Coprescription of opioid antagonists to at-risk patients, including, but not limited to, patients who meet any of the following criteria:

(A) An opioid dosage of 90 morphine milligrams or more per day.

(B) Patients who are prescribed benzodiazepines.

(C) Patients with a history of substance use disorder.

(6) Referral guidelines and policies between primary care and specialty care, including, but not limited to, pain specialists.

(7) Mechanisms for prescriber peer-to-peer review and cooperation.

(8) Procedures for periodic review of the protocol for effectiveness in reducing opioid prescription.

(9) Procedures for updating the protocol, as appropriate.

(10) Mechanisms for patient education on the side effects of opioids, including the risk of addiction and overdose.

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

(e) A health care practitioner or a group of practitioners may adopt the federal Centers for Medicare and Medicaid Services opioid prescribing guidelines as the safe prescribing protocol.

(f) If, in the health care practitioner's professional judgment, adherence to the safe prescribing protocol is not appropriate for a patient's condition, the practitioner shall note in the patient's medical record the reason the protocol was not followed.

(g) This section does not apply to a health care practitioner who is authorized to prescribe opioids if the prescription of those opioids is limited to patients undergoing treatment for chronic pain, cancer, substance use disorder, or hospice or end-of-life care.

(h) Failure to develop or adhere to the protocol established pursuant to this section, except as provided in subdivision (f), is

unprofessional conduct and enforceable by the health care practitioner's licensing board.

(i) The State Department of Public Health, utilizing data from the CURES database for the year ending December 31, 2016, shall monitor progress toward the goal stated in subdivision (a) and, notwithstanding Section 10231.5 of the Government Code, shall report this information to the Legislature annually. The report shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. Section 11154.5 is added to the Health and Safety Code, to read:~~

~~11154.5. (a) A prescriber shall not prescribe an opioid listed in subdivision (b) or (c) of Section 11055 in an amount greater that the patient needs for a three-day period unless the prescriber believes, in his or her professional judgment, that a larger prescription is needed to treat a medical condition or that a larger prescription is necessary for the treatment of chronic pain. If a prescription is written for more than a three-day supply, the prescriber shall include in the patient's record, in detail, why the excess prescription was needed, what other medications were considered, the patient's injury or illness, and the milligram dosage of the prescription.~~

~~(b) When a prescriber writes a fourth prescription for an opioid listed in subdivision (b) or (c) of Section 11055 where the dosage of the prescription has not decreased, the prescriber shall include in the patient's record, in detail, why the additional prescription is needed, what other medications were considered, the patient's injury or illness, and the milligram dosage of the prescription.~~

~~(c) Prior to prescribing an opioid listed in subdivision (b) or (c) of Section 11055, a prescriber shall do all of the following:~~

~~(1) Consult with the patient regarding the quantity of the prescription and the option for a partial fill pursuant to Section 4052.10 of the Business and Professions Code.~~

~~(2) Inform the patient of the risks of opioid addiction and overdose.~~

~~(3) Inform the patient of the treatment options for opioid addiction, including medication-assisted therapy.~~

~~(4) Offer the patient a referral to psychological counseling and behavioral therapy.~~

~~(d) This section does not apply to prescriptions for either of the following:~~

~~(1) Management of pain associated with cancer.~~

~~(2) Use in palliative, end-of-life, or hospice care.~~

~~SEC. 2. Section 11190 of the Health and Safety Code is amended to read:~~

~~11190. (a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:~~

~~(1) The name and address of the patient.~~

~~(2) The date.~~

~~(3) The character, including the name, strength, and quantity of controlled substances involved.~~

~~(b) The prescriber's record shall show the pathology and purpose for which the controlled substance was administered or prescribed.~~

~~(c) (1) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance that is dispensed by a prescriber pursuant to Section 4170 of the Business and Professions Code, the prescriber shall record and maintain the following information:~~

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

~~(B) The prescriber's category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.~~

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

~~(D) Quantity of the controlled substance dispensed.~~

~~(E) ICD-9 (diagnosis code), if available.~~

~~(F) Number of refills ordered.~~

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

~~(H) Date of origin of the prescription.~~

~~(2) (A) Each prescriber that dispenses controlled substances shall provide the Department of Justice the information required by this subdivision on a weekly basis in a format set by the Department of Justice pursuant to regulation.~~

~~(B) The reporting requirement in this section shall not apply to the direct administration of a controlled substance to the body of an ultimate user.~~

~~(d) (1) For an opioid listed in subdivision (b) or (c) of Section 11055, when a prescription is for an amount larger than that needed for three days or when the prescription is the fourth prescription without the dosage decreasing, the practitioner shall report, in detail, why the longer or additional prescription was needed, what other medications were considered, the patient's injury or illness, and the milligram dosage of the prescription.~~

~~(2) In addition to the penalties authorized by Section 11191, a practitioner who fails to submit the report required pursuant to this subdivision shall be referred to the appropriate licensing board for administrative action, as deemed appropriate by that board.~~

~~(e) The reporting requirement in this section for Schedule IV controlled substances shall not apply to any of the following:~~

~~(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.~~

~~(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005.~~

~~(f) Notwithstanding paragraph (2) of subdivision (c), the reporting requirement of the information required by this section for a Schedule II or Schedule III controlled substance, in a format set by the Department of Justice pursuant to regulation, shall be on a monthly basis for all of the following:~~

~~(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.~~

~~(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005.~~

~~SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2086
Author: Gallagher
Bill Date: April 3, 2018, Amended
Subject: Controlled Substances: CURES Database
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a prescriber to access the Controlled Substances Utilization Review and Evaluation System (CURES) database for a list of patients for whom that prescriber is listed as a prescriber.

BACKGROUND:

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

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

ANALYSIS

According to the author, currently, physicians can only pull up individual patients to check that patient's prescription history in CURES. DOJ has historically interpreted statute to prohibit prescribers from receiving a list of patients to whom they are listed in CURES as having prescribed controlled substances, which makes it difficult for prescribers to identify whether a patient has been presenting fraudulent or forged prescriptions in that prescriber's name. This bill would allow prescribers of controlled

substances to access the CURES database for a list of patients for whom they are listed as being the prescriber in CURES. The author believes this bill will help prevent fraudulent prescriptions of controlled substances.

The Medical Board of California (Board) believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent doctor shopping. This bill will give physicians access to more information in CURES, which will make it even more effective for physicians. Board staff suggests that the Board support this bill.

FISCAL: None to the Board

SUPPORT: California Dental Association; California District Attorneys Association; CaliforniaHealth+ Advocates; California Hospital Association; California Medical Association; California Police Chiefs Association; and California Society of Anesthesiologists

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 3, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2086

Introduced by Assembly Member Gallagher
(Coauthors: Assembly Members Gipson and Mathis)

February 7, 2018

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

LEGISLATIVE COUNSEL'S DIGEST

AB 2086, as amended, Gallagher. Controlled substances: CURES database.

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

This bill would allow prescribers to ~~request from the Department of Justice~~ *access the CURES database for* a list of patients for whom that prescriber is listed as a prescriber in the CURES database.

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

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

SECTION 1. Section 11165 of the Health and Safety Code is amended to read:

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

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

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

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party, unless authorized by, or pursuant to, state and

federal privacy and security laws and regulations. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

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

(C) A prescriber ~~may request from the Department of Justice~~ *shall be allowed to access the CURES database for* a list of patients for whom that prescriber is listed as a prescriber in the CURES database.

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

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

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

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

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

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

(5) Quantity of the controlled substance dispensed.

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

(7) Number of refills ordered.

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

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

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

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

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 2138
Author:	Chiu and Low
Bill Date:	April 2, 2018, Amended
Subject:	Licensing boards: denial of application: revocation or suspension of licensure: criminal conviction
Sponsor:	Anti-Recidivism Coalition; East Bay Community Law Center; Legal Services for Prisoners with Children; and Root & Rebound

DESCRIPTION OF CURRENT LEGISLATION:

This bill would prohibit denial or revocation and suspension of a license for specified convictions. This bill would prohibit regulatory boards from requiring an applicant to self-disclose criminal history information. This bill would require boards to collect and publish demographic data regarding applicants who are denied licensure or who have licenses revoked or suspended, among other provisions.

ANALYSIS

This bill would, among other things, significantly limit the Medical Board of California's (Board) ability to ask about an applicant's or licensee's criminal history, and would restrict the Board's ability to deny a license or take disciplinary action against a licensee for criminal convictions.

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

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

- The applicant has been convicted of a crime for which the applicant is presently incarcerated or for a conviction occurring within the preceding five years. However, the preceding five year limitation would not apply to a conviction for a violent felony.
- The crime is directly and adversely related to the qualification, functions, or duties of the business or profession for which the application is made.
- The applicant has been subjected to formal discipline by a board within the preceding five years based on professional misconduct that would have been cause for discipline before the board for which the present application is made and that is directly and adversely related to the qualifications, functions, or duties of the business or profession for which the present application is made. However, prior disciplinary action by a board within the preceding five years shall not be the basis for denial of a license if the basis for that disciplinary

action was a conviction that has been dismissed pursuant to the Penal Code, or a comparable dismissal or expungement.

This bill would specify that denial of a license includes denial of an unrestricted license by issuance of a restricted or probationary license.

This bill would allow a board to suspend or revoke a license on the ground that the licensee has been convicted of a crime for which the applicant is presently incarcerated or for a conviction occurring within the preceding five years. However, the preceding five year limitation shall not apply to a conviction for a violent felony. This bill would allow a board to suspend or revoke a license only if the crime is directly and adversely related to the qualifications, functions, or duties of the business or profession for which application is made.

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

This bill would specify that a board can only discipline a licensee for conviction of a crime if the crime is directly and adversely related to the qualifications, functions, or duties of the business and profession for which the license was issued, and if the licensee was convicted of the crime within the preceding five years or is presently incarcerated for the crime. This bill would specify that the preceding five year limitation does not apply to a conviction for a violent felony. This bill would prohibit a board from suspending or revoking a license on the basis of a conviction, or the acts underlying a conviction, where that conviction has been dismissed pursuant to the Penal Code or a comparable dismissal or expungement. This bill would prohibit a board from suspending or revoking a license on the basis of an arrest that resulted in a disposition other than a conviction, including an arrest that resulted in an infraction, citation, or juvenile adjudication.

This bill would specify that the provisions in this bill do not prohibit any agency from taking disciplinary action against a licensee for professional misconduct in the course and scope of the licensee's profession that is based on evidence that is independent of an arrest.

This bill would prohibit any board from taking disciplinary action against a licensee or from denying a license for professional misconduct if the applicant or licensee successfully completes any diversion program under the Penal Code, successfully

completes any non-statutory diversion program or entry of judgment, or successfully completes an alcohol and drug problem assessment program.

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

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

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

- The number of applicants with a criminal record who received notice of denial or disqualification of licensure and the number of licensees with a criminal record who received notice of potential revocation or suspension of their license or who had their license revoked
- The number of applicants and licensees with a criminal record who provided evidence of mitigation or rehabilitation.
- The number of applicants with a criminal record who appealed any denial or disqualification of licensure and the number of licensees with a criminal record who appealed any suspension or revocation of a license.
- The final disposition and demographic information, including, but not limited to, voluntarily provided information on race or gender, of any applicant or licensee described in the above bullets.

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

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

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

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

This bill would require each board to post on its Internet Web site a summary of the criteria used to consider whether a crime is considered to be directly and adversely related to the qualifications, functions, or duties of the business or profession it regulates.

This bill would require probationary terms or restrictions placed on a license by a board to be limited to two years or less. This bill would only allow additional conditions to be imposed if the board determines that there is clear and convincing evidence that additional conditions are necessary to address a risk shown by clear and convincing evidence. This bill would require each board to develop criteria to aid it when considering the imposition of probationary conditions or restrictions to determine what conditions may be imposed to address a risk shown by clear and convincing evidence.

This bill would allow a licensee whose license has been placed on probation to petition the board for a change to the probation, including modification or termination of probation, one year from the effective date of the decision. This bill would require the board to issue its decision on the petition within 90 days of submission of the petition. This bill would specify that the petition shall be deemed granted by operation of law if the board does not file a decision denying the petition within 90 days of submission of the petition. This bill would specify that the one-year time period to petition for modification or termination of penalty shall control over longer time periods under a licensing act under this code or initiative act.

This bill would prohibit a board from denying a license based in whole or in part on a conviction without considering evidence of rehabilitation.

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

- The applicant or licensee has completed the criminal sentence at issue without a violation of parole or probation.
- The applicant or licensee documents that he or she has worked in a related field continuously for at least one year prior to licensure or successfully completed a course of training in a related field, unless the board finds a public record of an official finding that the applicant committed professional misconduct in the

course of that work. Work in a related field may include, but is not limited to, work performed without compensation and work performed while incarcerated. "Related field" means a field of employment whose duties are substantially similar to the field regulated by the board.

- The applicant or licensee has satisfied criteria for rehabilitation developed by the board.

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

This bill would significantly narrow the authority of the Board to deny a license and take disciplinary action for criminal convictions and actions taken by other licensing boards, even for crimes involving sexual misconduct, fraud, and alcohol or substance abuse. This bill would not allow the Board to deny a license on the basis of the acts underlying a conviction. This bill would define denial to also include a probationary license. This bill would allow applicants to lie on their application and not be met with any consequences, as the Board would no longer be able to issue a probationary license based on the applicant not disclosing information. The bill would limit the length of probation that the Board can require for a probationary license to two years, which is less than the Board typically imposes for unprofessional conduct. Moreover, this bill is unnecessary, because the Board already complies with the Administrative Procedures Act. Applicants and licensees have the right to have their matters heard through the administrative process, and then to appeal to a superior court if they disagree with the Board's decisions.

This bill would result in significant fiscal impact to the Board for the record retention and reporting requirements and the timeframes to process a petitions for termination/modification of probation. This bill would significantly narrow the Board's ability to deny licenses, issue probationary licenses, and take disciplinary action for convictions. This bill is not in line with the Board's mission of consumer protection and Board staff suggests the Board take an oppose position on this bill.

FISCAL: Board staff estimates it will need one half-time office technician position to ensure the Board is meeting the record retention requirements. The Board would also need a .25 Information Technology Specialist I to create and run the annual report required by this bill. This is estimated at a cost of $61,000 per year for both positions. This bill will also result in costs related to the provision in this bill that would allow a licensee whose license has been placed on probation to petition the board for a change to the probation, including modification or termination of probation, one year from the effective date of the decision. This bill would require the board to issue its decision on the petition within 90 days of submission of the petition. This would result in significant costs to the Board to get this petition through the process of Board approval in 90 days. This means that the petitions would have to be reviewed by Board staff, the Board, the

Attorney General's Office (AG) and heard by an Administrative Law Judge in this time period. Board staff estimates the fiscal impact of this provision to be approximately $750,000 for more Board staff for this increased workload, AG costs, and Office of Administrative Hearing costs.

SUPPORT: Anti-Recidivism Coalition (Sponsor); East Bay Community Law Center (Sponsor); Legal Services for Prisoners With Children (Sponsor); Root & Rebound (Sponsor); All of Us or None; Anchor of Hope Ministries; Because Black is Still Beautiful; Californians for Prop 57; Californians for Safety and Justice; Center for Employment Opportunities; Center for Living and Learning; Checkr; Los Angeles Regional Reentry Partnership; National Association of Social Workers – California Chapter; Prisoner Reentry Network; Project Rebound: Expanded; Roberts Enterprise Development Fund; Rise Together Bay Area; San Jose State University Record Clearance Project; and The Young Women's Freedom Center

OPPOSITION: None on file

POSITION: Recommendation: Oppose

AMENDED IN ASSEMBLY APRIL 2, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2138

Introduced by Assembly Members Chiu and Low

February 12, 2018

An act to amend ~~Sections 480 and~~ *Sections 7.5, 480, 481, 482, 488, 490, 492, 493, 1005, and* 11345.2 ~~of~~ *of, to add Section 481.5 to, and to repeal Section 490.5 of,* the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

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

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

business or profession the board regulates and requires a board to develop criteria to evaluate the rehabilitation of a person when considering the denial, suspension, or revocation of a license.

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

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

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

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

Existing law authorizes a board to suspend a license if a licensee is not in compliance with a child support order or judgment.

This bill would repeal that authorization.

Existing law authorizes specified agencies to take disciplinary action against a licensee or deny a license for professional misconduct if the licensee has successfully completed certain diversion programs or alcohol and drug problem assessment programs.

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

Existing law authorizes a board after a specified hearing requested by an applicant for licensure to take various actions, including imposing probationary conditions on the license.

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

This bill would also make necessary conforming changes.

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

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

SECTION 1. Section 7.5 of the Business and Professions Code is amended to read:

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

establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of ~~sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.~~ *sentence.* However, a board may not deny a license to an applicant who is otherwise qualified pursuant to subdivision (b) *or (c)* of Section 480.

~~Nothing~~

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

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

~~SECTION 1.~~

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

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

~~(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 that 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, irrespective of a subsequent order under the provisions of Section 1203.4, 1203.4a, or 1203.41 of the Penal Code.~~

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

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

~~(B) 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.~~

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

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

(B) The applicant has been subjected to formal discipline by a licensing board within the preceding five years based on professional misconduct that would have been cause for discipline before the board for which the present application is made and that is directly and adversely related to the qualifications, functions, or duties of the business or profession for which the present application is made. However, prior disciplinary action by a licensing board within the preceding five years shall not be the basis for denial of a license if the basis for that disciplinary action was a conviction that has been dismissed pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code or a comparable dismissal or expungement.

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

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

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

shall provide proof of the dismissal if it is not reflected on the report furnished by the Department of Justice.

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

~~(c)~~

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

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

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

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

(A) The denial or disqualification of licensure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The nature and gravity of the offense.

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

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

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

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

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

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

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

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

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

SEC. 5. Section 482 of the Business and Professions Code is amended to read:

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

~~(a)~~

(1) Considering the denial of a license by the board under Section ~~480; or~~ *480.*

~~(b)~~

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

~~Each~~

(b) Each board shall ~~take into account all competent evidence of rehabilitation furnished by the applicant or licensee.~~ *find that an applicant or licensee has made a showing of rehabilitation if any of the following are met:*

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

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

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

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

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

SEC. 6. Section 488 of the Business and Professions Code is amended to read:

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

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

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

(c) Deny the license.

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

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

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

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

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

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

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

~~(c) A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. An action that 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, irrespective of a subsequent order under Section 1203.4 of the Penal Code.~~

~~(d) The Legislature hereby finds and declares that the application of this section has been made unclear by the holding in Petropoulos v. Department of Real Estate (2006) 142 Cal.App.4th 554, and~~

~~that the holding in that case has placed a significant number of statutes and regulations in question, resulting in potential harm to the consumers of California from licensees who have been convicted of crimes. Therefore, the Legislature finds and declares that this section establishes an independent basis for a board to impose discipline upon a licensee, and that the amendments to this section made by Chapter 33 of the Statutes of 2008 do not constitute a change to, but rather are declaratory of, existing law.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 8. Section 490.5 of the Business and Professions Code is repealed.

~~490.5. A board may suspend a license pursuant to Section 17520 of the Family Code if a licensee is not in compliance with a child support order or judgment.~~

SEC. 9. Section 492 of the Business and Professions Code is amended to read:

492. *(a)* Notwithstanding any other provision of law, successful completion of any diversion program under the Penal Code, *successful completion by a licensee or applicant of any nonstatutory diversion program, deferred entry of judgment,* or successful completion of an alcohol and drug problem assessment program under Article 5 (commencing with Section 23249.50) of Chapter 12 of Division 11 of the Vehicle Code, shall ~~not~~ prohibit any ~~agency established under Division 2 (commencing with Section~~

~~500) of this code, or any initiative act referred to in that division,~~ *board* from taking disciplinary action against a licensee or from denying a license for professional ~~misconduct, notwithstanding that evidence of that misconduct may be recorded in a record pertaining to an arrest.~~ *misconduct.*

~~This section shall not be construed to apply to any drug diversion program operated by any agency established under Division 2 (commencing with Section 500) of this code, or any initiative act referred to in that division.~~

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

SEC. 10. Section 493 of the Business and Professions Code is amended to read:

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

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

(A) The nature and gravity of the offense.

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

(C) The nature and duties of the profession.

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

~~As~~

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

SEC. 11. Section 1005 of the Business and Professions Code is amended to read:

1005. The provisions of Sections 12.5, 23.9, 29.5, 30, 31, 35, 104, 114, 115, 119, 121, 121.5, 125, 125.6, 136, 137, 140, 141, 143, 163.5, 461, 462, 475, 480, 484, 485, 487, 489, 490, ~~490.5,~~ 491, 494, 495, 496, 498, 499, 510, 511, 512, 701, 702, 703, 704, 710, 716, 730.5, 731, and 851 are applicable to persons licensed by the State Board of Chiropractic Examiners under the Chiropractic Act.

~~SEC. 2.~~

SEC. 12. Section 11345.2 of the Business and Professions Code is amended to read:

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

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

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

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2174
Author: Waldron
Bill Date: March 15, 2018, Amended
Subject: Heroin and Opioid Public Education Act
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the California Department of Public Health (CDPH), upon appropriation by the Legislature or receipt of adequate state or federal grant funding, to develop, coordinate, implement and oversee a comprehensive multicultural public awareness campaign, to be known as the Heroin and Opioid Public Education (HOPE) Program, to combat the growing heroin and opioid medication epidemic in California. This bill would sunset the HOPE Program on January 1, 2023.

BACKGROUND:

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

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

In 2014, the Director of CDPH launched a state agency Prescription Opioid Misuse and Overdose Prevention Workgroup (Workgroup) to share information and develop collaborative strategies to curb prescription drug misuse, abuse, and overdose deaths in California. The Workgroup started as a multi-sector group consisting of more than 10

state agencies, including CDPH, Department of Justice, Department of Health Care Services, Department of Managed Health Care, Department of Education, Department of Industrial Relations, Department of Corrections and Rehabilitation, Department of Consumer Affairs (including the Board, Dental Board, Board of Pharmacy, and Board of Registered Nursing), Emergency Medical Services Authority, and others. The Workgroup initially commenced a multi-phase plan involving enhancement of the state's Prescription Drug Monitoring Program (PDMP), promoting the release and adoption of the Board's revised Guidelines for Prescribing Controlled Substances for Pain, and development of a comprehensive public education campaign to increase public awareness about the potential dangers of opioid medications and to create better understanding and expectations among the public regarding proper prescribing, use, storage and disposal of opioids.

ANALYSIS

This bill makes findings and declarations regarding the epidemic in California stemming from the use of heroin and the abuse of opioid medications and the need for awareness and dissemination of information. This bill would require CDPH, upon appropriation by the Legislature or receipt of adequate state or federal grant funding, to develop, coordinate, implement and oversee a comprehensive multicultural public awareness campaign, to be known as the HOPE Program, to combat the growing heroin and opioid medication epidemic in California. This bill would sunset the HOPE Program on January 1, 2023.

This bill would require the HOPE Program to provide for the coordinated and widespread public dissemination of individual case stories and other generalized information using appropriate types of media, including new technologies in media, print media, television and radio, and internet and social media. This dissemination of information shall focus on the following:

- Identifying the pathways that can lead to opioid medication abuse and heroin use.
- Showing the many faces of addiction and rebutting the commonly accepted myths and stereotypes about heroin users and opioid medication abusers.
- Educating the public on the negative impact of abuse and diversion of opioid medication, while recognizing the legitimate use of opioids.
- Describing the effects and warning signs of heroin use and opioid medication abuse to enable members of the public to know when help is needed.
- Showing the link that exits between heroin and opioid medication addiction and suicidal behavior.
- Identifying pathways that are available for individuals to seek help, and indicating telephone hotline systems for persons who wish to report cases of drug abuse or engage in substance abuse treatment.
- Highlighting the availability of naloxone hydrochloride as a means to avert death from a heroin or opioid medication overdose, identifying pathways for members of the public to obtain naloxone and training, and promoting the proper use of naloxone.
- Highlighting the benefits of substance abuse treatment.

- Highlighting the benefits of medication-assisted therapy using medications approved by the federal Food and Drug Administration, such as methadone, buprenorphine, extended-release injectable naltrexone, or other similar drugs, and destigmatizing the use of the medication-assisted therapy.
- Identifying the methods that can be used by an individual to help finance the costs of substance abuse treatment.
- Identifying the steps that individuals can take to prevent and deter others from misusing opioid medications.
- Identifying the proper methods for safeguarding and disposing of opioid medications.
- Addressing any other issues that CDPH may deem appropriate and necessary to proactively educate the public about the state's heroin or opioid medication epidemic and actions that can be taken by the members of the public to reduce the likelihood of heroin or opioid medication addiction.

In disseminating this information, the HOPE program shall employ a variety of complementary educational themes and messages that shall be tailored to appeal to different target audiences. At a minimum, the HOPE program shall incorporate all of the following:

- At least one message directed at individuals who are personally at risk of heroin use or opioid medication abuse or who have already started down a pathway of addiction.
- At least one message directed at family members and friends of addicted persons, teachers, school nurses, medical practitioners, and employers.
- At least one message that is directed at the dangers of teen drug pilfering from the household medicine cabinet and how this could be avoided through the use of safe storage products.

This bill would require information under the HOPE Program to be disseminated using culturally and linguistically appropriate means, and when feasible and appropriate, the information shall be made available in a variety of languages.

This bill would allow CDPH to enter into public-private partnerships with pharmaceutical or health care insurance companies, nonprofit social services organizations, mental health service providers and clinics, law enforcement, health care agencies, and school districts, that provide services in the state in order to facilitate the dissemination of information under the HOPE Program.

This bill would require CDPH to submit a report to the Governor and the Legislature on at least an annual basis that summarizes the actions undertaken by CDPH to implement this bill and to include an assessment of the effectiveness of the HOPE Program, including, but not limited to, effects on the rate of new opioid and heroin addictions by populations, mitigation of the effects of opioid or heroin addiction, crime rates, hospitalization rates, death rates, and other calculable results as determined by CDPH. The report shall provide any recommendations for legislative or executive action that may be necessary to facilitate the ongoing success of the HOPE Program.

According to the author, there is an epidemic in California of heroin use stemming from the abuse of opioid medications and this epidemic demands our attention. The author believes that in order for California to combat this epidemic, citizens must be armed with information that will allow them to recognize and undertake appropriate actions when they or their loved ones are at risk of succumbing to a heroin or opioid medication addiction.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. This bill will increase awareness and provide education to help prevent heroin use and opioid medication abuse. This bill includes that same language that was included in AB 182 from last year, which the Board supported. Since this bill contains the same language and promotes the Board's mission of consumer protection, staff suggests that the Board take a support position on this bill.

FISCAL: None to the Board

SUPPORT: AIDS Healthcare Foundation
Association of California Healthcare Districts
California Pharmacists Association
California Police Chiefs Association

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY MARCH 15, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2174

Introduced by Assembly Member Waldron

February 12, 2018

An act to ~~amend Section 1367.005~~ *add and repeal Article 5 (commencing with Section 11774) of Chapter 1 of Part 2 of Division 10.5* of the Health and Safety Code, relating to ~~health care coverage.~~ *drug abuse.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2174, as amended, Waldron. ~~Health care coverage: essential health benefits.~~ *Heroin and Opioid Public Education (HOPE) Act.*

Existing law tasks the State Department of Public Health with certain specified duties related to health information and strategic planning, including opioid misuse and overdose prevention. Among other duties, existing law directs the department, upon appropriation by the Legislature, to award naloxone grant funding to local health departments, local government agencies, or other entities, as specified, in order to reduce the rate of fatal overdose from opioid drugs including heroin and prescription opioids.

This bill would require the department, in consultation with stakeholders, to develop, coordinate, implement, and oversee a comprehensive multicultural public awareness campaign, to be known as "Heroin and Opioid Public Education (HOPE)," upon appropriation by the Legislature or receipt of state or federal grant funding, until January 1, 2023. The bill would require the HOPE program to provide for the coordinated and widespread public dissemination of individual case stories and other generalized information that focuses on, among

other things, the effects and warning signs of heroin use and opioid medication and identifying available pathways for individuals seeking help. The bill would require the HOPE program to effectuate the dissemination of information by using appropriate types of media, as specified, employing a variety of complementary educational themes and messages that are tailored to appeal to different target audiences, and using culturally and linguistically appropriate means.

The bill would require the department to submit a report to the Governor and Legislature on at least an annual basis, that summarizes the actions that have been undertaken by the department to implement the bill and includes an assessment of the effectiveness of the HOPE program, as specified.

~~The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. The act requires an individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2017, to, at a minimum, cover essential health benefits, and defines "essential health benefits" to include health benefits covered by other particular benchmark plans, including a certain plan offered during the first quarter of 2014. A willful violation of the act is a crime.~~

~~This bill would make technical, nonsubstantive changes to this provision.~~

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. This act shall be known, and may be cited, as the "HOPE Act."

SEC. 2. Article 5 (commencing with Section 11774) is added to Chapter 1 of Part 2 of Division 10.5 of the Health and Safety Code, to read:

Article 5. Heroin and Opioid Public Education (HOPE)

11774. The Legislature finds and declares all of the following:

(a) There is an epidemic in this state stemming from the use of heroin and the abuse of opioid medications.

(b) Prescription drug overdoses now kill more people than car accidents.

(c) Every day, 2,500 children 12 to 17, inclusive, years of age abuse a prescription painkiller for the first time, and more people are becoming addicted to prescription drugs.

(d) Data from the federal Centers for Disease Control and Prevention suggests that the nonmedical use of prescription painkillers costs public and private health insurers seventy-two billion eight hundred million dollars ($72,800,000,000) annually.

(e) In order for the state to combat this epidemic, citizens in all walks of life shall be alerted to the problem, and shall be armed with information that will allow them to recognize, and undertake appropriate actions, when they or their loved ones are at risk of, or are succumbing to, a heroin or opioid medication addiction.

(f) The widespread dissemination of information necessary to combat the state's heroin and opioid medication epidemic could be successfully achieved through the institution and maintenance of a multicultural statewide public awareness campaign, which would be carefully coordinated through all available multimedia channels to reach a wide variety of audiences, including drug users, their family members and friends, medical practitioners and nurses, emergency personnel, and employers.

11774.1. (a) The State Department of Public Health, upon appropriation by the Legislature or receipt of adequate state or federal grant funding, and in consultation with stakeholders, as appropriate, shall develop, coordinate, implement, and oversee a comprehensive multicultural public awareness campaign, to be known as "Heroin and Opioid Public Education (HOPE)," which shall allow for the coordinated and widespread dissemination of information designed to combat the growing heroin and opioid medication epidemic in the state.

(b) Using the means described in subdivision (c), HOPE shall provide for the coordinated and widespread public dissemination of individual case stories and other generalized information that focuses on any of the following:

(1) Identifying the pathways that can lead to opioid medication abuse and heroin use, and the reasons why opioid medication abuse may evolve into heroin use.

(2) Showing the many faces of heroin and opioid medication addiction and rebutting the commonly accepted myths and stereotypes about heroin users and opioid medication abusers.

(3) Educating the public on the negative impact of abuse and diversion of opioid medication, while recognizing the legitimate use of those same opioid drugs as medications.

(4) Describing the effects and warning signs of heroin use and opioid medication abuse, so as to better enable members of the public to determine when help is needed.

(5) Showing the link that exists between heroin and opioid medication addiction and suicidal behavior.

(6) Identifying the pathways that are available for individuals to seek help in association with their own, or another person's, heroin or opioid medication addiction, and indicating the various telephone hotline systems that exist in the state for persons who wish to report a case of drug abuse or engage in substance abuse treatment.

(7) Highlighting the availability of naloxone hydrochloride as a means to avert death from a heroin or opioid medication overdose, identifying pathways for members of the public to obtain a prescription for naloxone hydrochloride and training in the emergency administration of naloxone hydrochloride, and promoting the proper use of naloxone hydrochloride in crisis situations.

(8) Highlighting the benefits of substance abuse treatment and the potential for treatment to allow for the reclaiming of lives that have been upset by addiction, and underscoring the fact that relapses occur not because treatment is ineffective, but because of the nature of addiction, which is a recurring and relapsing disorder.

(9) Highlighting the benefits of medication-assisted therapy using medications approved by the federal Food and Drug Administration, such as methadone, buprenorphine, extended-release injectable naltrexone, or other similar drugs, and destigmatizing the use of that medication-assisted therapy.

(10) Identifying the methods that can be used by an individual to help finance the costs of substance abuse treatment.

(11) Identifying the steps that individuals can take to prevent and deter family members, friends, students, patients, coworkers, and others from first experimenting with inappropriately obtained

opioid medications, and from misusing or mismanaging lawful opioid medications.

(12) Identifying the proper methods for safeguarding, and for safely disposing of, legitimate opioid medications.

(13) Addressing any other issues that the department may deem appropriate and necessary to proactively educate the public about the state's heroin and opioid medication epidemic and the actions that can be taken by members of the public to reduce the likelihood of heroin or opioid medication addiction, or to otherwise respond to, or mitigate the effects of, heroin or opioid medication addiction in cases in which it is present.

(c) (1) The HOPE program shall effectuate the dissemination of information described in subdivision (b) by using appropriate types of media to achieve the goal efficiently and effectively, including new technologies in media, print media, television and radio, and Internet and social media.

(2) In disseminating the information described in subdivision (b), the HOPE program shall employ a variety of complementary educational themes and messages that shall be tailored to appeal to different target audiences in the state. At a minimum, the HOPE program shall incorporate all of the following:

(A) At least one message that is directed at, and is tailored to influence and resonate with, individuals who are personally at risk of heroin use or opioid medication abuse or who have already started down a pathway to addiction.

(B) At least one message that is directed at, and is tailored to influence and resonate with, the family members and friends of addicted persons, teachers, school nurses, medical practitioners, and employers.

(C) At least one message that is directed at the dangers of teen drug pilfering from the household medicine cabinet and how this could be avoided through the use of safe storage products.

(3) Information under the HOPE program shall be disseminated using culturally and linguistically appropriate means, in a manner that demonstrates respect for individual dignity and cultural differences. Where feasible and appropriate, the information shall be made available in a variety of languages.

(4) The department may enter into public-private partnerships with pharmaceutical or health care insurance companies, nonprofit social services organizations, mental health services providers

and clinics, law enforcement, health care agencies, and school districts, that provide services in the state in order to facilitate the dissemination of information under the HOPE program.

11774.2. (a) The department shall submit to the Governor and the Legislature on at least an annual basis, a report that summarizes the actions that have been undertaken by the department to implement this article and includes an assessment of the effectiveness of the program, including, but not limited to, effects on the rate of new opioid and heroin addictions by populations, mitigation of the effects of opioid or heroin addiction, crime rates, hospitalization rates, death rates, and other calculable results as determined by the department. The report shall provide any recommendations for legislative or executive action that may be necessary to facilitate the ongoing success of the program.

(b) A report to be submitted to the Legislature pursuant to this section shall be submitted in compliance with Section 9795 of the Government Code.

11774.3. The department may adopt regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) as necessary to implement this article.

11774.4. This article shall remain in effect only until January 1, 2023, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2023, deletes or extends that date.

~~SECTION 1. Section 1367.005 of the Health and Safety Code is amended to read:~~

~~1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2017, shall, at a minimum, include coverage for essential health benefits pursuant to PPACA and as outlined in this section. For purposes of this section, "essential health benefits" shall mean all of the following:~~

~~(1) The health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services~~

~~and chronic disease management, and pediatric services, including oral and vision care.~~

~~(2) (A) The health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2014, as follows, regardless of whether the benefits are specifically referenced in the evidence of coverage or plan contract for that plan:~~

~~(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 and in Section 1300.67 of Title 28 of the California Code of Regulations.~~

~~(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha-fetoprotein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).~~

~~(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.~~

~~(iv) The health benefits covered by the plan that are not otherwise required to be covered under this chapter, to the extent required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22,~~

~~1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the California Code of Regulations.~~

~~(v) Any other health benefits covered by the plan that are not otherwise required to be covered under this chapter.~~

~~(B) If there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under this chapter that were enacted prior to December 31, 2011, the requirements of this chapter shall be controlling, except as otherwise specified in this section.~~

~~(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall be deemed to not be in conflict with this chapter.~~

~~(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a contract subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, or guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).~~

~~(3) With respect to habilitative services, in addition to any habilitative services and devices identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, and guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services and devices shall be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract. Limits on habilitative and rehabilitative services and devices shall not be combined.~~

~~(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2014. The pediatric vision care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).~~

~~(5) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental benefit received~~

~~by children under the Medi-Cal program as of 2014, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).~~

~~(b) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).~~

~~(c) Except as provided in subdivision (d), nothing in this section shall be construed to permit a health care service plan to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.~~

~~(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, a plan may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) as long as the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.~~

~~(e) A health care service plan, or its agent, solicitor, or representative, shall not issue, deliver, renew, offer, market, represent, or sell any product, contract, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section.~~

~~(f) This section applies regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.~~

~~(g) This section shall not be construed to exempt a plan or a plan contract from meeting other applicable requirements of law.~~

~~(h) This section shall not be construed to prohibit a plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.~~

~~(i) Subdivision (a) does not apply to any of the following:~~

~~(1) A specialized health care service plan contract.~~

~~(2) A Medicare supplement plan.~~

~~(3) A plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA or any rules, regulations, or guidance issued pursuant to that section.~~

~~(j) This section shall not be implemented in a manner that conflicts with a requirement of PPACA.~~

~~(k) This section shall be implemented only to the extent essential health benefits are required pursuant to PPACA.~~

~~(*l*) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.~~

~~(m) This section does not obligate the state to incur costs for the coverage of benefits that are not essential health benefits as defined in this section.~~

~~(n) A plan is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.~~

~~(o) (1) The department may adopt emergency regulations implementing this section. The department may, on a one-time basis, readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.~~

~~(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.~~

~~(3) The initial adoption of emergency regulations implementing this section made during the 2015–16 Regular Session of the Legislature and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the~~

~~readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.~~

~~(4) The director shall consult with the Insurance Commissioner to ensure consistency and uniformity in the development of regulations under this subdivision.~~

~~(5) This subdivision shall become inoperative on July 1, 2018.~~

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

~~(1) "Habilitative services" shall mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.~~

~~(2) (A) "Health benefits," unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, shall mean health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.~~

~~(B) "Health benefits" does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.~~

~~(3) "PPACA" shall mean the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.~~

~~(4) "Small group health care service plan contract" shall mean a group health care service plan contract issued to a small employer, as defined in Section 1357.500.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2193
Author: Maienschein
Bill Date: February 12, 2018, Introduced
Subject: Maternal Mental Health
Sponsor: 2020 Mom

DESCRIPTION OF CURRENT LEGISLATION:

This bill would mandate screening for maternal mental health disorders. This bill would also require health insurers and health care service plans to develop case management plans when it is determined that an enrollee may have a maternal mental health condition.

BACKGROUND

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

ANALYSIS

This bill would require any health care practitioner that treats or attends to a mother or child, or both, to screen the mother for maternal mental health conditions at least once during pregnancy and once during the postpartum period, unless the practitioner receives confirmation from a treating psychiatrist that the mother will remain under the psychiatrist's care during pregnancy and the postpartum period. This bill would require the health care practitioner to report the findings of that screening to the mother's primary care physician if the practitioner is not the mother's primary care physician.

This bill would require any facility where a health care practitioner treats or attends the mother, child, or both in the first post-delivery appointment to ensure that the health care practitioner conducts the screening and reports the findings, as required by this bill.

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

This bill would state that it should not be construed to limit when and how often a mother post-delivery is screened for maternal mental health conditions. This bill would specify that a violation of its requirements would constitute unprofessional conduct and be grounds for disciplinary action for a health care practitioner and would subject a facility to punishment by the facility's licensing entity.

This bill would require health insurers and health care service plans, by July 1, 2019, to develop a case management program, as specified, that is available for an enrollee and his or her treating provider when the provider, acting within his or her scope of practice, determines that an enrollee may have a maternal mental health condition. This bill would also require health insurers and health care service plans, beginning July 1, 2019, and annually thereafter, to notify providers in writing of the availability of the case management program. This bill would require health insurers and health care service plans to develop a maternal mental health quality management program to track specified information in order to understand the effectiveness of the case management program and to make changes as needed to improve utilization. This bill would require a health care service care plan contract and a health insurance policy issued, amended, or renewed on or after January 1, 2019 to provide coverage for maternal mental health conditions and for the case management program required by this bill.

This bill would set the standard of care in statute. The practice of medicine is ever-evolving and it is not appropriate to statutorily mandate the standard of care. This does not allow for changes in practice consistent with the evolution of medicine. Historically, the Board has opposed any bill that sets the standard of care in statute. Board staff is suggesting the Board take an oppose position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Oppose

ASSEMBLY BILL No. 2193

Introduced by Assembly Member Maienschein

February 12, 2018

An act to add Section 685 to the Business and Professions Code, to add Section 1367.625 to the Health and Safety Code, and to add Section 10123.867 to the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

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

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

This bill would make it the duty of licensed health care practitioners who treat or attend the mother or child, or both, to screen the mother for maternal mental health conditions, as defined, at least once during pregnancy and once during the postpartum period and to report the findings of the screening to the mother's primary care physician if the health care practitioner is not the mother's primary care physician. The bill would also make it the duty of any facility where those practitioners treat or attend the mother or child, or both, in the first postdelivery appointment to ensure that those practitioners perform the required screening and report the findings. The bill would make a violation of its requirements grounds for disciplinary action by the licensee's licensing entity and would make the facility subject to punishment by

its licensing entity, except that a violation of this requirement would not constitute a crime.

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

This bill would require health care service plans and health insurers to develop, by July 1, 2019, a case management program that is available for enrollees and insureds and their treating providers when the provider determines that an enrollee or insured may have a maternal mental health condition, as specified. The bill would require that case management program to meet specified standards and would require plans and insurers to notify providers of the availability of the program and to develop a quality management program in order to understand the effectiveness of the case management program. The bill would require health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2019, to provide coverage for maternal mental health conditions and the above-described case management program. Because a willful violation of the bill's requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

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

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

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

SECTION 1. Section 685 is added to the Business and Professions Code, to read:

685. (a) It shall be the duty of any health care practitioner who treats or attends a mother or child, or both, to screen the mother

for maternal mental health conditions at least once during pregnancy and once during the postpartum period, unless the health care practitioner has received confirmation from a treating psychiatrist that she will remain under the treating psychiatrist's care during pregnancy and the postpartum period, as applicable. The health care practitioner shall, in a manner consistent with applicable federal privacy law, report the findings of that screening to the mother's primary care physician if the health care practitioner is not the mother's primary care physician.

(b) It shall be the duty of any facility where a health care practitioner treats or attends the mother or child, or both, in the first postdelivery appointment to ensure that the health care practitioner conducts the screening and reports the findings of the screening as described in subdivision (a).

(c) This section shall not be construed to limit when and how often a mother postdelivery is screened for maternal mental health conditions.

(d) A violation of subdivision (a) constitutes unprofessional conduct and grounds for disciplinary action by the health care practitioner's licensing entity. A violation of subdivision (a) shall not constitute a crime.

(e) A facility subject to subdivision (b) that violates subdivision (b) shall be subject to punishment by the facility's licensing entity, except that a violation of subdivision (b) shall not constitute a crime.

(f) Nothing in this section shall prohibit another provider type from screening for maternal mental health conditions.

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

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

(2) "Health care practitioner" means an individual who is certified or licensed pursuant to this division or an initiative act referred to in this division and is acting within his or her scope of practice.

SEC. 2. Section 1367.625 is added to the Health and Safety Code, to read:

1367.625. (a) By July 1, 2019, a health care service plan shall develop a case management program that is available for an enrollee and his or her treating provider when the provider, acting

within his or her scope of practice, determines that the enrollee may have a maternal mental health condition.

(b) The case management program required by subdivision (a) shall do all of the following:

(1) Provide the provider and enrollee direct support in accessing treatment and, if available, managing care in accordance with the provider's treatment plan.

(2) Provide direct access to a clinician assigned to both the provider and the patient.

(3) Support the provider and enrollee in accessing care in a timely manner, consistent with appointment time standards developed pursuant to Section 1367.03, to provide both of the following services:

(A) Direct access for the enrollee to a therapist trained in maternal mental health.

(B) Direct access for both the provider and enrollee to a provider-to-provider psychiatric consultation with a psychiatrist familiar with the latest research surrounding treatment of pregnant and lactating women.

(4) When a treatment plan is available, require clinical case managers in the program to extend the capacity of the enrollee's provider by following the enrollee's treatment access, symptoms, and symptom severity, and recommending potential changes to the treatment plan when clinically indicated. A clinical case manager shall also provide written reports on an enrollee's status to the enrollee's provider on a periodic basis of no less than once every eight months.

(c) Commencing July 1, 2019, and annually thereafter, a health care service plan shall notify providers in writing of the availability of the case management program described in this section and the process by which a provider can access that program.

(d) (1) In order to understand the effectiveness of the case management program developed by a plan under this section and to make changes as needed to improve utilization, a health care service plan shall develop a maternal mental health quality management program that tracks all of the following information:

(A) The number, ratio, and geographical distance of behavioral providers trained to treat maternal mental health conditions, including therapists and psychiatrists.

(B) Case management utilization, including utilization by individual providers.

(C) The effectiveness of the program in reducing symptoms.

(D) Enrollee and provider satisfaction with the program, if available.

(2) The information in paragraph (1) shall be reported to a quality assurance committee of the health care service plan on an annual basis, and the plan shall institute corrective actions when warranted.

(e) Nothing in this section shall be construed to prohibit either of the following:

(1) A health care service plan from accepting a referral from another treating provider or case management program with respect to a maternal mental health condition.

(2) A health care service plan from transferring a case to another case management program designed to treat mental health issues after the postpartum period expires.

(f) A health care service plan contract issued, amended, or renewed on or after January 1, 2019, shall provide coverage for maternal mental health conditions and for the case management program developed by the plan under this section. This section shall not apply to a specialized health care service plan contract that does not deliver mental or behavioral health services to enrollees.

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

(1) "Case management program" means a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes. Case management programs include care management or disease management programs.

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

(3) "Provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division.

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

10123.867. (a) By July 1, 2019, a health insurer shall develop a case management program that is available for an insured and his or her treating provider when the provider, acting within his or her scope of practice, determines that the insured may have a maternal mental health condition.

(b) The case management program required by subdivision (a) shall do all of the following:

(1) Provide the provider and insured direct support in accessing treatment and, if available, managing care in accordance with the provider's treatment plan.

(2) Provide direct access to a clinician assigned to both the provider and the insured.

(3) Support the provider and insured in accessing care in a timely manner, consistent with the timely access regulations dopted under Section 10133.5, to provide both of the following services:

(A) Direct access for the insured to a therapist trained in maternal mental health.

(B) Direct access for both the provider and insured to a provider-to-provider psychiatric consultation with a psychiatrist familiar with the latest research surrounding treatment of pregnant and lactating women.

(4) When a treatment plan is available, require clinical case managers in the program to extend the capacity of the insured's provider by following the insured's treatment access, symptoms, and symptom severity, and recommending potential changes to the treatment plan when clinically indicated. A clinical case manager shall also provide written reports on the insured's status to the insured's provider on a periodic basis of no less than once every 8 months.

(c) Commencing July 1, 2019, and annually thereafter, a health insurer shall notify providers in writing of the availability of the case management program described in this section and the process by which a provider can access that program.

(d) (1) In order to understand the effectiveness of the case management program developed by a health insurer under this section and to make changes as needed to improve utilization, a health insurer shall develop a maternal mental health quality management program that tracks all of the following information:

(A) The number, ratio, and geo-distance of behavioral providers trained to treat maternal mental health conditions, including therapists and psychiatrists.

(B) Case management utilization, including utilization by individual providers.

(C) The effectiveness of the program in reducing symptoms.

(D) Insured and provider satisfaction with the program, if available.

(2) The information in paragraph (1) shall be reported to a quality assurance committee of the health insurer on an annual basis, and the health insurer shall institute corrective actions when warranted.

(e) Nothing in this section shall be construed to prohibit either of the following:

(1) A health insurer from accepting a referral from another treating provider or case management program.

(2) A health insurer from transferring a case to another case management program designed to treat mental health issues after the postpartum period expires.

(f) A health insurance policy issued, amended, or renewed on or after January 1, 2019, shall provide coverage for maternal mental health conditions and for the case management program developed by the insurer under this section. This section shall not apply to a specialized health insurance policy that does not deliver mental or behavioral health services to insureds.

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

(1) "Case management program" means a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes. Case management programs include care management or disease management programs.

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

(3) "Provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the

Business and Professions Code, or an initiative act referred to in that division.

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 2311
Author:	Arambula
Bill Date:	February 13, 2018, Introduced
Subject:	Medicine: Trainees: International Medical Graduates
Sponsor:	Medical Board of California and University of California
Position:	Co-Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

AB 2311 would remove the pilot program status in existing law for the University of California Los Angeles (UCLA) International Medical Graduate (IMG) Program, which allows trainees to engage in supervised patient care activities.

BACKGROUND:

In 2006, the UCLA Department of Family Medicine developed an innovative program to prepare bilingual (English-Spanish speaking), bi-cultural IMGs to enter accredited family medicine programs in California and to pursue licensure and board-certification as family physicians. This program functions as a pre-residency training program. The program recruits proficient bilingual IMGs from international medical schools with curricula that meet the educational requirements set forth by the Medical Board of California (the Board) for purposes of physician licensure. To be eligible for the UCLA IMG program, participants must have U.S. citizenship or Permanent Resident or Refugee Status. UCLA IMG graduates commit to 24-36 months of post-residency employment in a California health care facility located in a designated medically underserved area.

All states, including California, require physicians to be licensed to practice medicine, including resident physicians who are training and working in California residency or fellowship programs. California law allows for regularly matriculated medical students to engage in the practice of medicine whenever and wherever prescribed as part of their required/approved course of study (Business and Professions Code Section 2064).
Before the pilot program was authorized, trainees in UCLA's International Medical Graduate (IMG) Program were placed in approved clinical teaching environments that provide and ensure supervision by licensed physician faculty. Because these trainees were neither "medical students" enrolled in the School of Medicine (since they have already graduated from medical school in their country), nor "medical residents" enrolled in residency training, these individuals were not recognized by state law as trainees who are authorized to engage in "hands on" clinical training as part of their course of study.

The result of this was that UCLA IMG trainees (who are well prepared graduates of international medical schools) were required to function as "observers," even when supervised by licensed physicians who are teaching in accredited California training programs. AB 1533 (Mitchell, Statutes of 2012) created a pilot program to allow UCLA IMG trainees to actively participate in hands-on clinical training. The UCLA IMG Program has a successful record of preparing bi-lingual individuals who match with family residency programs in California. As of March 2018, the UCLA IMG program has matched a total of 129 UCLA IMG Program graduates in family medicine residency programs in California. The most recent class of 2018 matched 11 graduates to family medicine residency programs.

ANALYSIS

AB 2311 would remove the pilot program status in existing law and continues to allow the UCLA IMG Program trainees to engage in supervised patient care activities for a typical assignment lasting 16 weeks, as part of an approved and supervised clinical clerkship/rotation at UCLA health care facilities, or with other approved UCLA affiliates. All such training occurs with supervision provided by licensed physicians. Making this change permanent in statute will allow UCLA IMG program trainees to receive valuable clinical learning opportunities and not be at risk for disciplinary action by the Board.

The Board believes making this pilot program permanent will benefit the UCLA IMG program, its participants, and California family medicine programs seeking to increase the recruitment of bilingual physicians to their programs. Allowing for hands-on clinical training in the UCLA IMG Program permanently will ensure that the program continues to improve the preparation and readiness of UCLA IMG program participants. Because UCLA IMG graduates commit to 24-36 months of post-residency employment in a California health care facility located in a designated medically underserved area, the continued success of the UCLA program offers longer term benefits for underserved communities throughout California. The Board already voted to co-sponsor/support this bill with the University of California Office of the President.

FISCAL: No fiscal impact to the Board. The UCLA IMG program is funded by private sources. Funding sponsors include Kaiser Permanente Community Benefit, UniHealth Foundation, The California Endowment, Molina Family Foundation, New America Alliance, Kaplan educational programs and, private individuals.

SUPPORT: Medical Board of California (Co-Sponsor)
University of California Office of the President (Co-Sponsor)
America's Physician Groups
California Medical Association

OPPOSITION: None on file

ASSEMBLY BILL No. 2311

Introduced by Assembly Member Arambula

February 13, 2018

An act to amend Section 2066.5 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2311, as introduced, Arambula. Medicine: trainees: international medical graduates.

The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and imposes various requirements in that regard. Existing law requires an applicant for a license as a physician and surgeon to successfully complete a specified medical curriculum, a clinical instruction program, and a training program. Existing law provides that nothing in the Medical Practice Act shall be construed to prohibit a foreign medical graduate from engaging in the practice of medicine whenever and wherever required as part of a clinical service program, subject to certain conditions.

Existing law, until January 1, 2019, authorizes a clinical instruction pilot program for certain international medical graduates at the David Geffen School of Medicine of the University of California at Los Angeles (UCLA) as part of an existing preresidency training program, at the option of UCLA. Existing law requires the program to include specified elements relating to the qualifications of the program participants, the clinical instruction, and the training timeframe requirements. Under existing law, those international medical graduates

(IMGs) selected for the program are authorized to receive hands-on clinical instruction in specified core courses of study.

This bill would eliminate the reference to the specific courses authorized to be offered to the IMG participants. The bill would also remove the repeal date of January 1, 2019, thereby extending the operation of these provisions indefinitely. The bill would additionally remove various references to the program operating as a pilot.

Existing law specifies that nothing in those provisions should be construed to alter the licensure requirements, and also provides that the board may consider participation in the clinical instruction of the program as remediation for medical education deficiencies, as specified. Existing law also requires UCLA, on or before January 1, 2018, to prepare a report for the board and the Legislature on topics related to the pilot program.

This bill would delete the above provisions.

This bill would make legislative findings and declarations as to the necessity of a special statute for the UCLA International Medical Graduate 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 2066.5 of the Business and Professions Code is amended to read:

2066.5. (a) The ~~pilot~~ program authorized by this section shall be known and may be cited as the University of California at Los Angeles David Geffen School of Medicine's International Medical Graduate ~~Pilot~~ Program.

(b) Nothing in this chapter shall be construed to prohibit a foreign medical graduate from engaging in the practice of medicine when required as part of the ~~pilot~~ program authorized by this section.

(c) There is currently a preresidency training program at the University of California, Los Angeles David Geffen School of Medicine, Department of Family Medicine, hereafter referred to as UCLA, for selected international medical graduates (IMGs). Participation in the ~~pilot~~ program authorized by this section shall be at the option of UCLA. This section authorizes those IMGs, through the ~~new pilot~~ program authorized by this section, to

receive, through the existing program, hands-on clinical ~~instruction in the courses specified in subdivision (c) of Section 2089.5.~~ *instruction.* The ~~pilot~~ program, as administered by UCLA, shall include all of the following elements:

(1) Each ~~pilot~~ program participant shall have done all of the following:

(A) Graduated from a medical school recognized by the Medical Board of California at the time of selection.

(B) Taken and passed the United States Medical Licensing Examination Steps 1 and 2 (Clinical Knowledge and Clinical Science).

(C) Submitted an application and materials to the Educational Commission for Foreign Medical Graduates.

(2) A ~~pilot~~ program participant shall receive all clinical instruction at health care facilities operated by the University of California, Los Angeles, or other approved UCLA-designated teaching sites, which shall be hospitals or clinics with either a signed formal affiliation agreement with UCLA or a signed letter of agreement.

(3) Participation of a trainee in clinical instruction offered by the ~~pilot~~ program shall not generally exceed 16 weeks. However, at the discretion of UCLA, an additional eight weeks of clinical instruction may be granted. In no event shall a participant receive more than 24 weeks of clinical instruction under the ~~pilot~~ program.

(4) The clinical instruction shall be supervised by licensed physicians on faculty at UCLA or faculty affiliated with UCLA as specified in an approved affiliation agreement between UCLA and the affiliated entity.

(5) The clinical instruction shall be provided pursuant to written affiliation agreements for clinical instruction of trainees established by UCLA.

(6) The supervising faculty shall evaluate each participant on a regular basis and shall document the completion of each aspect of the clinical instruction portion of the program for each participant.

(d) UCLA shall provide the board with the names of the participants in the ~~pilot~~ program on an annual basis, or more frequently if necessary to maintain accuracy. Upon a reasonable request of the board, UCLA shall provide additional information such as the courses successfully completed by program participants, the dates of instruction, and other relevant information.

~~(e) Nothing in this section shall be construed to alter the requirements for licensure set forth in Sections 2089 and 2089.5. The board may consider participation in the clinical instruction portion of the pilot program as remediation for medical education deficiencies identified in a participant's application for licensure or authorization for postgraduate training should such a deficiency apply to that applicant.~~

~~(f) On or before January 1, 2018, UCLA is requested to prepare a report for the board and the Legislature. Topics to be addressed in the report shall include the number of participants in the pilot program, the number of participants in the pilot program who were issued physician's and surgeon's certificates by the board, the number of participants who practice in designated medically underserved areas, and the potential for retention or expansion of the pilot program.~~

~~(g) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.~~

SEC. 2. The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because the UCLA International Medical Graduate Program provides a unique medical training program, serving as a leading producer of Family Medicine physicians in California and serves a critical role in increasing the number of highly skilled physicians with the bicultural and bilingual abilities to meet the needs of patients in California's underserved rural and inner urban communities.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2409
Author: Kiley
Bill Date: April 16, 2018, Amended
Subject: Professions and Vocations: Occupational Regulations
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would make changes to existing law regarding applicants who have criminal convictions and would establish a process for an applicant to petition the Medical Board of California (Board) to review an occupational regulation, or to determine if the individual's criminal record will automatically disqualify the person from obtaining a license. In addition, this bill would change the burden of proof from the applicant to the Board, among other provisions.

ANALYSIS

This bill would make findings and declarations about barriers to occupational licensure. This bill would state that an individual has a right to engage in a lawful profession or vocation without being subject to an occupational regulation that imposes a substantial burden on that right. This bill would require each occupational regulation to be limited to what is demonstrably necessary and to be narrowly tailored to fulfill a legitimate public health, safety, or welfare objective. This bill would define an occupational regulation as a regulation, rule, policy, condition, test, permit, administrative practice, or other state government-prescribed requirement for an individual to engage in a lawful profession or vocation. This bill would state that an individual with a criminal record has a right to not have a board use that individual's criminal record as an automatic or mandatory permanent bar to engaging in a lawful profession or vocation.

This bill includes the right of an individual behind on his or her taxes or student loan payments to obtain a license, and not use taxes or student loans as an automatic or mandatory permanent bar to engage in a lawful profession or vocation.

This bill would allow an individual to petition a board to review an occupational regulation within a board's jurisdiction for compliance with the requirements of this bill. This bill would require a board to respond, within 90 days after the petition is submitted, and inform the petitioner the decision to do one of the following:

- Repeal the occupational regulation, subject to the Administrative Procedures Act (APA).
- Amend the occupational regulation to bring it into compliance with the requirements of the bill, subject to the APA.
- Recommend the enactment of legislation by the Legislature.
- State the basis on which a board concludes the occupational regulations comply with the requirements of this bill.

This bill would allow an individual to appeal a board's determination by filing an action in a court of general jurisdiction for declaratory judgment, injunctive relief, or other equitable relief. A board would bear the burden of proof by a preponderance of the evidence in the appeal. If a board fails to meet the burden of proof, this bill would allow the court to enjoin further enforcement of the occupational regulation and shall award reasonable attorney's fees and costs to the petitioner.

This bill would allow an individual with a criminal record to petition a board at any time for a determination of whether the individual's criminal record will automatically disqualify the individual from obtaining a license. This bill would require the individual to include in the petition their criminal record or authorize a board to obtain their criminal record. This bill would only allow a board to find that the individual's criminal record disqualifies the individual if both of the following are met:

- The individual's criminal record includes a conviction for a felony or violent misdemeanor.
- A board concludes that the state has an important interest in protecting public safety that is superior to the individual's right A board may make this conclusion only if it determines, by clear and convincing evidence at the time of the petition, that all of the following are met:
    - The specific offense for which the individual was convicted is substantially related to the state's interest in protecting public safety.
    - The individual, based on the nature of the specific offense for which he or she was convicted and his or her circumstances, would be put in a position in which the individual would be more likely to re-offend by having the license than if the individual did not obtain that license.
    - A re-offense by the individual would cause greater harm than it would if the individual did not have a license and was not put in a position in which the individual is more likely to re-offend.

This bill would require all boards, including the Board, to make a determination of the appeal, within 90 days of the petition being filed. This bill would require the determination to be in writing and include, but not be limited to, the individual's criminal record, findings of fact, and a board's legal conclusions.

This bill would not allow the Board to automatically deny a license pursuant to a criminal record. Existing law allows the Board to automatically deny a license for registered sex offenders, and this bill would no longer allow this automatic denial. This bill would only allow the Board to deny a license for an applicant with a felony or a violent misdemeanor. This does not allow the Board to take into consideration crimes for fraud or substance abuse, which could be substantially related to the duties of a physician. The Board already complies with the Administrative Procedures Act; however, 90 days may not be enough time to make a determination on the appeal of the occupational regulations and would increase the Board's workload. This bill would shift the burden of proof from the applicant to the Board. This bill would also require the Board to pay attorney's fees if the Board cannot meet the burden of proof for occupational regulations. In addition, this bill would allow an individual to petition the Board at any time and would require the Board to review the individual's criminal record to determine, within 90 days, if it will automatically disqualify the individual

from obtaining a license. This will result in significant fiscal impact to the Board. This bill is not in line with the Board's mission of consumer protection and Board staff suggests the Board take an oppose position on this bill.

FISCAL: Significant fiscal impact, estimated to be $500,000 for paying attorney's fees and costs if the Board fails to meet the burden of proof in court. The Board would also need a full-time staff person at the Associate Governmental Program Analyst level to handle both petition processes and ensure the petitions are completed and responded to within 90 days. This position would cost the Board $119,000 for the first year and $111,000 thereafter.

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Oppose

AMENDED IN ASSEMBLY APRIL 16, 2018

AMENDED IN ASSEMBLY MARCH 23, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2409

Introduced by Assembly Member Kiley

February 14, 2018

An act to add Section 37 to the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 2409, as amended, Kiley. Professions and vocations: occupational regulations.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs and provides that those boards are established for the purpose of ensuring that those private businesses and professions deemed to engage in activities that have potential impact upon the public health, safety, and welfare are adequately regulated in order to protect the people of California. Existing law authorizes a board to deny a license if an applicant has been convicted of a crime, done any act involving dishonesty, fraud, or deceit with intent to substantially benefit himself or herself or another or substantially injure another, or does any act that, if done by a licentiate of the business or profession, would be grounds for suspension or revocation.

This bill would establish that a person has a right to engage in a lawful profession or vocation without being subject to an occupational regulation, as defined, that imposes a substantial burden on that right, and would require each occupational regulation to be limited to what

is demonstrably necessary and narrowly tailored to fulfill a legitimate public health, safety, or welfare objective. The bill would include within this the right of a person with a criminal record to ~~obtain a license and~~ not ~~to~~ have ~~a board use~~ the person's criminal record *used by a board* as an automatic or mandatory permanent bar to engaging in a lawful profession or ~~vocation. The bill would also include~~ *vocation, except as specified, and* the right of a person who is behind on his or her taxes or student ~~loans to petition a board not to use these factors against that person, as prescribed.~~ *loan payments to not have a board use that fact as an automatic or mandatory permanent bar to engaging in a lawful profession or vocation.*

The bill would authorize a person ~~who is denied a license to file a petition and appeal to the board. The bill would prescribe procedures and legal standards by which a board may determine that a person's criminal record disqualifies that person. The bill would also permit a person, following the response to an administrative petition, to file an appeal to a court for a declaratory judgment or injunctive or other equitable relief, in accordance with certain legal procedures and criteria.~~ *to petition a board to review an occupational regulation, as defined, within the board's jurisdiction for compliance with the above rights, as specified. The bill would authorize a person with a criminal record to petition a board at any time for a determination of whether the person's criminal record will automatically disqualify the person from obtaining a license from the board and would specify the criteria a board is allowed to use in making that determination.* The bill would include related definitions and declare the intent of the Legislature in this regard.

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 may be known as the "Occupational Opportunity Act."

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

(a) Each individual has the right to pursue a chosen profession and vocation, free from arbitrary or excessive government interference.

(b) The freedom to earn an honest living traditionally has provided the surest means for economic mobility.

(c) In recent years, many regulations of entry into professions and vocations have exceeded legitimate public purposes and have had the effect of arbitrarily limiting entry and reducing competition.

(d) The burden of excessive regulation is borne most heavily by individuals outside the economic mainstream, for whom opportunities for economic advancement are curtailed.

(e) It is in the public interest to do all of the following:

(1) Ensure the right of all individuals to pursue legitimate entrepreneurial and professional opportunities to the limits of their talent and ambition.

(2) Provide the means for the vindication of this right.

(3) Ensure that regulations of entry into professions and vocations are demonstrably necessary and narrowly tailored to fulfill legitimate health, safety, and welfare objectives.

SEC. 3. Section 37 is added to the Business and Professions Code, to read:

37. (a) (1) Notwithstanding Section 480 or any other law, a person has a right to engage in a lawful profession or vocation without being subject to an occupational regulation that imposes a substantial burden on that right. To achieve this purpose, each occupational regulation shall be limited to what is demonstrably necessary and shall be narrowly tailored to fulfill a legitimate public health, safety, or welfare objective.

(2) Notwithstanding any other law, the right set forth in paragraph (1) includes the right of a person with a criminal record ~~to obtain a license to engage in a profession or vocation, and the right to not have a board use the person's criminal record as an automatic or mandatory permanent bar to engaging in a lawful profession or vocation.~~ *to not have the person's criminal record be used by a board as an automatic or mandatory permanent bar to engaging in a lawful profession or vocation, unless for reasons specified in this section.*

(3) Notwithstanding any other law, the right set forth in paragraph (1) also includes the right of a person who is behind on his or her taxes or student ~~loans~~ *loan payments* to obtain a license to engage in a profession or vocation, and the right to not have the board use the person's status with respect to his or her taxes or student ~~loans~~ *loan payments* as an automatic or mandatory permanent bar to engaging in a lawful profession or vocation.

~~(b) (1) (A) A person denied a license may file a petition and appeal to the board.~~

~~(B) If the person has a criminal record, the person shall include in the petition a copy of his or her criminal record or shall authorize the board to obtain a copy that record. The person may additionally include information about his or her current circumstances, including, but not limited to, the time passed since the offense, completion of the criminal sentence, other evidence of rehabilitation, testimonials, employment history, and employment aspirations.~~

~~(C) Notwithstanding any other law, the board may find that the person's criminal record disqualifies that person from obtaining a license only if the person's criminal record includes a conviction for a felony or a violent misdemeanor and the board concludes that the state has an important interest in protecting public safety that is superior to the person's individual right. The board may make this conclusion only if it determines, by clear and convincing evidence at the time of the petition, all of the following:~~

~~(i) The specific offense for which the person was convicted is substantially related to the qualifications, functions, or duties of the profession or vocation for which application was denied.~~

~~(ii) The person, based on the nature of the specific offense for which he or she was convicted and his or her current circumstances, would be put in a position in which that person is more likely to reoffend by having the license than if the person did not obtain that license.~~

~~(iii) A reoffense by the person would cause greater harm than it would if the person did not have a license and was not put in a position in which the person is more likely to reoffend.~~

~~(2) Within 90 days of a petition filed pursuant to paragraph (1), the board shall make a determination on the appeal, based on the standards set forth in subdivision (a).~~

~~(c) (1) Following the response to an administrative petition pursuant to paragraph (2) of subdivision (b), a person may file an appeal to a court of general jurisdiction for a declaratory judgment or injunctive relief or other equitable relief for a violation of subdivision (a).~~

~~(2) In such an action, the board bears the burden of proving by preponderance of the evidence that the challenged occupational~~

~~regulation meets the criteria set forth in paragraph (1) of subdivision (a).~~

~~(3) If the board fails to meet the burden of proof and the court finds by a preponderance of evidence that the challenged occupational regulation fails to meet the criteria set forth in paragraph (1) of subdivision (a), the court shall enjoin further enforcement of the occupational regulation and shall award reasonable attorney's fees and costs to the plaintiff.~~

~~(4) A court shall liberally construe this section to protect the rights established in paragraph (1) of subdivision (a).~~

(b) (1) A person may petition a board to review an occupational regulation within the board's jurisdiction for compliance with subdivision (a). The board shall respond within 90 days after the petition is submitted, and shall, in writing, inform the petitioner of the board's decision to do one of the following depending on the circumstances:

(A) Subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), repeal the occupational regulation.

(B) Subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), amend the occupational regulation to bring it into compliance with subdivision (a).

(C) Recommend the enactment of legislation by the Legislature.

(D) State the basis on which the board concludes the occupational regulation complies with subdivision (a).

(2) A person may appeal the board's determination in paragraph (1) by filing an action in a court of general jurisdiction for declaratory judgment, injunctive relief, or other equitable relief.

(A) In such an action, the board bears the burden of proving by a preponderance of the evidence that the challenged occupational regulation is in compliance with subdivision (a).

(B) If the board fails to meet the burden of proof and the court finds by a preponderance of the evidence that the challenged occupational regulation does not comply with subdivision (a), the court shall enjoin further enforcement of the occupational regulation and shall award reasonable attorney's fees and costs to the petitioner.

(c) (1) Notwithstanding any other law, a person with a criminal record may petition a board at any time for a determination of

whether the person's criminal record will automatically disqualify the person from obtaining a license from the board.

(2) The person shall include in the petition the person's criminal record or authorize the board to obtain the person's criminal record.

(3) Notwithstanding any other statute or rule, the board may find the individual's criminal record disqualifies the individual from obtaining a license only if both of the following are met:

(A) The person's criminal record includes a conviction for a felony or violent misdemeanor.

(B) The board concludes the state has an important interest in protecting public safety that is superior to the person's right in subdivision (a). The board may make this conclusion only if it determines, by clear and convincing evidence at the time of the petition, that all of the following are met:

(i) The specific offense for which the person was convicted is substantially related to the state's interest in protecting public safety.

(ii) The person, based on the nature of the specific offense for which he or she was convicted and the person's current circumstances, will be put in a position where the person is more likely to reoffend by having the license than if the individual did not have the license.

(iii) A reoffense will cause greater harm than if the individual did not have a license and was not put in the position where the individual is more likely to reoffend.

(4) The board shall issue its determination within 90 days after the board receives the petition. The determination shall be in writing and include, but not be limited to, the person's criminal record, findings of fact, and the board's legal conclusions.

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

(1) "Board" has the same meaning as set forth in Section 22.

(2) "License" has the same meaning as set forth in Section 23.7.

(3) "Occupational regulation" means a regulation, rule, policy, condition, test, permit, administrative practice, or other state government-prescribed requirement for a person to engage in a lawful profession or vocation.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2461
Author: Flora and Obernolte
Bill Date: February 14, 2018, Introduced
Subject: Criminal History Information: Subsequent Arrest Notification
Sponsor: Authors

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Department of Justice (DOJ) to provide all subsequent state and federal criminal history to any entity authorized by state or federal law to receive this information for any person whose fingerprints are maintained on file at DOJ or the Federal Bureau of Investigation (FBI).

ANALYSIS

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

This bill would require DOJ to provide all subsequent federal criminal information to the authorized state entities, including the Board. This will ensure that these entities are aware of the arrest and disposition information for any individual whose fingerprints are maintained on file at DOJ or FBI.

The Board depends on the DOJ notifications to be informed that a licensee has been arrested or convicted of a crime. This is very important information for the Board to receive so it can look into the matter and take appropriate action. The Board currently receives subsequent arrest records for acts within California and reported to DOJ. However, the Board does not receive subsequent arrest information from the FBI. Requiring DOJ to provide information from the FBI is essential for the Board to meet its mission of consumer protection. Board staff suggests that the Board take a support position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

ASSEMBLY BILL No. 2461

Introduced by Assembly Members Flora and Obernolte

February 14, 2018

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

LEGISLATIVE COUNSEL'S DIGEST

AB 2461, as introduced, Flora. Criminal history information: subsequent arrest notification.

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

This bill would require the department to provide that information.

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

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

SECTION 1. Section 11105.2 of the Penal Code is amended to read:

11105.2. (a) The Department of Justice ~~may~~ *shall* provide subsequent state or federal arrest or disposition notification to any entity authorized by state or federal law to receive state or federal summary criminal history information to assist in fulfilling employment, licensing, certification duties, or the duties of approving relative caregivers, nonrelative extended family members, and resource families upon the arrest or disposition of any person whose fingerprints are maintained on file at the Department of Justice or the Federal Bureau of Investigation as the result of an application for licensing, employment, certification, or approval. ~~Nothing in this section shall~~ *This section does not* authorize the notification of a subsequent disposition pertaining to a disposition that does not result in a conviction, unless the department has previously received notification of the arrest and has previously lawfully notified a receiving entity of the pending status of that arrest. ~~When~~ *If* the department supplies subsequent arrest or disposition notification to a receiving entity, the entity shall, at the same time, expeditiously furnish a copy of the information to the person to whom it relates if the information is a basis for an adverse employment, licensing, or certification decision. ~~When~~ *If the copy is not* furnished ~~other than~~ in person, the copy shall be delivered to the last contact information provided by the applicant.

(b) For purposes of this section, "approval" means those duties described in subdivision (d) of Section 309 of the Welfare and Institutions Code for approving the home of a relative caregiver or of a nonrelative extended family member for placement of a child supervised by the juvenile court, and those duties in Section 16519.5 of the Welfare and Institutions Code for resource families.

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

(d) ~~Any~~ *An* entity that submits the fingerprints of applicants for licensing, employment, certification, or approval to the Department of Justice for the purpose of establishing a record of the applicant

to receive notification of subsequent state or federal arrests or dispositions shall immediately notify the department when the employment of the applicant is terminated, when the applicant's license or certificate is revoked, when the applicant may no longer renew or reinstate the license or certificate, or when a relative caregiver's or nonrelative extended family member's approval is terminated. The Department of Justice shall terminate state or federal subsequent notification on any applicant upon the request of the licensing, employment, certifying, or approving authority.

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

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

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

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 2483
Author:	Voepel
Bill Date:	April 9, 2018, Amended
Subject:	Indemnification of Public Officers and Employees: Antitrust Awards
Sponsor:	Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require, as specified, a public entity to pay for a judgement or settlement for treble damage antitrust awards against a member of a regulatory board for an act or omission occurring within the scope of his or her official capacity as a member of a regulatory board. This bill would also specify that the treble damages awarded are not punitive or exemplary damages.

BACKGROUND:

In 2010, the Federal Trade Commission brought an administrative complaint against the North Carolina State Board of Dental Examiners for excluding non-dentists from the practice of teeth whitening. The FTC alleged that the North Carolina Board's decision was anticompetitive under the FTC Act because the North Carolina Board was not acting as a state agent. The North Carolina Board appealed to the Supreme Court, arguing that it was acting on behalf of the government and should be afforded immunity from antitrust lawsuits. The Supreme Court ruled in the FTC's favor, stating that regulatory bodies comprised of active market participants in the occupation regulated by that body may invoke state-action antitrust immunity only if it is subject to active supervision by the state. The Supreme Court has stated that to qualify as active supervision "the [state] supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy." (N. Carolina State Bd., 135 S. Ct. at 1116)

An Attorney General Opinion was requested by Senator Jerry Hill regarding "what constitutes 'active state supervision' of a state licensing board for purposes of the state action immunity doctrine in antitrust actions, and what measures might be taken to guard against antitrust liability for board members." Opinion No. 15-402 concluded that "active state supervision" requires that a state official must "review the substance of a regulatory decision made by a state licensing board, in order to determine whether the decision actually furthers a clearly articulated state policy to displace competition with regulation in a particular market." The opinion states that "the official reviewing the decision must not be an active member of the market being regulated, and must have and exercise the power to approve, modify, or disapprove the decision."

The Attorney General's opinion also stated that board members' "uncertainty about the legal status of treble damage awards could be reduced significantly by amending state

law to specify that treble damage antitrust awards are not punitive damages within the meaning of the Government Claims Act."

ANALYSIS

This bill would require, as specified, a public entity to pay for a judgement or settlement for treble damage antitrust awards against a member of a regulatory board for an act or omission occurring within the scope of his or her official capacity as a member of a regulatory board. This bill would also specify that the treble damages awarded are not punitive or exemplary damages.

This protection is needed for board members serving on regulatory boards to make it clear that the state will indemnify board members against personal liability for reasonable, good faith actions taken as part of their role as board members who serve on a regulatory board. Board staff suggests the Board take a support position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 9, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2483

Introduced by Assembly Member Voepel

February 14, 2018

An act to ~~add Chapter 10 (commencing with Section 473) to Division 1 of the Business and Professions~~ *amend Section 825 of the Government* Code, relating to ~~professions.~~ *liability.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2483, as amended, Voepel. ~~Department of Consumer Affairs: Office of Supervision of Occupational Boards.~~ *Indemnification of public officers and employees: antitrust awards.*

The Government Claims Act, except as provided, requires a public entity to pay any judgment or any compromise or settlement of a claim or action against an employee or former employee of the public entity if the employee or former employee requests the public entity to defend him or her against any claim or action against him or her for an injury arising out of an act or omission occurring within the scope of his or her employment as an employee of the public entity, the request is made in writing not less than 10 days before the day of trial, and the employee or former employee reasonably cooperates in good faith in the defense of the claim or action. That act prohibits the payment of punitive or exemplary damages by a public entity, except as specified.

This bill would require a public entity to pay a judgment or settlement for treble damage antitrust awards against a member of a regulatory board within the Department of Consumer Affairs for an act or omission occurring within the scope of the member's official capacity as a member of that regulatory board. The bill would specify that treble

damages awarded pursuant to a specified federal law for violation of another federal law are not punitive or exemplary damages within the act.

~~Under existing law, the Department of Consumer Affairs is composed of various boards, bureaus, commissions, committees, and similarly constituted agencies that license and regulate the practice of various professions and vocations for the purpose of protecting the people of California. With certain exceptions, decisions of these entities with respect to setting standards, conducting examinations, passing candidates, and revoking licenses, are final and are not subject to review by the Director of Consumer Affairs.~~

~~This bill would establish an Office of Supervision of Occupational Boards within the department to exercise active supervision over a "covered board," defined as specific licensing and regulatory agencies within the department, to ensure compliance with specific policies established in the bill regarding licensing and enforcement (established policies). The bill would require the office, in the exercise of active supervision, to be involved in the development of a covered board's rules and policies, to disapprove the use of any board rule or policy and terminate any enforcement action that is not consistent with the established policies, and to review and affirmatively approve only rules, policies, and enforcement actions consistent with the established policies. The bill would require the office to review and approve or reject any rule, policy, enforcement action, or other occupational licensure action proposed by each covered board before adoption or implementation. The bill would establish procedures for complaints, investigation, remedial action, and appeal relating to a rule, policy, enforcement action, or other occupational licensure action of a covered board inconsistent with the established policies.~~

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 825 of the Government Code is amended to read:

825. (a) Except as otherwise provided in this section, if an employee or former employee of a public entity requests the public entity to defend him or her against any claim or action against him or her for an injury arising out of an act or omission occurring

within the scope of his or her employment as an employee of the public entity and the request is made in writing not less than 10 days before the day of trial, and the employee or former employee reasonably cooperates in good faith in the defense of the claim or action, the public entity shall pay any judgment based thereon or any compromise or settlement of the claim or action to which the public entity has agreed.

If the public entity conducts the defense of an employee or former employee against any claim or action with his or her reasonable good-faith cooperation, the public entity shall pay any judgment based thereon or any compromise or settlement of the claim or action to which the public entity has agreed. However, where the public entity conducted the defense pursuant to an agreement with the employee or former employee reserving the rights of the public entity not to pay the judgment, compromise, or settlement until it is established that the injury arose out of an act or omission occurring within the scope of his or her employment as an employee of the public entity, the public entity is required to pay the judgment, compromise, or settlement only if it is established that the injury arose out of an act or omission occurring in the scope of his or her employment as an employee of the public entity.

Nothing in this section authorizes a public entity to pay that part of a claim or judgment that is for punitive or exemplary damages.

(b) Notwithstanding subdivision (a) or any other provision of law, a public entity is authorized to pay that part of a judgment that is for punitive or exemplary damages if the governing body of that public entity, acting in its sole discretion except in cases involving an entity of the state government, finds all of the following:

(1) The judgment is based on an act or omission of an employee or former employee acting within the course and scope of his or her employment as an employee of the public entity.

(2) At the time of the act giving rise to the liability, the employee or former employee acted, or failed to act, in good faith, without actual malice and in the apparent best interests of the public entity.

(3) Payment of the claim or judgment would be in the best interests of the public entity.

As used in this subdivision with respect to an entity of state government, “a decision of the governing body” means the

approval of the Legislature for payment of that part of a judgment that is for punitive damages or exemplary damages, upon recommendation of the appointing power of the employee or former employee, based upon the finding by the Legislature and the appointing authority of the existence of the three conditions for payment of a punitive or exemplary damages claim. The provisions of subdivision (a) of Section 965.6 shall apply to the payment of any claim pursuant to this subdivision.

The discovery of the assets of a public entity and the introduction of evidence of the assets of a public entity shall not be permitted in an action in which it is alleged that a public employee is liable for punitive or exemplary damages.

The possibility that a public entity may pay that part of a judgment that is for punitive damages shall not be disclosed in any trial in which it is alleged that a public employee is liable for punitive or exemplary damages, and that disclosure shall be grounds for a mistrial.

(c) Except as provided in subdivision (d), if the provisions of this section are in conflict with the provisions of a memorandum of understanding reached pursuant to Chapter 10 (commencing with Section 3500) of Division ~~4 of Title 1,~~ *4*, the memorandum of understanding shall be controlling without further legislative action, except that if those provisions of a memorandum of understanding require the expenditure of funds, the provisions shall not become effective unless approved by the Legislature in the annual Budget Act.

(d) The subject of payment of punitive damages pursuant to this section or any other provision of law shall not be a subject of meet and confer under the provisions of Chapter 10 (commencing with Section 3500) of Division ~~4 of Title 1,~~ *4*, or pursuant to any other law or authority.

(e) Nothing in this section shall affect the provisions of Section 818 prohibiting the award of punitive damages against a public entity. This section shall not be construed as a waiver of a public entity's immunity from liability for punitive damages under Section 1981, 1983, or 1985 of Title 42 of the United States Code.

(f) (1) Except as provided in paragraph (2), a public entity shall not pay a judgment, compromise, or settlement arising from a claim or action against an elected official, if the claim or action is based on conduct by the elected official by way of tortiously

intervening or attempting to intervene in, or by way of tortiously influencing or attempting to influence the outcome of, any judicial action or proceeding for the benefit of a particular party by contacting the trial judge or any commissioner, court-appointed arbitrator, court-appointed mediator, or court-appointed special referee assigned to the matter, or the court clerk, bailiff, or marshal after an action has been filed, unless he or she was counsel of record acting lawfully within the scope of his or her employment on behalf of that party. Notwithstanding Section 825.6, if a public entity conducted the defense of an elected official against such a claim or action and the elected official is found liable by the trier of fact, the court shall order the elected official to pay to the public entity the cost of that defense.

(2) If an elected official is held liable for monetary damages in the action, the plaintiff shall first seek recovery of the judgment against the assets of the elected official. If the elected official's assets are insufficient to satisfy the total judgment, as determined by the court, the public entity may pay the deficiency if the public entity is authorized by law to pay that judgment.

(3) To the extent the public entity pays any portion of the judgment or is entitled to reimbursement of defense costs pursuant to paragraph (1), the public entity shall pursue all available creditor's remedies against the elected official, including garnishment, until that party has fully reimbursed the public entity.

(4) This subdivision shall not apply to any criminal or civil enforcement action brought in the name of the people of the State of California by an elected district attorney, city attorney, or attorney general.

(g) Notwithstanding subdivision (a), a public entity shall pay for a judgment or settlement for treble damage antitrust awards against a member of a regulatory board within the Department of Consumer Affairs for an act or omission occurring within the scope of the member's official capacity as a member of that regulatory board.

(h) For purposes of this section, treble damages awarded pursuant to the federal Clayton Act (Sections 12 to 27, inclusive, of Title 15 of, and Sections 52 and 53 of Title 29 of, the United States Code) for a violation of the federal Sherman Act (Sections 1 to 7, inclusive, of Title 15 of the United States Code) are not punitive or exemplary damages under this division.

SECTION 1. Chapter 10 (commencing with Section 473) is added to Division 1 of the Business and Professions Code, to read:

CHAPTER 10. OFFICE OF SUPERVISION OF OCCUPATIONAL BOARDS

473. The following are policies of the state:

(a) Occupational licensing laws should be construed and applied to increase economic opportunity, promote competition, and encourage innovation.

(b) Regulators should displace competition through occupational licensing only where less restrictive regulation will not suffice to protect consumers from present, significant, and substantiated harms that threaten public health, safety, or welfare.

(c) An occupational licensing restriction should be enforced against an individual only to the extent the individual sells goods and services that are included explicitly in the statute or regulation that defines the occupation's scope of practice.

473.1. As used in this chapter:

(a) "Covered board" means any entity listed in Section 101.

(b) "Office" means the Office of Supervision of Occupational Boards established in Section 473.2.

473.2. (a) There is hereby established an Office of Supervision of Occupational Boards within the department.

(b) (1) Notwithstanding Section 109, the office shall be responsible for exercising active supervision over each covered board to ensure compliance with the policies in Section 473.

(2) In exercising active supervision over covered boards under paragraph (1), the office shall independently do the following:

(A) Play a substantial role in the development of a covered board's rules and policies to ensure they benefit consumers and do not serve the private interests of providers of goods and services regulated by the covered board.

(B) Disapprove the use of any rule or policy of a covered board and terminate any enforcement action, including any action pending on January 1, 2019, that is not consistent with Section 473.

(C) Exercise control over each covered board by reviewing and affirmatively approving only rules, policies, and enforcement actions that are consistent with Section 473.

~~(D) Analyze existing and proposed rules and policies and conduct investigations to gain additional information to promote compliance with Section 473, including, but not limited to, less restrictive regulatory approaches.~~

~~(3) In exercising active supervision over covered boards under paragraph (1), the office shall be staffed by not fewer than one attorney who does not provide general counsel to any covered board.~~

~~(c) (1) Notwithstanding Section 109, the office shall review and approve or reject any rule, policy, enforcement action, or other occupational licensure action proposed by each covered board before the covered board may adopt or implement the rule, policy, enforcement action, or other occupational licensure action.~~

~~(2) For purposes of paragraph (1), approval by the office shall be express and silence or failure to act shall not constitute approval.~~

~~473.3. (a) Any person may file a complaint to the office about a rule, policy, enforcement action, or other occupational licensure action of a covered board that the person believes is not consistent with Section 473.~~

~~(b) Not later than 90 days after the date on which the office receives a complaint filed under paragraph (1), notwithstanding Section 109, the office shall investigate the complaint, identify remedies, and instruct the covered board to take action as the office determines to be appropriate, and respond in writing to the complainant.~~

~~(c) (1) There shall be no right to appeal a decision of the office under subdivision (b) unless the challenged rule, policy, enforcement action, or other occupational licensure action would prevent the complainant from engaging in a lawful occupation or employing or contracting others for the performance of a lawful occupation and the complainant has taken material steps in an attempt to engage in a lawful occupation or employ or contract others for the performance of a lawful occupation.~~

~~(2) Any appeal authorized under paragraph (1) shall be to the superior court.~~

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 2487
Author:	McCarty
Bill Date:	April 16, 2018, Amended
Subject:	Physicians and Surgeons: Continuing Education: Opiate-Dependent Patient Treatment and Management
Sponsor:	Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would also require all physicians to take opioid addiction continuing medical education (CME).

BACKGROUND

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

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

Existing CME courses approved by the Medical Board of California's (Board) Licensing Program include:

- Programs accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA), the American Medical Association (AMA), and the

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

ANALYSIS

This bill would require all licensed physicians, within six months of receiving a federal Drug Enforcement Administration (DEA) registration, to complete a mandatory CME course on the treatment and management of opiate-dependent patients. This course must include eight hours of training in buprenorphine treatment of opioid use disorders. For physicians that already possess a federal DEA registration, they must complete this CME within six months of renewing their DEA registration.

This bill would specify that physicians that are already qualified to prescribe buprenorphine are exempt from this requirement. This bill would require the Board to determine whether a physician has met the requirements of this bill.

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

The Board adopted a policy compendium in 2014, in which the Board opposed the concept of mandated CME topics. The compendium states that the Board believes that each licensed physician should decide which type of continuing education is most appropriate for their particular practice. As such, Board staff suggests that the Board take an oppose position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: County Health Executives Association of California; Depression and Bipolar Support Alliance; and National Health Law Program

OPPOSITION: American College of Obstetricians and Gynecologists; Biocom; California Academy of Family Physicians; California Chapter of American College of Emergency Physicians; and California Medical Association

POSITION: Recommendation: Oppose

AMENDED IN ASSEMBLY APRIL 16, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2487

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

February 14, 2018

An act ~~to amend Section 2082 of, and~~ to add Section 2190.6 ~~to,~~ *to* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

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

Existing state law, the Medical Practice Act, establishes the Medical Board of California within the Department of Consumer Affairs. The board is responsible for the licensure and regulation of physicians and ~~surgeons. The act requires each application for a physician's and surgeon's certificate to include, among other things, proof of satisfactory completion of specified requirements. The act also requires the board~~ *surgeons, and is required by the act* to adopt and administer standards for the continuing education of *those* physicians and surgeons.

Existing federal law, the Comprehensive Addiction Recovery Act of 2016, requires physicians and surgeons who dispense narcotic drugs for patient treatment to obtain a separate registration from the United States Attorney ~~General or qualify for a waiver of that registration.~~ *General. The United States Drug Enforcement Administration, within the federal Office of the Attorney General, administers the registration and requires physicians and surgeons to renew that registration at specified intervals.* A physician and surgeon qualifies for ~~the~~ *a* waiver *of the registration* if he or she is licensed under state law and completes

at least one specified training, such as 8 hours of training in the treatment and management of opiate-dependent patients.

~~This bill would require the application for a physician's and surgeon's certificate to include proof of satisfactory completion of a course on opiate-dependent patient treatment and management that meets the requirement, at a minimum, of the federal Comprehensive Addiction Recovery Act of 2016 and also includes at least eight hours of instruction in buprenorphine treatment of opioid use disorders. The~~ *This* bill would ~~also~~ require a ~~licensed~~ physician and surgeon to complete a continuing education course on opiate-dependent patient treatment and management, as specified, *within 6 months of first receiving, or next renewing, a federal Drug Enforcement Administration registration to dispense narcotic drugs for patient treatment,* unless the physician and surgeon meets the requirements of a qualifying physician within the federal Comprehensive Addiction Recovery Act of 2016.

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 2082 of the Business and Professions Code is amended to read:~~

~~2082. Each application shall include the following:~~

~~(a) A diploma issued by an approved medical school. The requirements of the school shall have been at the time of granting the diploma in no degree less than those required under this chapter or by any preceding medical practice act at the time that the diploma was granted. In lieu of a diploma, the applicant may submit evidence satisfactory to the board of having possessed the same.~~

~~(b) An official transcript or other official evidence satisfactory to the board showing each approved medical school in which a resident course of professional instruction was pursued covering the minimum requirements for certification as a physician and surgeon, and that a diploma and degree were granted by the school.~~

~~(c) Other information concerning the professional instruction and preliminary education of the applicant as the board may require.~~

~~(d) Proof of passage of the written examinations as provided under Article 9 (commencing with Section 2170) with a score acceptable to the board.~~

~~(e) Proof of satisfactory completion of the postgraduate training required under Section 2096 on a form approved by the board.~~

~~(f) Proof of satisfactory completion of a course on the treatment and management of opiate-dependent patients that shall meet the requirement, at a minimum, of subclause (IV) of clause (ii) of subparagraph (G) of paragraph (2) of subsection (g) of Section 823 of Title 21 of the United States Code, the Comprehensive Addiction Recovery Act of 2016 (Public Law 114–198), as that subclause read on January 1, 2018, and shall also include at least eight hours of instruction in buprenorphine treatment of opioid use disorders.~~

~~(g) An affidavit showing to the satisfaction of the board that the applicant is the person named in each diploma and transcript that he or she submits, that he or she is the lawful holder thereof, and that the diploma or transcript was procured in the regular course of professional instruction and examination without fraud or misrepresentation.~~

~~(h) Either fingerprint cards or a copy of a completed Live Scan form from the applicant in order to establish the identity of the applicant and in order to determine whether the applicant has a record of any criminal convictions in this state or in any other jurisdiction, including foreign countries. The information obtained as a result of the fingerprinting of the applicant shall be used in accordance with Section 11105 of the Penal Code, and to determine whether the applicant is subject to denial of licensure under the provisions of Division 1.5 (commencing with Section 475) and Section 2221.~~

~~(i) Beginning January 1, 2020, if the applicant attended a foreign medical school approved by the board pursuant to Section 2084, an official Educational Commission for Foreign Medical Graduates (ECFMG) Certification Status Report submitted by the Educational Commission for Foreign Medical Graduates confirming the graduate is ECFMG certified.~~

~~(j) Beginning January 1, 2020, if the applicant attended a foreign medical school approved by the board pursuant to Section 2084, official evidence satisfactory to the board of completion of all formal requirements of the medical school for graduation, except~~

~~the applicant shall not be required to have completed an internship or social service or be admitted or licensed to practice medicine in the country in which the professional instruction was completed.~~

~~SEC. 2.~~

SECTION 1. Section 2190.6 is added to the Business and Professions Code, to read:

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

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

~~(b)~~

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

~~(c)~~

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2539
Author: Mathis
Bill Date: April 5, 2018, Amended
Subject: California Physician Corps Program: Practice Setting
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would revise the definition of "practice setting" for purposes of eligibility under the Physician Corps Loan Repayment Program (Program), which includes the Steven M. Thompson Loan Repayment Program (STLRP) and the Physician Volunteer Program, for community clinics and physician offices. This bill would sunset the revised definitions on January 1, 2021.

BACKGROUND:

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

ANALYSIS

This bill would revise the definition of a practice setting for the purposes of Program eligibility to allow community clinics who enroll in the program from January 1, 2019 to January 1, 2021 to participate in the Program if 30% of their patient population qualifies as medically underserved, if the setting is in a rural area, or 50% if the area is not in a rural area. After January 1, 2021, the requirements would go back to the existing requirements of 50% of their patient population qualifies as medically underserved.

This bill would revise the definition of a practice setting for the purposes of Program eligibility to allow physician offices that provide primary care who enroll in the Program from January 1, 2019 to January 1, 2021 to participate in the Program if 30% of their patient population is in a rural area, or 50% of their patient population not in a rural area, are patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250 percent of the federal poverty level. After January 1, 2021, the requirements would go back to the existing eligibility requirements and not make a special allowance for rural areas.

This bill would define a "rural area" as a medical service study area with a population density of fewer than 250 persons per square mile and no population center in excess of 50,000 within the area, as determined by the Office of Statewide Health Planning and Development (OSHPD).

This bill would require the Health Professions Education Foundation (HPEF) to prepare a study to determine the effect of the revised practice setting definition in this bill on funding for loan repayments granted during the calendar years 2019 and 2020. By March 1, 2020, HPEF would be required to submit a report of the study to the Legislature, including program data for calendar year 2019, as compared to program data for calendar years 2017 and 2018. By March 1, 2021, HPEF would be required to submit a report of the study to the Legislature, including program data for calendar year 2020. The reports, at a minimum, would be required to identify all of the following:

- The name and location of all practice settings with program participants, with the practice settings disaggregated by type.
- The number of patients in a practice setting, disaggregated by type of area, including a rural area, among others, and the number of total patients in that practice setting.
- The number of awards and amount of funding for loan repayments granted under the revised definition, disaggregated by type of program participants.

This bill would appropriate $120,000 from the General Fund to OSHPD to fund workload, including amending regulations, providing technical assistance to the STLRP and to prepare the study and reports required by this bill.

According to the author, rural areas struggle to incentivize quality physicians to take up residency in these areas, and this bill is designed to give rural areas a greater chance to obtain the benefits of the STLRP and recruit physicians to these areas. According to a report submitted by HPEF, only 15 of the total 126 STLRP awardees were in rural areas in 2015/16. Supporters of this bill state that access to high quality health care in rural areas is dependent upon an adequate supply of health care providers and loan repayment programs are a great way to attract high quality physicians with diverse qualifications. This bill has the potential to expand the number of rural practice settings eligible for this Program.

The current practice setting definition specifies that community clinics and physician offices are eligible for the Program if 50% of their patient population qualifies as medically underserved. This bill only changes the definition for rural areas, all other areas still must meet the 50% threshold in order to be eligible. This bill would also specify that the revised definition only applies to program participants that enroll in the Program on or after January 1, 2019. After January 1, 2021, the practice setting definition would go back to the original practice setting definition, requiring all areas to meet the 50% medically underserved patient population requirement.

Although the Board supported the bill in 2013 that originally added the 50% medically underserved patient population requirement for practice settings, AB 565 (Salas, Chapter 378), it appears that some rural areas cannot meet this requirement and as a result are not

eligible for the Program. This bill will not increase the funding for the Program, but it will expand eligibility for practice settings in rural areas until January 1, 2021, which may help to incentivize physicians to practice in those areas. This bill includes the same language that was included in AB 148 from 2017. The Board took a neutral position on AB 148, as such, Board staff is suggesting that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 5, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2539

Introduced by Assembly Member Mathis
(Coauthor: Assembly Member Wood)

February 14, 2018

An act to amend Sections 128552 and 128553 of, and to add and repeal Section 128557.5 of, the Health and Safety Code, relating to physicians and surgeons, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2539, as amended, Mathis. California Physician Corps Program: practice setting.

Existing law establishes the Steven M. Thompson Physician Corps Loan Repayment Program (program) in the California Physician Corps Program within the Health Professions Education Foundation, which provides financial incentives, including repayment of educational loans, to a physician and surgeon who practices in a medically underserved area, as defined. Existing law establishes the Medically Underserved Account for Physicians, a continuously appropriated account, within the Health Professions Education Fund, to primarily provide funding for the ongoing operations of the program. Existing law requires the foundation and the Office of Statewide Health Planning and Development to develop guidelines using specified criteria for selection and placement of applicants.

Existing law defines "practice setting," for these purposes, to include a community clinic, as defined, a clinic owned or operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill

the county's role to serve its indigent population, that is located in a medically underserved area and at least 50% of whose patients are from a medically underserved population. Existing law also defines "practice setting," for these purposes, to include a physician owned and operated medical practice setting that provides primary care located in a medically underserved area and has a minimum of 50% of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250% of the federal poverty level.

This bill would instead require, for purposes of this definition, only until January 1, 2021, and only for program participants who enroll in the program on or after January 1, 2019, and before January 1, 2021, that the clinic or the physician owned and operated medical practice setting have at least 30% of patients, if the area is a rural area, as defined, or at least 50% of patients, if the area is not a rural area, who are from the above-described populations. By expanding the authorization for the use of moneys in the continuously appropriated Medically Underserved Account for Physicians, this bill would make an appropriation.

The bill would require the foundation to prepare a study to determine the effect that the revised definition has on funding for loan repayment granted under the program during the calendar years 2019 and 2020. The bill would require the foundation to submit 2 reports of the study by March 1, 2020, and March 1, 2021, respectively, including program data for certain years and identifying specified information.

The bill would appropriate $120,000 from the General Fund to the office to amend regulations, as applicable, to provide technical assistance to the increased number of program applicants, and to prepare the above-described study and reports, for the purpose of implementing this bill.

The bill would also make conforming changes to related provisions.

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

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

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

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

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

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

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

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

(e) "Medically underserved area" means an area defined as a health professional shortage area in Part 5 of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225.

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

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

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

(i) "Practice setting," for the purposes of this article only, means either of the following:

(1) A community clinic as defined in subdivision (a) of Section 1204 and subdivision (c) of Section 1206, a clinic owned or operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role pursuant to Section 17000 of the Welfare and Institutions Code, which is located in a medically underserved area and meets the following conditions:

(A) For program participants who enrolled in the program before January 1, 2019, and who continue to participate in the program on or after that date, the clinic has at least 50 percent of patients who are from a medically underserved population.

(B) Until January 1, 2021, for program participants who enroll in the program on or after January 1, 2019, and before January 1,

2021, the clinic has at least 30 percent of patients, if the area is a rural area, or at least 50 percent of patients, if the area is not a rural area, who are from a medically underserved population.

(C) Commencing January 1, 2021, for program participants who enroll in the program on or after January 1, 2021, and for program participants described in subparagraph (A) or (B), the clinic has at least 50 percent of patients who are from a medically underserved population.

(2) A physician owned and operated medical practice setting that provides primary care located in a medically underserved area and meets the following conditions:

(A) For program participants who enrolled in the program before January 1, 2019, and who continue to participate in the program on or after that date, the medical practice setting has a minimum of 50 percent of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

(B) Until January 1, 2021, for program participants who enroll in the program on or after January 1, 2019, and before January 1, 2021, the medical practice setting has at least 30 percent of patients, if the area is a rural area, or at least 50 percent of patients, if the area is not a rural area, who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

(C) Commencing January 1, 2021, for program participants who enroll in the program on or after January 1, 2021, and for program participants described in subparagraph (A) or (B), the medical practice setting has a minimum of 50 percent of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

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

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

(*l*) "Rural area" means a medical service study area with a population density of fewer than 250 persons per square mile and no population center in excess of 50,000 within the area, as determined by the office.

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

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

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

(b) The foundation and the office shall develop guidelines using the criteria specified in subdivision (c) for selection and placement of applicants. The foundation shall interpret the guidelines to apply to both osteopathic and allopathic physicians and surgeons.

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

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

(A) Speak a Medi-Cal threshold language.

(B) Come from an economically disadvantaged background.

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

(D) Have three years of experience providing health care services to medically underserved populations or in a medically underserved area, as defined in subdivision (e) of Section 128552.

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

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

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

(4) Give preference to applicants who agree to practice in a medically underserved area, as defined in subdivision (e) of Section 128552, and who agree to serve a medically underserved population.

(5) Give priority consideration to applicants from rural communities who agree to practice in a physician owned and operated medical practice setting as defined in paragraph (2) of subdivision (i) of Section 128552.

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

(7) Provide priority consideration to applicants who agree to practice in a geriatric care setting and are trained in geriatrics, and who can meet the cultural and linguistic needs and demands of a diverse population of older Californians. On and after January 1, 2009, up to 15 percent of the funds collected pursuant to Section 2436.5 of the Business and Professions Code shall be dedicated to loan assistance for physicians and surgeons who agree to practice in geriatric care settings or settings that primarily serve adults over the age of 65 years or adults with disabilities.

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

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

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

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

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

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

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

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

(h) The foundation may recommend to the office any other standards of eligibility, placement, and termination appropriate to

achieve the aim of providing competent health care services in approved practice settings.

SEC. 3. Section 128557.5 is added to the Health and Safety Code, to read:

128557.5. (a) The foundation shall prepare a study to determine the effect that subparagraph (B) of paragraph (1) of, and subparagraph (B) of paragraph (2) of, subdivision (i) of Section 128552 have on funding for loan repayment granted under this article during the calendar years 2019 and 2020.

(b) (1) (A) By March 1, 2020, the foundation shall submit a report of the study described in subdivision (a) to the Legislature, including program data for the calendar year 2019 as compared to program data for the calendar years 2017 and 2018.

(B) By March 1, 2021, the foundation shall submit a report of the study described in subdivision (a) to the Legislature, including program data for the calendar year 2020.

(2) At a minimum, the reports described in paragraph (1) shall identify all of the following:

(A) The name and location of all practice settings with program participants, with the practice settings disaggregated by type as defined in paragraphs (1) and (2) of subdivision (i) of Section 128552.

(B) The number of patients described in subparagraph (B) of paragraph (1) of, or subparagraph (B) of paragraph (2) of, subdivision (i) of Section 128552 in a practice setting, disaggregated by type of area, including a rural area, among others, and the number of total patients in that practice setting.

(C) The number *of awards* and amount of funding for loan repayment granted under this article, disaggregated by type of program participants as described in paragraphs (1) and (2) of subdivision (i) of Section 128552.

(c) A report submitted pursuant to subdivision (b) shall be submitted in compliance with Section 9795 of the Government Code.

(d) Pursuant to Section 10231.5 of the Government Code, this section shall become inoperative on March 1, 2025, and shall be repealed on January 1, 2026.

SEC. 4. The sum of one hundred twenty thousand dollars ($120,000) is hereby appropriated from the General Fund to the

Office of Statewide Health Planning and Development to fund the following items for the purpose of implementing this act:

(a) Amending regulations as applicable.

(b) Providing technical assistance to the increased number of applicants under the Steven M. Thompson Physician Corps Loan Repayment Program as a result of the implementation of subparagraph (B) of paragraph (1) of, and subparagraph (B) of paragraph (2) of, subdivision (i) of Section 128552 of the Health and Safety Code.

(c) Preparing the study and reports described in Section 128557.5 of the Health and Safety Code.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 2682
Author:	Burke
Bill Date:	February 15, 2018, Introduced
Subject:	Nurse-Midwives
Sponsor:	California Nurse Midwives Association (CNMA) United Nurses Association of California (UNAC)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would remove the physician supervision requirement for certified nurse midwives (CNMs) allowing CNMs to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn in a variety of settings.

BACKGROUND:

CNMs are registered nurses with a certificate to practice midwifery, who have acquired additional training in the field of obstetrics and are certified by the American College of Nurse Midwives. Like licensed midwives (LMs), CNMS can practice in homes, birth centers and clinics; however, CNMs can also practice in hospital settings. In 2012, CNMs attended approximately 8.5 percent of all births in California, the majority of these births took place in a hospital, and the remainder took place in free-standing birthing centers. It is estimated that ninety percent of CNM attended births take place in a hospital setting. CNMs are required to practice under the supervision of a physician; California is one of the six states that require physician supervision of CNMs.

Existing law authorizes a CNM, under physician supervision, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care for the mother, and immediate care for the newborn. Existing law authorizes a CNM to furnish and order drugs or devices incidental to the provision of family planning services, routine health care or perinatal care, and care rendered consistently with the CNM's education, and in accordance with standardized procedures and protocols with the supervising physician. Existing law also authorizes a CNM to perform and repair episiotomies and repair first-degree and second degree lacerations of the perineum in a licensed acute care hospital and licensed alternate birth center, if performed pursuant to protocols developed and approved by the supervising physician.

AB 1308 (Bonilla, Chapter 665) was signed into law in 2013 and removed the physician supervision requirement for LMs. There were specific requirements on what type of patients LMs can accept, those that meet the criteria for normal pregnancy and childbirth, as specified. If a potential client does not meet the criteria for normal pregnancy and childbirth, then the LM must refer that client to a physician trained in obstetrics and gynecology for examination; the LM can only accept the client if the physician examines the client and determines that the risk

factors are not likely to significantly affect the course of pregnancy and childbirth. AB 1308 also allowed LMs to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to the practice of midwifery and consistent with the LMs scope of practice. AB 1308 was very narrow on what services could be provided and what patients LMs could accept. It also included other provisions related to hospital transfers and education program requirements.

ANALYSIS

This bill would authorize a CNM to provide the same range of services they are now authorized to provide, but without physician supervision. This bill would allow CNMs to practice in a variety of settings. This bill would specify that nurse-midwifery care emphasizes informed consent-shared decision making, preventative care, early detection, and referral of complications. This bill would require a CNM to consult with, and, if necessary, co-manage with, refer to, or transfer care to, a physician and surgeon in any of the following situations:

- The condition is beyond the CNM's scope of practice, based on education and preparation;
- There is evidence that a condition or disease likely jeopardized the health or life of the newborn or mother; and
- The necessary resources and personnel are not available in the setting of care.

This bill would require all consultation, referrals, and transfers to a physician to be documented in the patient record. This bill would require all emergencies to be referred to a physician immediately.

This bill removes physician supervision for CNMs. Although the Board was supportive of the bill in 2013 that removed physician supervisions for LMs, it was because the bill was very restricted and clear on what types of patients LMs could accept, and required physician consultation and approval for patients that did not meet the requirements. High risk patients cannot be accepted by an LM. This bill would allow a CNM to accept all patients, there are no clear limits on what types of patients a CNM could accept. The requirements for a CNM to consult, co-manage, or refer or transfer care to, a physician, are also not clearly defined. In addition, it is also unknown how this bill would affect corporate practice, as the bill does not address this issue. The Board's primary mission is consumer protection and this bill does not currently include parameters on independent CNM practice that would ensure consumer protection. The Board took an oppose unless amended position on a similar bill last year (AB 1612, Burke); Board staff is suggesting that the Board again take an oppose unless amended position on this bill.

FISCAL: None to the Board

SUPPORT: CNMA (Sponsor)
UNAC (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Oppose Unless Amended

ASSEMBLY BILL No. 2682

Introduced by Assembly Member Burke

February 15, 2018

An act to amend Section 2746.5 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2682, as introduced, Burke. Nurse-midwives.

The Nursing Practice Act provides for the licensure and regulation of registered nurses by the Board of Registered Nursing, which is within the Department of Consumer Affairs, and requires the board to issue a certificate to practice nurse-midwifery to a licensee who meets specified qualifications. That act authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn, and provides that the practice of nurse-midwifery constitutes the furthering or undertaking by a certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. The act prohibits supervision from being construed to require the physical presence of the supervising physician. The act requires all complications to be referred to a physician immediately. A violation of the act is a crime.

This bill would instead authorize a nurse-midwife to practice in a variety of settings without supervision by a physician and surgeon subject to certain situations requiring consultation or comanagement with, or referral or transfer to, a physician and surgeon. The bill would

also require all emergencies to be referred to a physician and surgeon immediately. By imposing new requirements, the violation of which would be a crime, 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. Section 2746.5 of the Business and Professions Code is amended to read:

2746.5. ~~(a) The~~ *Notwithstanding any other law:*

(a) The certificate to practice nurse-midwifery authorizes the ~~holder, under the supervision of a licensed physician and surgeon,~~ *holder* to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the ~~newborn.~~ *newborn, in a variety of settings.*

(b) As used in this chapter, the practice of nurse-midwifery constitutes the furthering or undertaking by any certified ~~person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics,~~ *person* to assist a woman in childbirth so long as progress meets criteria accepted as ~~normal. All complications shall be referred to a physician immediately.~~ *normal, subject to subdivisions (c) and (d).* The practice of nurse-midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.

~~(c) As used in this article, "supervision" shall not be construed to require the physical presence of the supervising physician.~~

(c) (1) Nurse-midwifery care emphasizes informed consent-shared decisionmaking, preventative care, early detection, and referral of complications. A certified nurse-midwife shall

consult with and, if necessary, comanage with, refer to, or transfer care to, a physician and surgeon in any of the following situations:

(A) The condition is beyond the certified nurse-midwife's scope of practice, based on education and preparation.

(B) There is evidence that a condition or disease likely jeopardizes the health or life of the newborn or mother.

(C) The necessary resources and personnel are not available in the setting of care.

(2) Consultations, referrals, and transfers required by paragraph (1) shall be documented in the patient record.

(d) All emergencies shall be referred to a physician and surgeon immediately.

~~(d)~~

(e) A certified nurse-midwife is not authorized to practice medicine and surgery by the provisions of this chapter.

~~(e)~~

(f) Any regulations promulgated by a state department that affect the scope of practice of a certified nurse-midwife shall be developed in consultation with the board.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2741
Author: Burke
Bill Date: April 2, 2018, Amended
Subject: Prescription Drugs: Opioid Medications: Minors
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would set a 5-day limit on all opioid prescriptions for acute pain management for minors. This bill would also require prescribers to assess whether the minor is being treated for a substance abuse disorder, to discuss the potential risks associated with opioid use, and obtain written consent from a minor's parent or guardian before prescribing the medication..

BACKGROUND:

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

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

In 2014, the Director of the California Department of Public Health (CDPH) launched a state agency Prescription Opioid Misuse and Overdose Prevention Workgroup (Workgroup) to share information and develop collaborative strategies to curb prescription drug misuse, abuse, and overdose deaths in California. The Workgroup started as a multi-sector group consisting of more than 10 state agencies, including

CDPH, Department of Justice, Department of Health Care Services, Department of Managed Health Care, Department of Education, Department of Industrial Relations, Department of Corrections and Rehabilitation, Department of Consumer Affairs (including the Board, Dental Board, Board of Pharmacy, and Board of Registered Nursing), Emergency Medical Services Authority, and others. The Workgroup initially commenced a multi-phase plan involving enhancement of the state's Prescription Drug Monitoring Program (PDMP), promoting the release and adoption of the Board's revised Guidelines for Prescribing Controlled Substances for Pain, and development of a comprehensive public education campaign to increase public awareness about the potential dangers of opioid medications and to create better understanding and expectations among the public regarding proper prescribing, use, storage and disposal of opioids.

ANALYSIS

This bill would prohibit a prescriber from prescribing more than a five-day supply of opioid medication to a minor unless the prescription is for any of the following:

- Management of pain associated with cancer.
- Use in palliative or hospice care.
- Management of chronic pain not associated with cancer.
- Treatment of a substance use disorder.

This bill would require a prescriber, before prescribing a minor a course of treatment of opioid medication, to do the following:

- Assess whether the minor has taken or is currently taking prescription drugs for treatment of a substance use disorder.
- Discuss with the minor and the minor's parent or guardian, all of the following:
    - The risks of addiction and overdose associated with opioid medication.
    - The increased risk of addiction of opioid medication to individuals suffering from mental or substance abuse disorders.
    - The dangers of taking opioid medication with benzodiazepines, alcohol, or other central nervous system depressants.
    - Any other information deemed necessary by the prescriber.
- Obtain written consent, on the standardized consent form, for the prescription from the minor's parent or guardian. This bill would require the prescriber to maintain the consent form in the minor's record.

This bill would require the Board, by January 1, 2020, to create a standardized consent form. This bill would require the Board to notify its licensees of the availability of the consent form and make it accessible on its website. The consent form would be required to contain all of the following:

- The brand name or generic name and the quantity of the opioid medication being prescribed and the amount of the initial dose.
- A statement indicating that opioid medication is a drug or other substance that the United States Drug Enforcement Administration has identified as having a potential for abuse.

- A statement certifying that the prescriber engaged in the discussion required by this bill.
- The signature of the minor's parent or guardian and the date of signing.

This bill would specify that the opioid limitation and the written consent requirements would not apply if the minor's treatment with opioid medication meets either of the following criteria:

- The treatment is associated with, or incident to, a medical emergency, as documented in the minor's medical record.
- In the prescriber's professional judgment, complying with these requirements would be detrimental to the minor's health or safety. The prescriber would be required to document in the minor's medical record the factor or factors that the prescriber believed constituted cause for not meeting these requirements.

The author believes this bill promotes safe prescribing strategies as recommended by the Centers for Disease Control and the Board for minors suffering from acute pain. The author believes this bill would ensure that parents or legal guardians are educated and made aware of the dangers of extended opioid use.

The growing opioid abuse epidemic remains a matter of concern for the Board. Providing education to parents on the risks of opioids will help to promote the Board's mission of consumer protection. Although this bill exempts management of chronic pain from this bill's requirements, there may be some recurring illnesses that aren't considered chronic but that are not acute. However, this bill does allow a physician to use their professional judgment on a case-by-case basis. In addition, if a minor is having a major surgical procedure, the 5-day limit may not be appropriate. There may be a limit that is more reasonable than five days. Lastly, this bill would require the Board to develop a consent form, however the same information could be required to be included in the patient's medical record without requiring a consent form. As such, Board staff recommends that the Board oppose this bill unless this bill is amended to address these issues.

FISCAL: Minimal and absorbable

SUPPORT: Gatekeeper Innovation

OPPOSITION: California Medical Association

POSITION: Recommendation: Oppose Unless Amended

AMENDED IN ASSEMBLY APRIL 2, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2741

Introduced by Assembly Member Burke
(Coauthor: Assembly Member Dahle)

February 16, 2018

An act to add Article 10.8 (commencing with Section 745) to Chapter 1 of Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2741, as amended, Burke. Prescription drugs: opioid medications: minors.

Existing law provides for the licensure and regulation of health care practitioners by various boards and requires prescription drugs to be ordered and dispensed in accordance with the Pharmacy Law. Existing law makes repeated acts of clearly excessive prescribing or administering of drugs or treatment unprofessional conduct for certain health care practitioners.

~~This bill would require a prescriber, as defined, to comply with specified conditions when prescribing opioid medication to a minor, including not prescribing more than a 5-day supply of an opioid medication to that minor except in specified instances.~~ *This bill would prohibit a prescriber, as defined, from prescribing more than a 5-day supply of opioid medication to a minor unless the prescription is for specified uses. The bill would also require a prescriber to take certain steps before prescribing a minor a course of treatment with opioid medication, including discussing opioid risks and obtaining specified written consent, except in specified instances.* The bill would make a

violation of the bill's provisions unprofessional conduct and would subject the prescriber to discipline by the board charged with regulating his or her license. The provisions of the bill requiring the prescriber to assess ~~the minor's substance abuse history,~~ *whether the minor has or is taking prescription drugs for treatment of a substance use disorder,* discuss opioid risks, and obtain written consent would not ~~be implemented~~ *apply* until the development of a consent form by the Medical Board of California.

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

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

SECTION 1. Article 10.8 (commencing with Section 745) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

Article 10.8. Opioid Medication For Minors

745. (a) For purposes of this ~~article,~~ *section,* the following definitions apply:

(1) "Opioid medication" means an opioid analgesic drug product, including, but not limited to, an abuse-deterrent opioid analgesic drug product.

(2) "Prescriber" means a person licensed, certified, registered, or otherwise subject to regulation pursuant to this division, or an initiative act referred to in this division, who is authorized to prescribe opioid medication.

(b) A prescriber authorized to prescribe a Schedule II controlled substance shall comply with this section when prescribing opioid medication to a minor.

(c) A prescriber shall not prescribe more than a five-day supply of opioid medication to a minor unless the prescription is for any of the following:

(1) Management of pain associated with cancer.

(2) Use in palliative or hospice care.

(3) Management of chronic pain not associated with cancer.

(4) Treatment of a substance use disorder.

(d) Except ~~as provided~~ in *the case of a prescription for a use listed in* subdivision ~~(b),~~ *(c),* before prescribing a minor a course

of treatment with opioid medication, regardless of whether the dosage is modified during that course of treatment, a prescriber shall do all of the following:

(1) Assess whether the minor has taken or is currently taking prescription drugs for treatment of a substance use disorder.

(2) Discuss with the minor and the minor's parent or guardian, or other authorized adult, all of the following:

(A) The risks of addiction and overdose associated with opioid medication.

(B) The increased risk of addiction to opioid medication to individuals suffering from mental or substance abuse disorders.

(C) The dangers of taking opioid medication with benzodiazepines, alcohol, or other central nervous system depressants.

(D) Any other information deemed necessary by the prescriber.

(3) Obtain written ~~consent~~ *consent, on the form created pursuant to subdivision (e),* for the prescription from the minor's parent or guardian, or authorized adult. *The prescriber shall maintain the consent form in the minor's record.*

(e) ~~(1)~~ The Medical Board of California, by January 1, 2020, shall create a standardized consent form to be used for purposes of this section. The board shall notify its licensees of the availability of the consent form and make it accessible on its member Internet Web site. The consent form shall contain all of the following:

~~(A)~~

(1) The brand name or generic name and quantity of the opioid medication being prescribed and the amount of the initial dose.

~~(B)~~

(2) A statement indicating that opioid medication is a drug or other substance that the United States Drug Enforcement Administration has identified as having a potential for abuse.

~~(C)~~

(3) A statement certifying that the prescriber engaged in the discussion described in subdivision (d).

~~(D)~~

(4) The signature of the minor's parent or guardian, or authorized adult, and the date of signing.

~~(2) The prescriber shall maintain a consent form completed under this section in the minor's record.~~

(f) Subdivision ~~(b) does~~ *(c) and paragraph (3) of subdivision (d) shall* not apply if the minor's treatment with opioid medication meets either of the following criteria:

(1) The treatment is associated with, or incident to, a medical emergency as documented in the minor's medical record.

(2) In the prescriber's professional judgment, complying with subdivision ~~(b)~~ *(c) or with paragraph (3) of subdivision (d), respectively,* with respect to the minor's treatment would be detrimental to the minor's health or safety. The prescriber shall document in the minor's medical record the factor or factors which the prescriber believed constituted cause for not fulfilling the requirements of subdivision ~~(b).~~ *(c) or paragraph (3) of subdivision (d).*

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

(h) Subdivision (d) shall not ~~be implemented~~ *apply* until the Medical Board of California has created the standardized consent form described in subdivision (e).

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2760
Author: Wood
Bill Date: April 3, 2018, Amended
Subject: Prescription Drugs: Naloxone Hydrochloride
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a health care practitioner authorized to prescribe controlled substances (prescriber) to co-prescribe a prescription for naloxone hydrochloride (naloxone) under specified conditions.

BACKGROUND

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

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

According to the author's office, the American Medical Association's Opioid Task Force recently issued updated naloxone guidelines recommending that family physicians and other clinicians consider a set of factors when determining whether to co-prescribe naloxone to a patient and/or their caregivers. Among others, those factors include whether the patient is on a concomitant benzodiazepine prescription and has a history of overdose or substance use disorder. (The risk of overdose death goes up nearly fourfold when benzodiazepines are combined with opioids. Overdose deaths involving benzodiazepines increased more than sevenfold between 1999 and 2015.)

ANALYSIS

This bill would make findings and declarations regarding opioid misuse and abuse and overdose deaths. This bill would require a prescriber to co-prescribe a prescription for naloxone when one or more of the following conditions are present:

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

This bill would also require the prescriber to provide education to patients receiving a prescription that would require a co-prescription for naloxone and their households on overdose prevention and the use of naloxone.

This bill would specify that any violation of this bill's requirements would constitute unprofessional conduct and be grounds for disciplinary action by the prescriber's licensing board, including the Medical Board of California (Board).

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

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

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: California Pharmacists Association; County Health Executives Association; and Drug Policy Alliance

OPPOSITION: California Medical Association

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 3, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2760

Introduced by Assembly Member Wood

February 16, 2018

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

LEGISLATIVE COUNSEL'S DIGEST

AB 2760, as amended, Wood. Prescription drugs: ~~nalolxone~~ *naloxone* hydrochloride.

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

This bill would require a prescriber, as defined, to prescribe naloxone hydrochloride for patients when certain conditions are present and to provide specified education to those patients and their ~~household.~~ *households*. The bill would make a violation of the bill's provisions unprofessional conduct and would subject the prescriber to discipline by the board charged with regulating his or her license.

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

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

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

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

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

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

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

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

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

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

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

Article 10.7 Opioid Medication

740. For purposes of this article, "prescriber" means a person licensed, certified, registered, or otherwise subject to regulation pursuant to this division, or an initiative act referred to in this division, who is authorized to prescribe prescription drugs.

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

(a) Prescribe naloxone hydrochloride for a patient when one or more of the following conditions are present:

(1) The prescription dosage for ~~a~~ *the* patient is ~~between 50 and 100~~ *90 or more* morphine milligram equivalents of an opioid medication per day.

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

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

(b) Provide education to patients receiving a prescription under subdivision (a) and their households on overdose prevention and the use of naloxone hydrochloride.

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2783
Author: O'Donnell
Bill Date: March 22, 2018, Amended
Subject: Controlled Substances: Schedules
Sponsor: California State Board of Pharmacy

DESCRIPTION OF CURRENT LEGISLATION:

This bill would clarify that in the event of any conflict between state and federal controlled substance schedules, prescribers and dispensers shall comply with the schedule that more narrowly regulates the controlled substance in question.

BACKGROUND:

The Controlled Substances Act (CSA) places all substances that were in some manner regulated under existing federal law into one of five schedules. This placement is based upon the substance's medical use, potential for abuse, and safety or dependence liability.

The CSA categorizes drugs into five distinct schedules, based upon the potential for abuse, evidence of pharmacological effect, the current scientific knowledge, its history and current pattern of abuse, the scope, duration, and significance of abuse, risk to the public, psychic or physiological dependence liability, and whether the substance is an immediate precursor of a substance already controlled.

The CSA schedules drugs on a federal level, but California has its own state-level schedule of drugs. According to the author's office, although they are generally consistent, there have been some discrepancies. For example, in 2014, the opioid drug hydrocodone was rescheduled federally from Schedule III to Schedule II; however, it remains on Schedule III at the state level.

ANALYSIS:

This bill would define a controlled substance as a substance listed in California law and a substance listed in the federal regulations as a controlled substance. This bill would specify that when there is a conflict between the federal and state schedules, the schedule that is more closely regulated shall control.

According to the author's office, discrepancies in federal and state controlled substance schedules can be confusing for prescribers and pharmacists who do not know what schedule to use. This bill seeks to reconcile these discrepancies and clarify compliance.

This bill would ensure that conflicts between federal and state controlled substance schedules are clarified, which will make it less confusing for prescribers and dispensers. It will also ensure that the more narrowly regulated schedule must be complied with by

prescribers and dispensers. This bill would promote the Board's mission of consumer protection and Board staff suggests that the Board take a support position on this bill.

FISCAL: None to the Board

SUPPORT: California State Board of Pharmacy (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY MARCH 22, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2783

Introduced by Assembly Member O'Donnell

February 16, 2018

An act *to amend Section 4021 of the Business and Professions Code, and to amend Section 11007 of the Health and Safety Code,* relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

AB 2783, as amended, O'Donnell. Controlled substances: schedules.

Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into 5 designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I, and the least restrictive limitations generally placed on controlled substances classified in Schedule V.

Existing federal law classifies controlled substances into 5 designated schedules, similar to the state schedules. Federal law authorizes updates of the substances on the federal schedules administratively by the federal Drug Enforcement Agency.

Existing law creates various crimes based on the schedule on which a controlled substance is placed, including prohibiting possession, transportation, and sale of a Schedule III, IV, or V controlled substance without a prescription.

This bill would ~~declare the intent of the Legislature to enact legislation to resolve discrepancies between California's controlled substance schedules and the corresponding federal controlled substance schedules, as specified.~~ *define controlled substances for the purposes of California law as any of the substances listed on the California and federal*

schedules, including substances that have been added to the federal schedules in regulations. The bill would provide that when the state and federal controlled substances schedules conflict, the schedule that is more closely regulated shall control. By expanding the definition of a crime, 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: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

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

SECTION 1. Section 4021 of the Business and Professions Code is amended to read:

4021. *(a)* "Controlled substance" means ~~any~~ *a* substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety ~~Code.~~ *Code and a substance listed in the controlled substance schedules in federal law and regulations, including sections 1308.11, 1308.12, 1308.13, 1308.14, and 1308.15 of Title 21 of the Code of Federal Regulations.*

(b) When there is a conflict between the federal and state schedules, the schedule that is more closely regulated shall control.

SEC. 2. Section 11007 of the Health and Safety Code is amended to read:

11007. *(a)* "Controlled substance," unless otherwise specified, means a drug, substance, or immediate precursor ~~which~~ *that* is listed in any schedule in Section 11054, 11055, 11056, 11057, or ~~11058.~~ *11058 and a substance listed in the controlled substance schedules in federal law and regulations, including Sections 1308.11, 1308.12, 1308.13, 1308.14, and 1308.15 of Title 21 of the Code of Federal Regulations.*

(b) When there is a conflict between the federal and state schedules, the schedule that is more closely regulated shall control.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school

district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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

~~(a) Although they are generally consistent, over the last several years discrepancies have arisen between the federal controlled substance schedules, contained in Sections 1308.11, 1308.12, 1308.13, 1308.14, and 1308.15 of Title 21 of the Code of Federal Regulations and California's controlled substance schedules as set forth in Sections 11054, 11055, 11056, 11057, 11058 of the Health and Safety Code, both in terms of whether certain drugs are listed on those schedules at all, and in terms of the location of certain drugs on Schedule I, II, III, IV, or V.~~

~~(b) For example, hydrocodone combination products (HCPs), those drugs that combine hydrocodone with nonnarcotic ingredients including acetaminophen or ibuprofen, were previously listed on Schedule III for both the federal and California schedules. Effective October 6, 2014, however, HCPs were moved at the federal level from Schedule III to Schedule II. A corresponding change was not made in California, where these drugs remain on Schedule III.~~

~~(c) Similarly, whereas tramadol was added to the federal version of Schedule IV effective August 18, 2014 it remains an unscheduled drug under California law. Likewise, carisoprodol (Soma) was added to Schedule IV under federal law effective January 11, 2012, but California has not yet taken action to add carisoprodol to its schedules.~~

~~(d) These discrepancies have become noticeable enough that since 2012, pursuant to language added by Senate Bill 360 (Ch. 418, Stats. 2012), the California Controlled Substance Utilization Review and Evaluation System (CURES), the state database of controlled substances dispensed pursuant to prescription, has specified that what constitutes a Schedule II, III, or IV controlled substance for purposes of reporting shall be determined according to the federal rather than the California schedules.~~

~~(e) These discrepancies can also lead to confusion with respect to prescriber and dispenser responsibilities regarding the various~~

~~controlled substances, and their obligations as to prescribing, handling, dispensing, and record-keeping, particularly as to certain duties under California law. For instance, Section 11200 of the Health and Safety Code provides that prescriptions for Schedule III and IV controlled substances may only be refilled five times and only up to a 120-day supply, while it prevents Schedule II prescriptions from being refilled at all. Thus, because HCPs are Schedule III under California law, this would seem to permit refills of prescriptions for this substance. However, federal law would prohibit refilling a prescription for what is a Schedule II controlled substance under federal law.~~

~~SEC. 2. It is the intent of the Legislature to enact legislation to resolve discrepancies between California's controlled substance schedules and the corresponding federal controlled substance schedules in a consistent manner that will clarify applicable law for prescribers, health practitioners, and others who rely on those schedules, and to allow for current and future scheduling of drugs that do not appear on the federal controlled substance schedule or are recognized as having a higher abuse potential than has been recognized at the federal level.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

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

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require all prescriptions issued by licensed prescribers, on or after January 1, 2021, to be issued as electronic data transmission prescriptions (e-prescriptions).

BACKGROUND:

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

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

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

ANALYSIS

This bill would require a health care practitioner authorized to issue a prescription to have the capability to issue an e-prescription and to transmit an e-prescription to a pharmacy by January 1, 2020. This bill would require a pharmacy, pharmacist, or other practitioner authorized to dispense and furnish a prescription to have the capability to receive an e-prescription by January 1, 2020. This bill would require all prescriptions to be issued as e-prescriptions by January 2, 2021.

This bill would specify that it does not apply to any of the following:

- A prescription issued for a controlled substance for use by a patient who has a terminal illness.

- If an e-prescription is not available due to a temporary technological or electrical failure, which is defined as a failure of a computer system, application, or device, or the loss of electrical power to that system, application, or device, or any other service interruption affecting the certified electronic transmission prescription application used to transmit the prescription.
- If the prescribing health care practitioner is issuing a prescription to be dispensed by a pharmacy located outside of California.
- If the prescription is issued by a veterinarian.
- If the prescription is for eyeglasses or contact lenses.
- If the prescribing health care practitioner and the dispenser are the same entity.
- If the prescription is issued by a prescribing health care practitioner under circumstances whereby the practitioner reasonably determines that it would be impractical for the patient to obtain controlled substances prescribed by an e-prescription in a timely manner, and the delay would adversely impact the patient's medical condition.
- If the prescription that is issued includes elements not covered by the latest version of the National Council for Prescription Drug Programs' SCRIPT standard, as amended from time to time.

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

This bill would require a pharmacy that receives an e-prescription, who has not yet dispensed the medication to the patient, to immediately transfer or forward the e-prescription to an alternative pharmacy at the request of the patient. This bill would specify that if a pharmacy or its staff is aware that an attempted e-prescription failed, is incomplete, or not appropriately received, the pharmacy shall immediately notify the prescriber. This bill would also specify that a pharmacist who receives a written, oral, or faxed prescription shall not be required to verify that the prescription properly falls under one of the exceptions; pharmacists may continue to dispense medications from legally valid written, oral, or fax prescriptions.

This bill would state that a violation of the bill's provisions constitutes unprofessional conduct and would be grounds for disciplinary action by the health care practitioner's licensing board, including the Medical Board of California (Board).

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

The Board's primary mission is consumer protection and the growing opioid abuse epidemic remains a matter of concern for the Board. Moving towards e-prescribing would help to eliminate fraudulent prescriptions, including prescriptions for opioids. However, it may be an issue for some physicians in California that do not have access to this kind of technology. In addition, there may be some prescriptions that are prescribed, but are only to be filled if needed. The Board should consider these issues in its discussion on this bill.

FISCAL: Minor and absorbable fiscal impact.

SUPPORT: America's Physician Groups; California Association of Health Underwriters; California State Board of Pharmacy; Healthcare Distribution Alliance; and Imprivata

OPPOSITION: California Medical Association

AMENDED IN ASSEMBLY APRIL 3, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2789

Introduced by Assembly Member Wood

February 16, 2018

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

This bill, on and after January 1, 2020, would require health care practitioners authorized to issue prescriptions to have the capability to transmit electronic *data* transmission prescriptions, and would require pharmacies to have the capability to receive those transmissions. The bill, on and after January 1, 2021, would require those health care practitioners to issue prescriptions as an electronic *data* transmission prescription, unless specified exceptions are met. The bill would not require the pharmacy to verify that a written, oral, or faxed prescription satisfies the specified exemptions. The bill would require the pharmacy receiving the electronic *data* transmission prescription to immediately notify the prescriber if the electronic *data* transmission prescription

fails, is incomplete, or is otherwise not appropriately received. The bill would authorize the pharmacy to transmit the prescription to another pharmacy at the request of the patient, as specified. The bill would make a violation of these provisions unprofessional conduct and would subject the health care practitioner to discipline by the board charged with regulating his or her license.

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

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

SECTION 1. Section 688 is added to the Business and Professions Code, to read:

688. (a) On and after January 1, 2020, a health care practitioner authorized to issue a prescription pursuant to Section 4040 shall have the capability to issue an electronic *data* transmission prescription, as defined under Section 4040, on behalf of a patient and to transmit that electronic *data* transmission prescription to a pharmacy selected by the patient.

(b) On and after January 1, 2020, a pharmacy, pharmacist, or other practitioner authorized under California law to dispense or furnish a prescription pursuant to Section 4040 shall have the capability to receive an electronic *data* transmission prescription on behalf of a patient.

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

(d) On and after January 1, 2021, a prescription prescribed by a health care practitioner shall be issued as an electronic *data* transmission prescription. This subdivision shall not apply to prescriptions issued pursuant to subdivision (e).

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

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

(2) An electronic *data* transmission prescription is not available due to a temporary technological or electrical failure. For purposes of this paragraph, "temporary technological or electrical failure" means failure of a computer system, application, or device, or the

loss of electrical power to that system, application, or device, or any other service interruption affecting the certified electronic *data* transmission prescription application used to transmit the prescription.

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

(4) The prescription is issued by a veterinarian.

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

~~(5)~~

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

~~(6)~~

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

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

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

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

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

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

(j) Notwithstanding any other law, a violation of this section constitutes unprofessional conduct and grounds for disciplinary action by the health care practitioner's licensing board.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 2968
Author:	Levine
Bill Date:	March 23, 2018, Amended
Subject:	Psychotherapist-Client Relationship: Victims of Sexual Behavior and Sexual Contact: Informational Brochure
Sponsor:	Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would update and modernize the Department of Consumer Affairs' (DCA) informational brochure for victims of psychotherapist-patient sexual impropriety.

BACKGROUND:

Existing law requires DCA to prepare and disseminate an informational brochure for victims of psychotherapist-patient sexual impropriety, currently entitled, "Professional Therapy Never Includes Sex". Existing law requires this brochure to be provided to each individual contacting the Medical Board of California (Board) and affiliated health boards, or the Board of Behavioral Sciences regarding a complaint involving psychotherapist-patient sexual relations. Existing law also requires psychotherapists to provide this brochure to clients if they become aware that the client alleges having had sexual intercourse or sexual contact with a previous psychotherapist during the course of treatment.

According to the author, existing law includes outdated language and is missing currently-recognized forms of sexual exploitation, modern modes of communication, and there are sexually exploitative behaviors that do not reach the level of sexual contact as defined in existing law.

ANALYSIS

This bill would amend existing law regarding the informational brochure that DCA is required to prepare and disseminate. Currently, the brochure is for victims of psychotherapist-patient sexual contact, this bill would change it to psychotherapist-client sexual behavior and contact. This bill would also delete the requirement in existing law that DCA must consult with the Office of Criminal Justice and the Office of the Attorney General in developing the brochure.

This bill would specifically name other boards that are required to disseminate the brochure if they receive specified complaints, specifically the Osteopathic Medical Board of California and the Board of Psychology, in addition to the Board and the Board of Behavioral Sciences. This bill would change the definition of a psychotherapist to any of the following: A physician or surgeon specializing in the practice of psychiatry or practicing psychotherapy; a psychologist; a psychological assistant; a registered psychologist; a trainee under the supervision of a licensed psychologist; a marriage and

family therapist; an associate marriage and family therapist; a marriage and family therapist trainee; a licensed educational psychologist; a clinical social worker; an associate clinical social worker; a licensed professional clinical counselor; an associate professional clinical counselor; and a clinical counselor trainee.

This bill would add sexual behavior and would define it as inappropriate contact or communication of a sexual nature. This bill would specify that sexual behavior does not include the provision of appropriate therapeutic interventions relating to sexual issues.

Per the author's office, this bill updates and modernizes existing statute by removing obsolete language, including currently recognized forms of sexual exploitation and modern modes of communication, and more clearly articulates to consumers the most effective course of action when reporting these types of allegations.

Medical Board staff worked with other affected boards to provide technical assistance on the language included in this bill. This bill would update existing law and the content for the required informational brochure, which will help consumers to know when to file a complaint. This bill would promote the Board's mission of consumer protection and Board staff suggests that the Board take a support position on this bill.

FISCAL: None

SUPPORT: California Board of Psychology
Osteopathic Medical Board of California

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY MARCH 23, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2968

Introduced by Assembly Member Levine

February 16, 2018

An act to amend ~~Section 105~~ *Sections 337 and 728* of the Business and Professions Code, relating to ~~consumer affairs.~~ *healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2968, as amended, Levine. ~~Consumer affairs.~~ *Psychotherapist-client relationship: victims of sexual behavior and sexual contact: informational brochure.*

Existing law requires the Department of Consumer Affairs to prepare and disseminate an informational brochure for victims of psychotherapist-patient sexual contact and their advocates, and requires that the brochure be developed by the department in consultation with the office of Criminal Justice Planning and the office of the Attorney General, as specified. Existing law requires the brochure to include specified subjects and requires the brochure to be provided to individuals who contact the Medical Board of California and affiliated health boards or the Board of Behavioral Sciences regarding a complaint involving psychotherapist-patient sexual relations.

This bill would eliminate the requirement that the department develop the brochure in consultation with the office of Criminal Justice Planning and the office of the Attorney General. The bill would require that the brochure also be for victims of psychotherapist-client sexual behavior. The bill would revise the required content of the brochure, and would require the brochure to be provided to each individual contacting the Medical Board of California, the Osteopathic Medical Board of

California, the Board of Psychology, or the Board of Behavioral Sciences regarding a complaint involving psychotherapist-client sexual behavior and sexual contact. The bill would make conforming changes.

Existing law requires a psychotherapist or an employer of a psychotherapist who becomes aware through a patient that the patient had alleged sexual intercourse or alleged sexual contact, as defined, with a previous psychotherapist to provide a brochure developed by the department that delineates the rights of, and remedies for, patients who have been involved sexually with their psychotherapists. Existing law defines "psychotherapist" for purposes of those provisions to include various mental health practitioners and makes a failure to comply unprofessional conduct.

This bill would make this requirement also apply in the case of alleged sexual behavior, as defined, with a previous psychotherapist and would specify that the required brochure is the above-described brochure developed by the department. The bill would also expand the list of mental health practitioners included in the definition of "psychotherapist" for those purposes.

~~Existing law establishes the Department of Consumer Affairs, which is comprised of various boards and requires members of a board to take an oath of office, as specified.~~

~~This bill would make a nonsubstantive change to that provision.~~

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

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

SECTION 1. Section 337 of the Business and Professions Code is amended to read:

337. (a) The department shall prepare and disseminate an informational brochure for victims of ~~psychotherapist-patient~~ *psychotherapist-client sexual behavior and* sexual contact and ~~advocates for those victims.~~ *their advocates.* This brochure shall be developed by the ~~department in consultation with members of the Sexual Assault Program of the Office of Criminal Justice Planning and the office of the Attorney General.~~ *department.*

(b) The brochure shall include, but is not limited to, the following:

(1) A legal and an informal definition of ~~psychotherapist-patient~~ *psychotherapist-client sexual behavior and* sexual contact.

(2) A brief description of common personal ~~reactions and histories of victims and victim's families.~~ *reactions.*

(3) A ~~patient's~~ *client's* bill of rights.

(4) ~~Options~~ *Instructions* for reporting ~~psychotherapist-patient sexual relations and instructions for each reporting option.~~ *psychotherapist-client sexual behavior and sexual contact.*

(5) A full description of ~~administrative, civil, and professional associations~~ *administrative* complaint procedures.

(6) A description of services available for support of victims.

(c) The brochure shall be provided to each individual contacting the Medical Board of ~~California and affiliated health boards~~ *California, the Osteopathic Medical Board of California, the Board of Psychology,* or the Board of Behavioral Sciences regarding a complaint involving ~~psychotherapist-patient sexual relations.~~ *psychotherapist-client sexual behavior and sexual contact.*

SEC. 2. Section 728 of the Business and Professions Code is amended to read:

728. (a) Any psychotherapist or employer of a psychotherapist who becomes aware through a ~~patient~~ *client* that the ~~patient~~ *client* had alleged sexual intercourse or alleged *sexual behavior or* sexual contact with a previous psychotherapist during the course of a prior treatment shall provide to the ~~patient~~ *client* a brochure ~~promulgated~~ *developed* by the department *pursuant to Section 337* that delineates the rights of, and remedies for, ~~patients~~ *clients* who have been involved sexually with their psychotherapists. Further, the psychotherapist or employer shall discuss with the ~~patient~~ *client* the brochure prepared by the department.

(b) Failure to comply with this section constitutes unprofessional conduct.

(c) For the purpose of this section, the following definitions apply:

(1) "Psychotherapist" means ~~a physician and surgeon specializing in the practice of psychiatry or practicing psychotherapy, a psychologist, a clinical social worker, a marriage and family therapist, a licensed professional clinical counselor, a psychological assistant, a marriage and family therapist registered intern or trainee, an intern or clinical counselor trainee, as specified in Chapter 16 (commencing with Section 4999.10), or an associate clinical social worker.~~ *any of the following:*

(A) A physician and surgeon specializing in the practice of psychiatry or practicing psychotherapy.

(B) A psychologist.

(C) A psychological assistant.

(D) A registered psychologist.

(E) A trainee under the supervision of a licensed psychologist.

(F) A marriage and family therapist.

(G) An associate marriage and family therapist.

(H) A marriage and family therapist trainee.

(I) A licensed educational psychologist.

(J) A clinical social worker.

(K) An associate clinical social worker.

(L) A licensed professional clinical counselor.

(M) An associate professional clinical counselor.

(N) A clinical counselor trainee.

(2) "Sexual behavior" means inappropriate contact or communication of a sexual nature. "Sexual behavior" does not include the provision of appropriate therapeutic interventions relating to sexual issues.

~~(2)~~

(3) "Sexual contact" means the touching of an intimate part of another person.

~~(3)~~

(4) "Intimate part" and "touching" have the same meaning as defined in subdivisions (g) and (e), respectively, of Section 243.4 of the Penal Code.

~~(4)~~

(5) "The course of a prior treatment" means the period of time during which a ~~patient~~ *client* first commences treatment for services that a psychotherapist is authorized to provide under his or her scope of practice, or that the psychotherapist represents to the ~~patient~~ *client* as being within his or her scope of practice, until the ~~psychotherapist-patient~~ *psychotherapist-client* relationship is terminated.

~~SECTION 1. Section 105 of the Business and Professions Code is amended to read:~~

~~105. Each member of a board in the department shall take an oath of office as provided in the Constitution and the Government Code.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 944
Author: Hertzberg
Bill Date: March 21, 2018, Amended
Subject: Community Paramedicine Act of 2018
Sponsor: California Professional Firefighters

DESCRIPTION OF LEGISLATION:

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

BACKGROUND

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

ANALYSIS

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

- Providing short-term post-discharge follow-up for persons recently discharged from a hospital due to a serious health condition.
- Providing directly observed case management services to frequent emergency medical services users.
- Providing hospice services to treat patients in their homes.
- Providing patients with transport to an alternate destination facility.

This bill would define a community paramedic as a paramedic who has completed the core curriculum for community paramedic training, has received certification in one or more of the

community paramedicine program specialties, and is accredited to provide community paramedic services by a local EMS agency as part of an approved community paramedicine program.

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

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

- Minimum standards and core curriculum for community paramedic training.
- Minimum standards for the scope of practice for each community paramedicine program specialty.
- A process for certifying a community paramedic who completes the required core curriculum.
- Minimum standards for approval, review, withdrawal, and revocation of a community paramedicine program.
- Minimum standards for collecting and submitting data to EMSA to ensure patient safety that include consideration of both quality assurance and quality improvement. These standards shall include all of the following:
    - Intervals for community paramedicine providers, participating health facilities, and local EMS agencies to submit community paramedicine data.
    - Relevant program use data.
    - Public posting of program analysis.
    - Emergency medical response system feedback, including feedback from the Committee.
    - If the community paramedicine program utilizes an alternate destination

facility, consideration of ambulance patient offload times for the alternate destination and existing emergency departments, the number of patients that are turned away, diverted, or required to be subsequently transferred to an emergency department, and the reasons.
    - An assessment of each community paramedicine program's medical protocols or other processes.
    - An assessment of the impact the implementation of a community paramedicine program has on the delivery of emergency medical services and response times in the local EMS agency's jurisdiction.

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

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

This bill would specify the process for local EMS agencies to solicit public agencies to provide the proposed community paramedicine program specialties and the process for local EMS agencies to follow after a community paramedicine program is selected.

This bill would only allow community paramedicine programs approved by EMSA to hold themselves out to, and to provide community paramedic services.

According to the author, the HWPP pilot programs have had many positive results on the communities they served. Absent legislative authorization, the current programs will sunset in November of 2018.

Board staff, working with a Board Member who is a physician, provided input to OSHPD on HWPP #173 and raised patient safety concerns. One of these concerns being that persons recently discharged from the hospital should be seen by their primary care physician for follow up care. The additional training that would be required would not be sufficient enough to teach paramedics the basics of disease management or how to diagnose and treat medical conditions. The other concern raised was that the pilot project did not specifically delineate what services will be allowed to be performed by community paramedics. The same is true for this bill; however, this bill does require the regulations for community paramedicine programs to be based upon, and informed by, the formation and implementation of the Community Paramedicine Pilot Program under HWPP #173. Board staff recommends that the Board take an oppose position on this bill.

FISCAL: None

SUPPORT: California Professional Firefighters (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Oppose

AMENDED IN SENATE MARCH 21, 2018

SENATE BILL No. 944

Introduced by Senator Hertzberg

January 29, 2018

An act *to amend Section 1797.272 of, and to add Chapter 13 (commencing with Section 1800) to Division 2.5 of, the Health and Safety Code,* relating to community paramedicine.

LEGISLATIVE COUNSEL'S DIGEST

SB 944, as amended, Hertzberg. ~~Community paramedicine programs: guidelines.~~ *Community Paramedicine Act of 2018.*

(1) Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The act establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of emergency medical services. Among other duties, the authority is required to develop planning and implementation guidelines for emergency medical services systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of emergency medical services systems, and receive plans for the implementation of emergency medical services and trauma care systems from local EMS agencies. A violation of the act or regulations adopted pursuant to the act is punishable as a misdemeanor.

This bill would create the Community Paramedicine Act of 2018. The bill would authorize a local EMS agency to develop a community paramedicine program, as defined, to provide specified community paramedic services. The bill would require the authority to review a local EMS agency's proposed community paramedicine program and

approve, approve with conditions, or deny the proposed program within 6 months after it is submitted by the local EMS agency. The bill would require a local EMS agency that opts to develop a community paramedicine program to, among other things, integrate the proposed program into the local EMS agency's emergency medical services plan, enter into an agreement with a community paramedicine provider for the delivery of community paramedic services within the local EMS agency's jurisdiction that is consistent with the proposed program, establish a process for training and certifying community paramedics, and facilitate and participate in any discussion between a community paramedicine provider and public or private health system participants to provide funding to support implementation of the proposed program.

The bill would create the Community Paramedicine Oversight Committee to advise the authority on, and approve minimum medical protocols for, community paramedicine program specialties. The bill would require the authority to develop, in consultation with the committee, regulations that establish minimum standards for the development of a community paramedicine program. The bill would require the authority to submit an annual report on the community paramedicine programs operating in California to the relevant policy committees of the Legislature beginning 6 months after the authority adopts the regulations and every January 1 thereafter for the next 5 years.

The bill would prohibit a person or organization from providing community paramedic services or representing, advertising, or otherwise implying that it is authorized to provide community paramedic services unless it is expressly authorized by a local EMS agency to provide those services as part of a community paramedicine program approved by the authority. The bill would also prohibit a community paramedic from providing community paramedic services if he or she has not been certified to perform those services and is working as an employee of an authorized community paramedicine provider. Because a violation of the act described above is punishable as a misdemeanor, and this bill would create new requirements within the act, the violation of which would be a crime, the bill would impose a state-mandated local program.

(2) Existing law authorizes a county to establish an emergency medical care committee and requires the committee, at least annually, to review the operations of ambulance services operating within the county, emergency medical care offered within the county, and first aid

practices in the county. Existing law requires the county board of supervisors to prescribe the membership, and appoint the members, of the committee.

This bill would require the committee to include additional members, as specified, and to advise a local EMS agency within the county on the development of its community paramedicine program if the local EMS agency develops a community paramedicine program.

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

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

~~Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The act establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of emergency medical services. Among other duties, the authority is required to develop planning and implementation guidelines for emergency medical services systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of emergency medical services systems, and receive plans for the implementation of emergency medical services and trauma care systems from local EMS agencies.~~

~~This bill would declare the intent of the Legislature to enact legislation that establishes statewide guidelines for, and authorizes the implementation of, community paramedicine programs in California, as specified.~~

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

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

SECTION 1. Section 1797.272 of the Health and Safety Code is amended to read:

1797.272. *(a)* The county board of supervisors shall prescribe the membership, and appoint the members, of the emergency medical care committee. If two or more adjacent counties establish a single committee, the county boards of supervisors shall jointly

prescribe the membership, and appoint the members of the committee.

(b) If a local EMS agency within the county develops a community paramedicine program pursuant to Section 1840, the emergency medical care committee shall also include the following members and shall advise the local EMS agency on the development of the community paramedicine program:

(1) Two emergency room physicians practicing at an emergency department within the local EMS agency's jurisdiction.

(2) Two registered nurses practicing within the local EMS agency's jurisdiction.

(3) Two emergency medical technician-paramedics practicing in the local EMS agency's jurisdiction. At least one of the emergency medical technician-paramedics shall be employed by a public agency.

(4) The medical director for the local EMS agency.

(5) One acute care hospital representative with an emergency department operating within the local EMS agency jurisdiction.

SEC. 2. Chapter 13 (commencing with Section 1800) is added to Division 2.5 of the Health and Safety Code, to read:

CHAPTER 13. COMMUNITY PARAMEDICINE

Article 1. General Provisions

1800. This chapter shall be known, and may be cited, as the Community Paramedicine Act of 2018.

1801. (a) It is the intent of the Legislature to establish state guidelines that govern the implementation of community paramedicine programs by local EMS agencies in California.

(b) It is the intent of the Legislature that a community paramedicine program developed by a local EMS agency be submitted to the Emergency Medical Services Authority for review and approval.

(c) It is the intent of the Legislature to improve the health of individuals in their communities by authorizing emergency medical technician paramedics, working under expert medical oversight, to deliver community paramedicine in California utilizing existing providers, promoting continuity of care, and maximizing existing

efficiencies within the first response and emergency medical services system.

(d) It is the intent of the Legislature that a community paramedicine program developed by a local EMS agency and authorized by the Emergency Medical Services Authority will do all of the following:

(1) Improve coordination among providers of medical services, behavioral health services, and social services.

(2) Reduce preventable ambulance transports, emergency department visits, and hospital readmissions.

(3) Preserve, protect, and deliver the highest level of patient care to every Californian.

(e) It is the intent of the Legislature that an alternate destination facility participating as part of an approved community paramedicine program will always be staffed by a higher medical authority, such as, at minimum, a registered nurse, if ensuring transfer of a patient from a community paramedic to the higher medical authority is in the best interests of the patient.

(f) It is the intent of the Legislature that the delivery of community paramedic services is a public good to be delivered in a manner that promotes continuity of care and continuity of providers and is consistent with, coordinated with, and complementary to, the existing first response and emergency medical response system in place in a local EMS agency's jurisdiction.

(g) It is the intent of the Legislature that a community paramedicine program be designed to improve community health and be implemented in a fashion that is respectful of the current emergency medical system and its providers. Whenever possible, and in furtherance of the public interest and public good, public agencies that provide first response services should deliver care under a community paramedicine program. In most circumstances, public agency providers are first on scene in a medical emergency.

(h) It is the intent of the Legislature that the development of any community paramedicine program reflects input from all practitioners of appropriate medical authorities, including, but not limited to, medical directors, physicians, nurses, mental health professionals, first responder paramedics, hospitals, and other entities within the emergency medical response system.

(i) It is the intent of the Legislature that local EMS agencies be authorized to develop a community paramedicine program to improve patient care and community health. A community paramedicine program should not be used solely to reduce personnel costs, harm working conditions of emergency medical and health care workers, or otherwise compromise the emergency medical response or health care system in a way that is focused primarily on containing costs. The highest priority of any community paramedicine program should be improving patient care and providing further efficiencies in the emergency medical system.

Article 2. Definitions

1810. Unless otherwise indicated in this chapter, the definitions contained in this article shall govern the provisions of this chapter.

1811. "Alternate destination facility" means a treatment location that is an authorized mental health facility or an authorized sobering center, but not a general acute care hospital, as defined in subdivision (a) of Section 1250.

1812. "Authorized mental health facility" means a facility that is a licensed psychiatric hospital, a licensed psychiatric health facility, or a certified crisis stabilization unit, and has at least one registered nurse staffed onsite at the facility at all times.

1813. "Authorized sobering center" means a facility that is a federally qualified health center or a federally qualified county clinic and has at least one registered nurse staffed onsite at the facility at all times.

1814. "Community paramedic" means a paramedic licensed under this division who has completed the core curriculum for community paramedic training described in paragraph (1) of subdivision (d) of Section 1831, has received certification in one or more of the community paramedicine program specialties described in subdivisions (a) to (e), inclusive, of Section 1815, and is accredited to provide community paramedic services by a local EMS agency as part of an approved community paramedicine program.

1815. "Community paramedicine program" means a program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide community paramedic

services consisting of one or more of the program specialties described in subdivisions (a) to (e), inclusive, under the direction of medical protocols developed by the local EMS agency that are consistent with the minimum medical protocols established by the authority. Community paramedic services may consist of the following program specialties:

(a) Providing short-term postdischarge followup for persons recently discharged from a hospital due to a serious health condition.

(b) Providing directly observed therapy to persons with tuberculosis.

(c) Providing case management services to frequent emergency medical services users.

(d) Providing hospice services to treat patients in their homes.

(e) Providing patients with transport to an alternate destination facility.

1816. "Community paramedicine provider" means an advanced life support provider who has entered into a contract to deliver community paramedic services as part of an approved community paramedicine program developed by a local EMS agency.

1817. "Public agency" means a city, county, city and county, special district, or other political subdivision of the state that provides first response services, including emergency medical care.

Article 3. State Administration

1830. (a) The Community Paramedicine Oversight Committee is hereby created within the Emergency Medical Services Authority to advise the authority on, and approve minimum medical protocols for, the community paramedicine program specialties described in Section 1815.

(b) The committee shall consist of the following 11 members appointed by the Governor:

(1) Two full-time physicians and surgeons, whose primary practice is emergency medicine, from a list of five names submitted by the California Chapter of the American College of Emergency Physicians.

(2) Two registered nurses from a list of five names provided by the California Labor Federation.

(3) Two emergency medical technician paramedics from a list of five names provided by the California Professional Firefighters and the California Labor Federation.

(4) Two medical directors of local EMS agencies from a list of five names submitted by the EMS Medical Directors Association of California.

(5) One local EMS agency administrator from a list of three names submitted by the Emergency Medical Services Administrators Association of California.

(6) One inpatient hospitalist from a list of three names submitted by the California Hospital Association.

(7) One mental health professional from a list of three names provided by the California Psychiatric Association.

1831. (a) The Emergency Medical Services Authority shall develop, in consultation with the Community Paramedic Oversight Committee, regulations that establish minimum standards for the development of a community paramedicine program.

(b) The Commission on Emergency Medical Services shall review and approve the regulations described in this section before the authority adopts the regulations.

(c) The regulations described in this section shall be based upon, and informed by, the formation and implementation of the Community Paramedicine Pilot Program under Health Workforce Pilot Project No. 173.

(d) The regulations that establish minimum standards for the development of a community paramedicine program shall consist of all of the following:

(1) Minimum standards and core curriculum for community paramedic training.

(2) Minimum standards for the scope of practice for each community paramedicine program specialty described in Section 1815.

(3) A process for certifying a community paramedic who completes the core curriculum training described in paragraph (1).

(4) Minimum standards for approval, review, withdrawal, and revocation of a community paramedicine program.

(5) Minimum standards for collecting and submitting data to the authority to ensure patient safety that include consideration of both quality assurance and quality improvement. These standards shall include all of the following:

(A) Intervals for community paramedicine providers, participating health facilities, and local EMS agencies to submit community paramedicine data.

(B) Relevant program use data.

(C) Public posting of program analysis.

(D) Emergency medical response system feedback, including feedback from the emergency medical care committee described in subdivision (b) of Section 1797.272.

(E) If the community paramedicine program utilizes an alternate destination facility, consideration of ambulance patient offload times for both the alternate destination facility and existing emergency departments, the number of patients that are turned away, diverted, or required to be subsequently transferred to an emergency department, and identification of the reasons for turning away, diverting, or transferring the patient.

(F) An assessment of each community paramedicine program's medical protocols or other processes.

(G) An assessment of the impact that implementation of a community paramedicine program has on the delivery of emergency medical services and response times in the local EMS agency's jurisdiction.

1832. (a) The Emergency Medical Services Authority shall develop and, after approval by the Community Paramedicine Oversight Committee, establish minimum medical protocols for each community paramedicine program specialty described in Section 1815.

(b) The protocols described in this section shall be based upon, and informed by, the formation and implementation of the Community Paramedicine Pilot Program under Health Workforce Pilot Project No. 173, and further refinements provided by local EMS agencies during the course and operation of the pilot program.

1833. (a) The Emergency Medical Services Authority shall submit an annual report on the community paramedicine programs operating in California to the relevant policy committees of the Legislature. The authority shall submit its first report six months

after the authority adopts the regulations described in Section 1831, and every January 1 thereafter for the next five years.

(b) The report may include recommendations for authorizing additional community paramedicine program specialties not authorized under this chapter, as it read on January 1, 2019, or recommendations for changes to, or the elimination of, community paramedicine program specialties that do not achieve the community health and patient goals expressed in Section 1801.

(c) (1) A report to be submitted pursuant to subdivision (a) shall be submitted in compliance with Section 9795 of the Government Code.

(2) This section shall be repealed six years after the authority adopts the regulations described in Section 1831.

1834. (a) The Emergency Medical Services Authority shall review a local EMS agency's proposed community paramedicine program to ensure it is consistent with the authority's regulations and the provisions of this chapter.

(b) The authority may impose conditions as part of the approval of a community paramedicine program that the local EMS agency is required to incorporate into its program to achieve consistency with the authority's regulations and the provisions of this chapter.

(c) The authority shall approve, approve with conditions, or deny the proposed community paramedicine program within six months after it is submitted by the local EMS agency.

1835. A community paramedicine pilot program approved under Health Workforce Pilot Project No. 173 before January 1, 2019, is authorized to continue operations until six months after the regulations described in Section 1831 become effective.

Article 4. Local Administration

1840. A local EMS agency may develop a community paramedicine program that is consistent with the Emergency Medical Services Authority's regulations and the provisions of this chapter and submit it to the authority for approval pursuant to Section 1834.

1841. A local EMS agency that opts to develop a community paramedicine program shall do all of the following:

(a) Integrate the proposed community paramedicine program into the local EMS agency's emergency medical services plan

described in Article 2 (commencing with Section 1797.250) of Chapter 4.

(b) Consistent with this article, develop a process to select community paramedicine providers at a periodic interval of no more than 10 years.

(c) (1) Enter into an agreement with a community paramedicine provider for the delivery of community paramedic services within the local EMS agency's jurisdiction that are consistent with the proposed community paramedicine program.

(2) A local EMS agency shall not include a community paramedic services agreement within an existing or proposed contract for the delivery of emergency medical services within an exclusive operating area described in a contract awarded pursuant to Section 1797.224 or the provision of, or administration of, emergency medical services authorized pursuant to Section 1797.201.

(d) If the community paramedicine program provides the program specialties described in subdivisions (a) to (d), inclusive, of Section 1815, the local EMS agency shall enter into an agreement for the provision of those specialties according to the following:

(1) A local EMS agency shall solicit every public agency that is located within its jurisdiction to provide the proposed community program specialties. If a public agency agrees to provide all of those specialties, the local EMS agency shall enter into a written agreement with the public agency to provide those specialties.

(2) If a public agency agrees to provide only some of the proposed community program specialties, the local EMS agency may establish a competitive bid process to select a community paramedicine provider to deliver the specialties not provided by the public agency.

(3) If no public agency chooses to provide the proposed community program specialties, the local EMS agency shall establish a competitive bid process to select a community paramedicine provider to deliver the specialties.

(e) If the community paramedicine program provides the program specialty described in subdivision (e) of Section 1815, the local EMS agency shall do all of the following:

(1) Enter into an agreement that continues the use of existing providers operating within the local EMS agency's jurisdiction in

the manner and scope in which that service has been provided by the existing provider pursuant to Section 1797.201 or Section 1797.224.

(2) Certify that the alternate destination facility authorized to receive patients has adequate licensed medical staff, facilities, and equipment that comply with the requirements of the Emergency Medical Services Authority's regulations and the provisions of this chapter.

(3) Collaborate with the emergency medical care committee to develop medical protocols that describe when the use of an alternate destination facility is in the best interests of the patient and, upon approval of the medical director of the local EMS agency, submit the protocols to the Emergency Medical Services Authority. The medical protocols shall be consistent with the requirements of the authority's regulations and the provisions of this chapter, and may include provisions describing the following:

(A) Qualified staff to care for the degree and severity of a patient's injuries and needs.

(B) The equipment and services available at an alternate destination facility necessary to care for patients requiring medical services.

(C) The time of day and any limitations that may apply for an alternate destination facility to treat patients requiring medical services.

(4) Secure an agreement with the alternate destination facility that requires the facility to notify the local EMS agency and the Emergency Medical Services Authority within 24 hours if there are changes in the status of the facility with respect to the protocols and the facility's ability to care for patients.

(5) Secure an agreement with the alternate destination facility attesting that the facility will operate in accordance with Section 1317 and providing that failure to comply with Section 1317 will result in the immediate termination of use of the facility as part of the community paramedicine program.

(f) Establish a process for training and certification of community paramedics in the proposed community paramedicine program's specialties.

(g) Facilitate and participate in any agreements between a community paramedicine provider and public or private health system participants to provide funding to support the

implementation of the local EMS agency's community paramedicine program.

Article 5. Miscellaneous

1850. A person or organization shall not provide community paramedic services or represent, advertise, or otherwise imply that it is authorized to provide community paramedic services unless it is expressly authorized by a local EMS agency to provide those services as part of a community paramedicine program approved by the Emergency Medical Services Authority.

1851. A community paramedic shall provide community paramedic services only if he or she has been certified to perform those services by a local EMS agency and is working as an employee of an authorized community paramedicine provider.

1852. The disciplinary procedures for a community paramedic shall be consistent with subdivision (d) of Section 1797.194.

1853. Entering into an agreement to be a community paramedicine provider pursuant to this chapter shall not alter or otherwise invalidate a public agency's authority to provide or administer emergency medical services pursuant to Section 1797.201 or 1797.224.

1854. The liability provisions described in Chapter 9 (commencing with Section 1799.100) shall also apply to this chapter.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. It is the intent of the Legislature to enact legislation that establishes statewide guidelines for, and authorizes the implementation of, community paramedicine programs in California that utilize existing providers, promote continuity of~~

~~care, and maximize existing efficiencies within the first response and emergency medical services system.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1109
Author: Bates
Bill Date: April 4, 2018, Amended
Subject: Controlled Substances: Schedule II Drugs: Opioids
Sponsor: San Diego District Attorney Summer Stephan

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require existing pain management continuing education courses to include the risks of addiction and overdose. This bill would also require a warning label on all Schedule II controlled substance prescription bottles on the associated addiction and overdose risks. This bill would require a minor's and a parent or guardian's signature on a specified form after a required consultation and discussion with a prescriber for any minor receiving an initial opioid prescription. Lastly, this bill would require an information sheet on the risks of opioids to be signed by a minor athlete and his or her parent or guardian before participation in an organized sports team.

BACKGROUND

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

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

Existing CME courses approved by the Medical Board of California's (Board) Licensing Program include:

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

ANALYSIS

This bill would make findings and declarations regarding opioid misuse and abuse and overdose. This would also state the intent of the Legislature to codify the Medical Board of California's (Board) Guidelines for Prescribing Controlled Substances for Pain, as it relates to patient counseling, consent, and pain management agreements.

This bill would require existing mandated pain management continuing education courses to include the risks of addiction and overdose for physicians licensed on or after January 1, 2019. This bill would require the information and educational material regarding pain management techniques and procedures disseminated by the Board to include the risks of addiction associated with the use of Schedule II drugs. This bill would also make the same continuing education changes for other prescribers.

This bill would require a prescriber, with exceptions for treatment of addicts or those with chronic pain, to do all of the following before directly dispensing or issuing for a minor the first prescription in a single course of treatment for a controlled substance containing an opioid:

- Discuss all of the following with the minor, with the minor's parent or guardian, or with another adult authorized to consent to the minor's medical treatment:
    - The risks of addiction and overdose associated with the use of opioids.
    - The increased risk of addiction to an opioid to an individual who is suffering from both mental and substance abuse disorders.
    - The danger of taking an opioid with a benzodiazepine, alcohol, or another central nervous system depressant.
    - Any other information required by law.
- Obtain the signature of the minor, and the minor's parent or guardian or other adult authorized to consent to the minor's medical treatment on the required consent form. The prescriber shall include the signed consent form in the minor's medical record.

This bill would specify that the informed consent discussion requirements would not apply in any of the following circumstances:

- If the minor's treatment is associated with or incident to a medical emergency.

- If the minor's treatment is associated with or incident to an emergency surgery, regardless of whether the surgery is performed on an inpatient or outpatient basis.
- If, in the prescriber's professional judgment, fulfilling the requirements would be detrimental to the minor's health or safety.

This bill would require the signed informed consent to be obtained in a form that is separate from any other document that a prescriber uses to obtain informed consent for the treatment of a minor and shall contain all of the following:

- The name and quantity of the controlled substance being prescribed for the minor and the amount of the initial dose.
- A statement indicating that a controlled substance is a drug or other substance that has been identified as having a potential for abuse.
- A statement certifying that the prescriber discussed the required topics with the minor, and with the minor's parent or guardian or with another adult authorized to consent to the minor's medical treatment.
- A space for the signature of the minor's parent or guardian or other adult authorized to consent to the minor's medical treatment, and a space to indicate the date that the minor's parent or guardian or other adult authorized to consent to the minor's medical treatment signed the form.

This bill would specify that failure to comply with the informed consent and written consent requirements would not constitute a criminal offense, but may subject the prescriber to disciplinary action for unprofessional conduct under the prescriber's respective licensing act.

Lastly, this bill would require an information sheet on the risks of opioids to be signed by a minor athlete and his or her parent or guardian before participation in an organized sports team.

According to the author's office, this bill is needed to continue educating everyone who comes in contact with opioid prescriptions. Ensuring that patients, minors, parents, and prescribers have the necessary information will help prevent future addiction and overdoses.

This bill will increase education for physicians and patients, which will further the Board's mission of consumer protection. Board staff is suggesting the Board take a neutral position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN SENATE APRIL 4, 2018

SENATE BILL No. 1109

Introduced by Senator Bates
(Coauthors: Senators Nguyen and Stone)
(Coauthors: Assembly Members Brough, Choi, and Mathis)

February 13, 2018

An act to amend Sections 2190.5, 2191, 2196.2, 2746.51, 2836.1, and 3502.1 of, and to add Section 4079 to, the Business and Professions Code, to add Section 49476 to the Education Code, and to add Sections 11158.1 and 124236 to the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 1109, as amended, Bates. Controlled substances: Schedule II drugs: opioids.

(1) The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under that act, the board is required to adopt and administer standards for the continuing education of physicians and surgeons. Existing law requires a physician and surgeon to complete a mandatory continuing education course in the subjects of pain management and the treatment of terminally ill and dying patients. That act requires the board to give its highest priority to considering a course in pain management among its continuing education requirements for licensees, and requires the board to periodically develop and disseminate information and educational material on pain management techniques and procedures to licensees and general acute care hospitals.

This bill would require, for physicians and surgeons licensed on or after January 1, 2019, the mandatory continuing education course to

also include the subject of the risks of addiction associated with the use of Schedule II drugs. The bill would require the board to give its highest priority to considering a course in the risks of addiction associated with the use of Schedule II drugs among its continuing education requirements for physicians and surgeons and would require the board to periodically develop and disseminate information and educational material on the risks of addiction associated with the use of Schedule II drugs to physicians and surgeons and general acute care hospitals.

(2) The Nursing Practice Act provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing and makes a violation of its provisions a crime. Existing law authorizes a certified nurse-midwife to furnish or order drugs or devices under specified circumstances, including board certification that the certified nurse-midwife has completed a course in pharmacology, as specified.

This bill would require the pharmacology course to include the risks of addiction and neonatal abstinence syndrome associated with the use of opioids.

Existing law also authorizes a nurse practitioner to furnish or order drugs or devices under specified circumstances, including board certification that the nurse practitioner has completed a course in pharmacology, as specified. Existing law requires nurse practitioners who are authorized to furnish Schedule II controlled substances to complete a mandatory continuing education course in Schedule II controlled substances.

This bill would require the mandatory continuing education course to include the risks of addiction associated with their use.

By expanding the scope of a crime under the Nursing Practice Act, the bill would impose a state-mandated local program.

(3) The Physician Assistant Practice Act provides for licensure and regulation of physician assistants by the Physician Assistant Board and authorizes a physician assistant to perform medical services as set forth by regulations when those services are rendered under the supervision of a licensed physician and surgeon, as specified. The act prohibits a physician assistant from administering, providing, or issuing a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that meets specific standards.

This bill would require that course to include the risks of addiction associated with the use of Schedule II controlled substances.

(4) The Pharmacy Law provides for the licensure and regulation of pharmacists, pharmacy technicians, and pharmacies by the California State Board of Pharmacy. Existing law requires the board to promulgate regulations that require a standardized, patient-centered, prescription drug label on all prescription medicine dispensed to patients in California. The act makes a violation of its provisions a crime.

This bill would require the board to adopt an emergency regulation requiring a warning label on all Schedule II controlled substance vials or prescription bottles that addresses the risk of addiction and overdose when using opioids. To the extent that this provision would expand the scope of a crime under the Pharmacy Law, the bill would impose a state-mandated local program.

(5) The California Uniform Controlled Substances Act classifies opioids as Schedule II controlled substances and places restrictions on the prescription of those drugs, including prohibiting refills and specifying the requirements of a prescription for these drugs. The act makes a violation of its provisions a crime.

This bill would require a prescriber to discuss specified information with and obtain the consent of the minor, the minor's parent or guardian, or other adult authorized to consent to the minor's medical treatment before directly dispensing or issuing for a minor the first prescription in a single course of treatment for a controlled substance containing an opioid. ~~Because a violation of those requirements would be a crime, the bill would expand an existing crime and impose a state-mandated local program.~~ *This bill would provide that a violation of these requirements is not a criminal offense, but would subject the prescriber to disciplinary action for unprofessional conduct under the prescriber's respective licensing act.*

(6) Existing law requires a school district, charter school, or private school that elects to offer an athletic program to take specified actions if an athlete is suspected to have sustained a concussion and to obtain a signed concussion and head injury information sheet from the athlete and athlete's parent or guardian before the athlete initiates practice or competition.

This bill would require a school district, charter school, or private school that elects to offer an athletic program to annually give an information sheet about the risks of opioid addiction to each athlete, and would require that sheet to be signed, as specified.

(7) Existing law requires a youth sports organization, as defined, that elects to offer an athletic program to, among other things, annually give

a concussion and head injury information sheet to each athlete and requires that the sheet be signed, as specified.

This bill would also require a youth sports organization that elects to offer an athletic program to annually give an information sheet about the risk of opioid addiction to each athlete, and would require that sheet to be signed, as specified.

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

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

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

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

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

(a) Addiction, misuse, and overdose of prescription opioids is a public health crisis affecting both adults and children.

(b) Urgent measures are needed to better inform the public of the risks associated with both the long-term and short-term use of opioids in an effort to address this problem.

(c) Both short-term and long-term prescriptions of opioids to minors fall within situations that require counseling and written consent under the Guidelines for Prescribing Controlled Substances for Pain issued by the Medical Board of California.

(d) It is the intent of the Legislature to codify the Medical Board of California's Guidelines for Prescribing Controlled Substances for Pain, as it relates to patient counseling, consent, and pain management agreements, and to ensure that health care providers and young athletes receive necessary education on this topic.

SEC. 2. Section 2190.5 of the Business and Professions Code is amended to read:

2190.5. (a) (1) All physicians and surgeons shall complete a mandatory continuing education course in the subjects of pain management and the treatment of terminally ill and dying patients. For the purposes of this section, this course shall be a one-time requirement of 12 credit hours within the required minimum established by regulation, to be completed by December 31, 2006.

All physicians and surgeons licensed on and after January 1, 2002, shall complete this requirement within four years of their initial license or by their second renewal date, whichever occurs first. The board may verify completion of this requirement on the renewal application form.

(2) For physicians and surgeons licensed on or after January 1, 2019, the course described in paragraph (1) shall also include the subject of the risks of addiction associated with the use of Schedule II drugs.

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

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

SEC. 3. Section 2191 of the Business and Professions Code is amended to read:

2191. (a) In determining its continuing education requirements, the board shall consider including a course in human sexuality, defined as the study of a human being as a sexual being and how he or she functions with respect thereto, and nutrition to be taken by those licensees whose practices may require knowledge in those areas.

(b) The board shall consider including a course in child abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected children.

(c) The board shall consider including a course in acupuncture to be taken by those licensees whose practices may require knowledge in the area of acupuncture and whose education has not included instruction in acupuncture.

(d) The board shall encourage every physician and surgeon to take nutrition as part of his or her continuing education, particularly a physician and surgeon involved in primary care.

(e) The board shall consider including a course in elder abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected persons 65 years of age and older.

(f) In determining its continuing education requirements, the board shall consider including a course in the early detection and treatment of substance abusing pregnant women to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these women.

(g) In determining its continuing education requirements, the board shall consider including a course in the special care needs of drug addicted infants to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these infants.

(h) In determining its continuing education requirements, the board shall consider including a course providing training and guidelines on how to routinely screen for signs exhibited by abused women, particularly for physicians and surgeons in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. In the event the board establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

(i) In determining its continuing education requirements, the board shall consider including a course in the special care needs of individuals and their families facing end-of-life issues, including, but not limited to, all of the following:

(1) Pain and symptom management.

(2) The psycho-social dynamics of death.

(3) Dying and bereavement.

(4) Hospice care.

(j) In determining its continuing education requirements, the board shall give its highest priority to considering a course on pain management and the risks of addiction associated with the use of Schedule II drugs.

(k) In determining its continuing education requirements, the board shall consider including a course in geriatric care for emergency room physicians and surgeons.

SEC. 4. Section 2196.2 of the Business and Professions Code is amended to read:

2196.2. The board shall periodically develop and disseminate information and educational material regarding pain management techniques and procedures, including the risks of addiction

associated with the use of Schedule II drugs, to each licensed physician and surgeon and to each general acute care hospital in this state. The board shall consult with the State Department of Public Health in developing the materials to be distributed pursuant to this section.

SEC. 5. Section 2746.51 of the Business and Professions Code is amended to read:

2746.51. (a) Neither this chapter nor any other provision of law shall be construed to prohibit a certified nurse-midwife from furnishing or ordering drugs or devices, including controlled substances classified in Schedule II, III, IV, or V under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code), when all of the following apply:

(1) The drugs or devices are furnished or ordered incidentally to the provision of any of the following:

(A) Family planning services, as defined in Section 14503 of the Welfare and Institutions Code.

(B) Routine health care or perinatal care, as defined in subdivision (d) of Section 123485 of the Health and Safety Code.

(C) Care rendered, consistent with the certified nurse-midwife's educational preparation or for which clinical competency has been established and maintained, to persons within a facility specified in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the Health and Safety Code, a clinic as specified in Section 1204 of the Health and Safety Code, a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code, a licensed birth center as defined in Section 1204.3 of the Health and Safety Code, or a special hospital specified as a maternity hospital in subdivision (f) of Section 1250 of the Health and Safety Code.

(2) The drugs or devices are furnished or ordered by a certified nurse-midwife in accordance with standardized procedures or protocols. For purposes of this section, standardized procedure means a document, including protocols, developed and approved by the supervising physician and surgeon, the certified nurse-midwife, and the facility administrator or his or her designee. The standardized procedure covering the furnishing or ordering of drugs or devices shall specify all of the following:

(A) Which certified nurse-midwife may furnish or order drugs or devices.

(B) Which drugs or devices may be furnished or ordered and under what circumstances.

(C) The extent of physician and surgeon supervision.

(D) The method of periodic review of the certified nurse-midwife's competence, including peer review, and review of the provisions of the standardized procedure.

(3) If Schedule II or III controlled substances, as defined in Sections 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician and surgeon. For Schedule II controlled substance protocols, the provision for furnishing the Schedule II controlled substance shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(4) The furnishing or ordering of drugs or devices by a certified nurse-midwife occurs under physician and surgeon supervision. For purposes of this section, no physician and surgeon shall supervise more than four certified nurse-midwives at one time. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:

(A) Collaboration on the development of the standardized procedure or protocol.

(B) Approval of the standardized procedure or protocol.

(C) Availability by telephonic contact at the time of patient examination by the certified nurse-midwife.

(b) (1) The furnishing or ordering of drugs or devices by a certified nurse-midwife is conditional on the issuance by the board of a number to the applicant who has successfully completed the requirements of paragraph (2). The number shall be included on all transmittals of orders for drugs or devices by the certified nurse-midwife. The board shall maintain a list of the certified nurse-midwives that it has certified pursuant to this paragraph and the number it has issued to each one. The board shall make the list available to the California State Board of Pharmacy upon its request. Every certified nurse-midwife who is authorized pursuant

to this section to furnish or issue a drug order for a controlled substance shall register with the United States Drug Enforcement Administration.

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section, including the risks of addiction and neonatal abstinence syndrome associated with the use of opioids. The board shall establish the requirements for satisfactory completion of this paragraph.

(3) A physician and surgeon may determine the extent of supervision necessary pursuant to this section in the furnishing or ordering of drugs and devices.

(4) A copy of the standardized procedure or protocol relating to the furnishing or ordering of controlled substances by a certified nurse-midwife shall be provided upon request to any licensed pharmacist who is uncertain of the authority of the certified nurse-midwife to perform these functions.

(5) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) under the following conditions:

(1) The drugs and devices are furnished or ordered in accordance with requirements referenced in paragraphs (2) to (4), inclusive, of subdivision (a) and in paragraphs (1) to (3), inclusive, of subdivision (b).

(2) When Schedule II controlled substances, as defined in Section 11055 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific

protocol approved by the treating or supervising physician and surgeon.

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure or protocol. Use of the term "furnishing" in this section shall include the following:

(1) The ordering of a drug or device in accordance with the standardized procedure or protocol.

(2) Transmitting an order of a supervising physician and surgeon.

(e) "Drug order" or "order" for purposes of this section means an order for medication or for a drug or device that is dispensed to or for an ultimate user, issued by a certified nurse-midwife as an individual practitioner, within the meaning of Section 1306.03 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by certified nurse-midwives; and (3) the signature of a certified nurse-midwife on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 6. Section 2836.1 of the Business and Professions Code is amended to read:

2836.1. Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:

(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and

approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.

(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

(e) For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.

(f) (1) Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.

(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed

pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.

(g) (1) The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section.

(2) A physician and surgeon may determine the extent of supervision necessary pursuant to this section in the furnishing or ordering of drugs and devices.

(3) Nurse practitioners who are certified by the board and hold an active furnishing number, who are authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances, and the risks of addiction associated with their use, based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

(h) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

(i) "Drug order" or "order" for purposes of this section means an order for medication which is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (3) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 7. Section 3502.1 of the Business and Professions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(2) If the physician assistant has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course (A) meets the standards, including pharmacological content, established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of Regulations, and (B) is provided either by an accredited continuing education provider or by an approved physician assistant training program, the supervising physician and surgeon shall review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the

patients cared for by the physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established in Section 1399.612 of Title 16 of the California Code of Regulations. Physician assistants who have a certificate of completion of the course described in paragraph (2) of subdivision (c) shall be deemed to have met the education course requirement of this subdivision.

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

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

SEC. 8. Section 4079 is added to the Business and Professions Code, to read:

4079. The board shall adopt an emergency regulation that requires a warning label on all Schedule II controlled substance vials or prescription bottles that addresses the risks of addiction and overdose when using opioids.

SEC. 9. Section 49476 is added to the Education Code, to read:

49476. (a) If a school district, charter school, or private school elects to offer an athletic program, the school district, charter school, or private school shall annually give an information sheet about the risk of opioid addiction to each athlete. The information sheet shall be signed and returned by the athlete before the athlete initiates practice or competition. If the athlete is 17 years of age or younger, the information sheet shall also be signed by the athlete's parent or guardian before the athlete initiates practice or competition. The information sheet may be sent and returned through an electronic medium, including, but not limited to, fax or email.

(b) This section does not apply to an athlete engaging in an athletic activity during the regular schoolday or as part of a physical

education course required pursuant to subdivision (d) of Section 51220.

SEC. 10. Section 11158.1 is added to the Health and Safety Code, to read:

11158.1. (a) Except when a patient is being treated as set forth in Sections 11159, 11159.2, and 11167.5, and Article 2 (commencing with Section 11215) of Chapter 5, pertaining to the treatment of addicts, or for a diagnosis of chronic intractable pain as used in Section 124960 of this code and Section 2241.5 of the Business and Professions Code, a prescriber shall do all of the following before directly dispensing or issuing for a minor the first prescription in a single course of treatment for a controlled substance containing an opioid:

(1) Discuss all of the following with the minor, with the minor's parent or guardian, or with another adult authorized to consent to the minor's medical treatment:

(A) The risks of addiction and overdose associated with the use of opioids.

(B) The increased risk of addiction to an opioid to an individual who is suffering from both mental and substance abuse disorders.

(C) The danger of taking an opioid with a benzodiazepine, alcohol, or another central nervous system depressant.

(D) Any other information required by law.

(2) Obtain the signature of the minor, and the minor's parent or guardian or other adult authorized to consent to the minor's medical treatment. The prescriber shall include the signed consent form in the minor's medical record.

(b) Paragraph (1) of subdivision (a) does not apply in any of the following circumstances:

(1) If the minor's treatment is associated with or incident to a medical emergency.

(2) If the minor's treatment is associated with or incident to an emergency surgery, regardless of whether the surgery is performed on an inpatient or outpatient basis.

(3) If, in the prescriber's professional judgment, fulfilling the requirements of paragraph (1) of subdivision (a) would be detrimental to the minor's health or safety.

(c) The consent described in paragraph (2) of subdivision (a) shall be obtained in a form that is separate from any other document

that a prescriber uses to obtain the informed consent for the treatment of a minor and shall contain all of the following:

(1) The name and quantity of the controlled substance being prescribed for the minor and the amount of the initial dose.

(2) A statement indicating that a controlled substance is a drug or other substance that has been identified as having a potential for abuse.

(3) A statement certifying that the prescriber discussed with the minor, and with the minor's parent or guardian or with another adult authorized to consent to the minor's medical treatment, the topics described in paragraph (1) of subdivision (a), unless the exemption in subdivision (b) applies.

(4) A space for the signature of the minor's parent or guardian or other adult authorized to consent to the minor's medical treatment, and a space to indicate the date that the minor's parent or guardian or other adult authorized to consent to the minor's medical treatment signed the form.

(d) Notwithstanding any other law, including Section 11374, failure to comply with this section shall not constitute a criminal offense, but may subject the prescriber to disciplinary action for unprofessional conduct under the prescriber's respective licensing act under Division 2 (commencing with Section 500) of the Business and Professions Code.

SEC. 11. Section 124236 is added to the Health and Safety Code, to read:

124236. (a) A youth sports organization, as defined in paragraph (3) of subdivision (b) of Section 124235, that elects to offer an athletic program shall annually give an information sheet about the risk of opioid addiction to each athlete. The information sheet shall be signed and returned by the athlete before the athlete initiates practice or competition. If the athlete is 17 years of age or younger, the information sheet shall also be signed by the athlete's parent or guardian before the athlete initiates practice or competition. The information sheet may be sent and returned through an electronic medium, including, but not limited to, fax or email.

(b) This section shall apply to all athletes participating in the activities of a youth sports organization, irrespective of their ages. This section shall not be construed to prohibit a youth sports organization, or any other appropriate entity, from adopting and

enforcing rules intended to provide a higher standard of safety for athletes than the standard established under this section.

SEC. 12. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1163
Author: Galgiani
Bill Date: April 16, 2018, Amended
Subject: Postmortem Examination or Autopsy: Attending Physician and Surgeon
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a postmortem examination or autopsy on an unidentified body or human remains be conducted by an attending physician and surgeon or the chief medical examiner. This bill would also require agencies tasked with specified exhumations to perform the exhumation under the direction of a board-certified forensic pathologist.

BACKGROUND

SB 1189 (Pan and Jackson, Chapter 787, Statutes of 2016) required that forensic autopsies be conducted by a licensed physician and surgeon and required that the results of a forensic autopsy only be determined by a licensed physician and surgeon. SB 1189 defined a forensic autopsy as an examination of a body of a decedent to generate medical evidence for which the cause and manner of death is determined.

ANALYSIS

This bill would expressly state that a postmortem examination or autopsy on an unidentified body or human remains must only be conducted by an attending physician and surgeon or the chief medical examiner who is a board-certified forensic pathologist certified by the American Board of Pathology.

This bill would define an attending physician and surgeon as a physician and surgeon licensed to practice medicine in this state performing a postmortem examination or autopsy pursuant to this section.

This bill would require any agency tasked with the exhumation of a body or skeletal remains of a deceased person that has suffered significant deterioration or decomposition, where the circumstances surrounding the death afford a reasonable basis to suspect that the death was caused by or related to the criminal act of another, to perform the exhumation under the direction of a board-certified forensic pathologist certified by the American Board of Pathology. This bill would allow the board-certified forensic pathologist to, at his or her discretion when necessary, retain the services of an anthropologist.

This bill would require for an unidentified body or human remains, appropriate samples of tissue and bone to be retained by the attending physician or chief medical examiner before the body or human remains are cremated or buried. The types of samples of tissue and bone that are taken must be determined by an attending physician and surgeon or chief medical examiner who is a board-certified forensic pathologist certified by the American Board of Pathology. This bill would require the samples obtained, the method of procurement or dissection of samples, and the handling, processing, and storage of samples to be within, and guided by, the generally accepted standards of practice of medicine and the generally accepted principles of medicine.

This bill contains other technical and clarifying changes.

According to the author's office, this bill would make clarifying changes to update existing law. This bill is in line with SB 1189 from 2016, which the Board supported. This bill will make it clear that postmortem examinations or autopsies on an unidentified body or human remains must be conducted by an attending physician and surgeon or the chief medical examiner, which is appropriate. Board staff suggests that the Board take a support position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE APRIL 16, 2018

AMENDED IN SENATE APRIL 3, 2018

SENATE BILL No. 1163

Introduced by Senator Galgiani

February 14, 2018

An act to amend Section 27521 of the Government Code, relating to autopsies.

LEGISLATIVE COUNSEL'S DIGEST

SB 1163, as amended, Galgiani. Postmortem examination or autopsy: unidentified body or human remains: medical examiner: attending physician and surgeon.

Existing law makes it the duty of a coroner to inquire into and determine the circumstances, manner, and cause of deaths under prescribed conditions, including deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another ~~and~~ *or* if the surviving spouse of the deceased requests the coroner to do so in writing. Existing law makes a postmortem examination or autopsy conducted at the discretion of a coroner, medical examiner, or other agency upon an unidentified human body or human remains subject to certain specified provisions of law.

This bill would require a postmortem examination or autopsy upon an unidentified body or human remains to only be conducted by an attending physician and surgeon or chief medical examiner who is a board-certified forensic pathologist. The bill would require an agency tasked with the exhumation of a body or skeletal remains of a deceased person that has suffered significant deterioration or decomposition, where the circumstances surrounding the death afford a reasonable basis to suspect that the death was caused by or related to the criminal act of

another, to perform the exhumation under the direction of a board-certified forensic pathologist and would authorize that board-certified forensic pathologist to retain the services of an anthropologist.

Existing law requires a postmortem examination or autopsy to include certain procedures, including, but not limited to, a dental examination that is authorized to be conducted by a qualified dentist as determined by the coroner. *Existing law authorizes the postmortem examination or autopsy of the unidentified body or remains to include full body X-rays.*

This bill would instead provide that the dental examination is authorized to be conducted by a qualified dentist as determined by the coroner, medical examiner, or attending physician and surgeon. *The bill would additionally authorize the postmortem examination or autopsy of the unidentified body or remains to include computed tomography scans.*

Existing law authorizes the use of an electronic image system during an autopsy at the sole discretion of a coroner, medical examiner, or other agency tasked with performing an autopsy, except as specified. Existing law requires a coroner, medical examiner, or other agency tasked with performing a postmortem examination or an autopsy to, among other things, submit dental ~~charts and dental X-rays~~ *charts, dental X-rays,* and the final report of investigation to the Department of Justice, as specified. Existing law, unless the coroner, medical examiner, or other agency performing a postmortem examination or autopsy determines the body of the unidentified deceased person has suffered significant deterioration or decomposition, prohibits the jaws from being removed until immediately before the body is cremated or buried and requires the coroner, medical examiner, or other agency to retain the jaws and other tissue samples for a specified period of time.

This bill would additionally apply those above-described provisions to an attending physician and surgeon. *The bill would require the coroner, medical examiner, attending physician and surgeon, or other agency to, instead, retain the samples of tissue and bone for a specified period of time.*

Existing law prohibits the body of an unidentified deceased person from being cremated or buried until the jaws and other tissues samples are retained for future possible use.

This bill would require the ~~jaws and other tissue samples~~ *appropriate samples of tissue and bone* to be retained by an attending physician and surgeon or a chief medical examiner who is a board-certified forensic

pathologist for future possible use, including, but not limited to, identification purposes. The bill would, for an unidentified body or human remains, require that appropriate samples of ~~tissues~~ *tissue and bone* be taken before the unidentified body or human remains are cremated or buried, as specified.

This bill would define "attending physician and surgeon" for the purposes of these provisions as a physician and surgeon licensed to practice medicine in this state performing a postmortem examination or autopsy, as specified.

By placing new requirements on local governments for performing postmortem examinations or autopsies, this bill would impose a state-mandated local program.

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

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

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

SECTION 1. Section 27521 of the Government Code is amended to read:

27521. (a) A postmortem examination or autopsy conducted at the discretion of a coroner, medical examiner, or other agency upon an unidentified body or human remains is subject to this section.

(b) A postmortem examination or autopsy upon an unidentified body or human remains shall only be conducted by an attending physician and surgeon or the chief medical examiner who is a board-certified forensic pathologist certified by the American Board of Pathology.

(c) Any agency tasked with the exhumation of a body or skeletal remains of a deceased person that has suffered significant deterioration or decomposition, where the circumstances surrounding the death afford a reasonable basis to suspect that the death was caused by or related to the criminal act of another, shall

perform the exhumation under the direction of a board-certified forensic pathologist certified by the American Board of Pathology. The board-certified forensic pathologist may, at his or her discretion when necessary, retain the services of an anthropologist.

(d) A postmortem examination or autopsy shall include, but shall not be limited to, the following procedures:

(1) Taking of all available fingerprints and palm prints.

(2) A dental examination consisting of dental charts and dental X-rays of the deceased person's teeth, which may be conducted on the body or human remains by a qualified dentist as determined by the coroner, medical examiner, or attending physician and surgeon.

(3) The collection of tissue, including a hair sample, or body fluid samples for future DNA testing, if necessary.

(4) Frontal and lateral facial photographs with the scale indicated.

(5) Notation and photographs, with a scale, of significant scars, marks, tattoos, clothing items, or other personal effects found with or near the body.

(6) Notations of observations pertinent to the estimation of the time of death.

(7) Precise documentation of the location of the remains.

(e) The postmortem examination or autopsy of the unidentified body or remains may include full body ~~X-rays.~~ *X-rays or computed tomography scans.*

(f) (1) At the sole and exclusive discretion of a coroner, medical examiner, attending physician and surgeon, or other agency tasked with performing an autopsy pursuant to Section 27491, an electronic image system, including, but not limited to, an X-ray *machine or* computed tomography scanning system, may be used to fulfill the requirements of subdivision (d) or of a postmortem examination or autopsy required by other law, including, but not limited to, Section 27520.

(2) This subdivision does not impose a duty upon any coroner, medical examiner, attending physician and surgeon, or other agency tasked with performing autopsies pursuant to Section 27491 to use an electronic image system to perform autopsies or to acquire the capability to do so.

(3) A coroner, medical examiner, attending physician and surgeon, or other agency tasked with performing an autopsy

pursuant to Section 27491 shall not use an electronic imaging system to conduct an autopsy in any investigation where the circumstances surrounding the death afford a reasonable basis to suspect that the death was caused by or related to the criminal act of another and it is necessary to collect evidence for presentation in a court of law. If the results of an autopsy performed using electronic imaging provides the basis to suspect that the death was caused by or related to the criminal act of another, and it is necessary to collect evidence for presentation in a court of law, then a dissection autopsy shall be performed in order to determine the cause and manner of death.

(4) An autopsy may be conducted using an X-ray *or* computed tomography ~~scanning system~~ *scans* notwithstanding the existence of a certificate of religious belief properly executed in accordance with Section 27491.43.

(g) The coroner, medical examiner, attending physician and surgeon, or other agency performing a postmortem examination or autopsy shall prepare a final report of investigation in a format established by the Department of Justice. The final report shall list or describe the information collected pursuant to the postmortem examination or autopsy conducted under subdivision (d)

(h) The body of an unidentified deceased person shall not be cremated or buried until the ~~jaws (maxilla and mandible with teeth), or other bone sample if the jaws are not available, and other tissue samples~~ *appropriate samples of tissue and bone* are retained by an attending physician and surgeon or the chief medical examiner who is a board-certified forensic pathologist certified by the American Board of Pathology for future possible use, including, but not limited to, identification purposes.

(i) For an unidentified body or human remains, appropriate samples of ~~tissues~~ *tissue and bone* shall be taken before the body or human remains are cremated or buried. The types of samples ~~or tissues~~ *of tissue and bone* that are taken shall be determined by an attending physician and surgeon or chief medical examiner who is a board-certified forensic pathologist certified by the American Board of Pathology. The samples ~~of tissues~~ obtained, the method of procurement or dissection of ~~tissues,~~ *those samples*, and the handling, processing, and storage of samples shall be within, and guided by, the generally accepted standards of practice of medicine and the generally accepted principles of medicine.

(j) ~~Unless the coroner, medical examiner, attending physician and surgeon, or other agency performing a postmortem examination or autopsy according to standards of medical practice has determined that the body of the unidentified deceased person has suffered significant deterioration or decomposition, the jaws and other tissue samples shall not be removed until immediately before the body is cremated or buried.~~ The coroner, medical examiner, attending physician and surgeon, or other agency responsible for a postmortem examination or autopsy shall retain the ~~jaws and other tissue samples~~ *samples of tissue and bone* for one year after a positive identification is made, and no civil or criminal challenges are pending, or indefinitely.

(k) If the coroner, medical examiner, attending physician and surgeon, or other agency performing a postmortem examination or autopsy with the aid of the dental examination and any other identifying findings is unable to establish the identity of the body or human remains, the coroner, medical examiner, or other agency shall submit dental charts and dental X-rays of the unidentified deceased person to the Department of Justice on forms supplied by the Department of Justice within 45 days of the date the body or human remains were discovered.

(*l*) If the coroner, medical examiner, attending physician and surgeon, or other agency performing a postmortem examination or autopsy with the aid of the dental examination and other identifying findings is unable to establish the identity of the body or human remains, the coroner, medical examiner, attending physician and surgeon, or other agency shall submit the final report of investigation to the Department of Justice within 180 days of the date the body or human remains were discovered. The final report of investigation shall list or describe the information collected pursuant to the postmortem examination or autopsy conducted under subdivision (b), (d), or (i) and any anthropology report, fingerprints, photographs, and autopsy report.

(m) For the purposes of this section, "attending physician and surgeon" means a physician and surgeon licensed to practice medicine in this state performing a postmortem examination or autopsy pursuant to this section.

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made

pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1238
Author: Roth
Bill Date: April 9, 2018, Amended
Subject: Patient Records: Maintenance and Storage
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require medical providers to notify their patients, using the patient's last known contact information, before their personal medical records are destroyed.

BACKGROUND

Existing law, Health & Safety Code Section 123100 et seq. establishes a patient's right to see and receive copies of his or her medical records, under specified conditions. The law only addresses the patient's request for copies of his or her own medical records and does not cover a patient's request to transfer records between health care providers.

Section 123110 of the Health & Safety Code specifically provides that any adult patient, or any minor patient who by law can consent to medical treatment (or certain patient representatives), is entitled to inspect patient records upon written request to a physician and upon payment of reasonable clerical costs to make such records available. The physician must then permit the patient to view his or her records during business hours within five working days after receipt of the written request. The patient or patient's representative may be accompanied by one other person of his or her choosing. Prior to inspection or copying of records, physicians may require reasonable verification of identity, so long as this is not used oppressively or discriminatorily to frustrate or delay compliance with this law.

The patient or patient's representative is entitled to copies of all or any portion of his or her records that he or she has a right to inspect, upon written request to the physician. The physician may charge a fee to defray the cost of copying, not to exceed 25 cents per page or 50 cents per page for records that are copied from microfilm, along with reasonable clerical costs. By law, a patient's records are defined as records relating to the health history, diagnosis, or condition of a patient, or relating to treatment provided or proposed to be provided to the patient. Physicians must provide patients with copies within 15 days of receipt of the request.

ANALYSIS

This bill would require a health care provider who creates patient records, at the time the initial patient record is created, to provide a statement to be signed by the patient or the patient's representative, that sets forth both of the following:

- The patient's rights to inspect his or her medical records, obtain copies of his or her medical records, and provide a written addendum, with respect to any item or statement in the records that the patient believes to be incomplete or incorrect.
- The intended retention period for the records, as specified in law or by the health care provider's retention policy.

This bill would exempt a health care provider from the signed statement requirements if he or she utilizes electronic health records and those records are stored in perpetuity.

This bill would specify that if the patient refuses to sign the statement, the record shall indicate that fact. This bill would allow the statement to be included in another form or statement provided to the patient or the patient's representative, at the time the initial patient record is created.

This bill would require the health care provider to notify the patient not fewer than 60 days before the health care provider plans to destroy the patient's records. The health care provider would be required to mail the notification via first-class mail, or by electronic mail, or both. The notification would be required to inform the patient of his or her rights to inspect the medical records. The health care provider would be required to provide a patient with the original medical records earlier than the retention period in the signed statement if the patient makes a request for the records before the date of the proposed destruction of the records. This bill would allow the patient to designate the method of delivery and would allow the health care provider to charge a patient for the actual costs incurred for copying, mailing, or shipping the records. This bill would not authorize charges for maintenance of patient records.

This bill would specify that a health care provider that violates this section may be cited and assessed an administrative penalty. This bill would not allow a citation to be issued or a penalty to be assessed upon the first violation, but only upon the second and each subsequent violation.

This bill would exempt patient records created by a psychiatrist from the requirements of this bill.

According to the author's office, existing law does not establish a standard on the number of years a health provider or plan must maintain medical records. Requiring a health care provider to notify patient prior to the destruction of records will help patients maintain and protect their personal health records as they pursue long-term treatment.

The Board receives many calls and inquiries from consumers regarding medical records and where to find them if a physician retires, moves away, or dies. There is no law requiring a physician to notify patients before destroying their medical records and there is no law requiring physicians to notify patients of their medical records retention schedule. Requiring this notification will help consumers gain access to their medical records before they are destroyed. This will help to ensure that their future physicians are well informed of their medical history, so they can be provided high quality medical care. Board staff suggests that the Board take a support position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE APRIL 9, 2018

AMENDED IN SENATE MARCH 19, 2018

SENATE BILL **No. 1238**

Introduced by Senator Roth

February 15, 2018

An act to add Section 123106 to the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 1238, as amended, Roth. Patient records: maintenance and storage.

Existing law establishes procedures for providing access to various types of health care records, including patient records, as defined, by patients and persons having responsibility for decisions respecting the health care of others. Existing law gives health care providers, as defined, various responsibilities in connection with providing access to these records.

This bill would require certain health care providers at the time of creation of a patient record to provide a statement to the patient, or the patient's representative, that sets forth the patient's rights and the intended retention period for the records. The bill would require certain health care providers that plan to destroy patient records to notify the patient at least 60 days before a patient's records are to be destroyed, as provided. The bill would require a health care provider to provide a patient with his or her original medical records that the provider plans to destroy if the patient makes a request for the records to the provider before the date of the proposed destruction of the records. The bill would authorize a health care provider to charge a patient for the actual costs of copying, ~~archiving,~~ mailing, or shipping the patient's records under

that provision. The bill would authorize the issuance of citations and the assessment of administrative penalties for violations.

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

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

SECTION 1. Section 123106 is added to the Health and Safety Code, to read:

123106. (a) A health care provider described in paragraphs (4), (5), (6), (8), and (9) of subdivision (a) of Section 123105, who creates patient records, as defined in subdivision (d) of Section 123105, shall, at the time the initial patient record is created, provide a statement to be signed by the patient, or the patient's representative, that sets forth both of the following:

(1) The patient's rights under this chapter to inspect his or her medical records, obtain copies of his or her medical records, and to provide a written addendum, pursuant to Section 123111, with respect to any item or statement in the patient's records that the patient believes to be incomplete or incorrect.

(2) The intended retention period for the records, as specified in applicable law or by the health care provider's retention policy.

(b) A copy of the signed statement required pursuant to subdivision (a) shall be provided to the patient.

(c) If a patient, or the patient's representative, is provided a statement at the time that the initial patient record is created, and the patient refuses to sign the statement, the patient's record shall indicate that the patient refused to sign the statement.

(d) The statement required by subdivision (a) may be included in another form or statement provided to the patient, or the patient's representative, at the time the initial patient record is created.

~~(d)~~

(e) If a health care provider to whom subdivision (a) applies plans to destroy patient records, the health care provider shall, no fewer than 60 days before a patient's records are to be destroyed, notify the patient, via first-class mail, electronic mail, or both, to the patient's last known mailing or electronic mail address, or both. The notification shall inform the patient that his or her records are scheduled to be destroyed and the date of the proposed destruction

of records. The notification shall also inform the patient of his or her rights under this chapter to inspect his or her medical records. A health care provider to whom subdivision (a) applies shall provide a patient with his or her original medical records that the provider plans to destroy earlier than the period specified in the signed statement if the patient makes a request for the records to the health care provider before the date of the proposed destruction of the records. The patient or the patient's authorized representative may designate delivery of patient records either by personal pickup, mail, overnight delivery, or other delivery means. This section does not reduce the length of record retention as otherwise required by law.

~~(e)~~

(f) A health care provider may charge a patient for the actual costs incurred by the health care provider for copying, ~~archiving,~~ mailing, or shipping the patient's records under this ~~section.~~ *section in accordance with subdivision (k) of Section 123110.* This section does not authorize a health care provider to charge a patient for maintenance of any patient records that the health care provider is obligated by law to maintain.

~~(f)~~

(g) A health care provider to whom subdivision (a) applies shall not be subject to this section for medical records that are created for a patient who is referred to the provider solely for a diagnostic evaluation, if the provider does not provide treatment to the patient and reports the results of the diagnostic evaluation to the patient's referring provider.

(h) A health care provider to whom subdivision (a) applies shall not be subject to this section if the health care provider utilizes electronic health records and those records are stored in perpetuity.

~~(g)~~

(i) A health care provider who violates this section may be cited and assessed an administrative penalty in accordance with Section 125.9 of the Business and Professions Code. A citation shall not be issued and a penalty shall not be assessed upon the first violation by a licensee of this section. Upon the second and each subsequent violation by a health care provider of this section, a citation may be issued and an administrative penalty may be assessed after appropriate notice and opportunity for hearings. Notwithstanding

any other law, the remedy described in this subdivision constitutes the exclusive remedy for a violation of this section. This section does not affect other existing rights, duties, or remedies provided by law.

~~(h)~~

(j) The patient records created by a psychiatrist, including psychotherapy notes, as defined in Section 164.501 of Title 45 of the Code of Federal Regulations, are not subject to this section. For the purposes of this subdivision, "psychiatrist" means a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or pursuant to the Osteopathic Initiative Act, who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1240
Author: Stone
Bill Date: April 9, 2018, Amended
Subject: Prescription Drugs: CURES Database
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would expand California's Controlled Substances Utilization Review and Evaluation System (CURES) to include all prescription drugs. It would also require additional data elements in CURES.

BACKGROUND:

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

ANALYSIS

This bill would require all prescriptions to be included in the CURES database. This bill would add to the information entered into CURES and would update the International Statistical Classification of Diseases (ICD) to the 10th revision. This bill would add the description of the diagnosis, condition, or purpose for which the prescription was issued and the direction for use to CURES.

According to the author, expanding CURES to record all prescription drugs facilitates more accurate admission and discharge reconciliation and patient history and gives all clinicians a complete and accurate prescription history.

Requiring all prescriptions to be entered into CURES would overburden the CURES system, without providing any clear benefit. In addition, this bill would impact the

reports run in CURES and make it difficult to run reports on individual patients. The main purpose of CURES is to prevent misuse and abuse of controlled substances, this bill would go far beyond that purpose. Board staff suggests that the Board take an oppose position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Oppose

AMENDED IN SENATE APRIL 9, 2018

SENATE BILL No. 1240

Introduced by Senator Stone

February 15, 2018

An act to amend Section 4040 of, and to add ~~Sections 4122.4 and~~ *Section* 4122.5 to, the Business and Professions Code, and to amend Section 11165 of the Health and Safety Code, relating to pharmacy.

LEGISLATIVE COUNSEL'S DIGEST

SB 1240, as amended, Stone. Prescription drugs: CURES database.

The Pharmacy Law provides for the licensing and regulation of pharmacies, pharmacists, intern pharmacists, and pharmacy technicians by the California State Board of Pharmacy, which is within the Department of Consumer Affairs. That law defines "prescription" as an oral, written, or electronic transmission order that includes specified information, including a legible clear notice of the condition or purpose for which the drug is being prescribed if requested by the patient, and is issued by an authorized prescriber. That law makes a knowing violation of its provisions punishable as a crime and makes any other violation punishable as an infraction.

This bill would instead require a prescription, if in writing or transmitted electronically, to include an International Statistical Classification of Diseases, 10th revision (ICD-10) Code or a legible clear notice of the condition or purpose for which the drug is being prescribed, unless the patient requests this information to be omitted and would require a prescription transmitted orally to include either an ICD-10 Code of a description of the condition or purpose for which the drug is being prescribed. ~~The bill would require a pharmacist, prior to processing clinical checks for prescriptions and dispensing the~~

~~prescriptions, to review the most recent continuity of care document provided by the health care facility or physician and surgeon treating the patient.~~ The bill would ~~also~~ require a pharmacy to immediately convey prescription profile information of a patient to a requesting pharmacy caring for that patient, except for the price and cost of a prescription. By placing new requirements on a ~~pharmacist and a pharmacy~~ *pharmacy,* this bill would expand an existing crime, and would, therefore, result in a state-mandated local program.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, administer, furnish, or dispense these controlled substances. Existing law requires dispensing pharmacies and clinics to report specified information for each prescription of a Schedule II, Schedule III, or Schedule IV controlled substance to the department.

This bill would additional apply those requirements to Schedule V controlled substances and dangerous drugs, as defined, and would additionally require a description of the diagnosis, condition, or purpose for which the prescription was issued and the directions for use to be provided to the Department of Justice.

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

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

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

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

SECTION 1. Section 4040 of the Business and Professions Code is amended to read:

4040. (a) "Prescription" means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) If in writing or transmitted electronically, International Statistical Classification of Diseases, 10th revision (ICD-10) Code or a legible, clear notice of the condition or purpose for which the drug is being prescribed, unless the patient requests this information to be omitted. If transmitted orally, either the International Statistical Classification of Diseases, 10th revision (ICD-10) Code or a description of the condition or purpose for which the drug is being prescribed.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, 2836.1, 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to Section 4052.1, 4052.2, or 4052.6.

(2) Issued by a physician, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7 or, if a drug order is issued pursuant to Section 2746.51, 2836.1, 3502.1, or 3460.5, by a certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor licensed in this state, or pursuant to Section 4052.1, 4052.2, or 4052.6 by a pharmacist licensed in this state.

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (2) of subdivision (a) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail.

(c) "Electronic transmission prescription" includes both image and data prescriptions. "Electronic image transmission prescription" means any prescription order for which a facsimile of the order is received by a pharmacy from a licensed prescriber. "Electronic data transmission prescription" means any prescription order, other than an electronic image transmission prescription, that is electronically transmitted from a licensed prescriber to a pharmacy.

(d) The use of commonly used abbreviations shall not invalidate an otherwise valid prescription.

(e) Nothing in the amendments made to this section (formerly Section 4036) at the 1969 Regular Session of the Legislature shall be construed as expanding or limiting the right that a chiropractor, while acting within the scope of his or her license, may have to prescribe a device.

~~SEC. 2. Section 4122.4 is added to the Business and Professions Code, to read:~~

~~4122.4. A pharmacist, prior to processing clinical checks for prescriptions and dispensing the prescriptions, shall review the most recent continuity of care document provided by the health care facility or physician and surgeon treating the patient.~~

~~SEC. 3.~~

SEC. 2. Section 4122.5 is added to the Business and Professions Code, to read:

4122.5. A pharmacy shall immediately convey prescription profile information of a patient to a requesting pharmacy caring for that patient, except that the price and cost of a prescription shall not be included.

~~SEC. 4.~~

SEC. 3. Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances and dangerous drugs, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, Schedule IV, schedule V controlled substances and dangerous drugs, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled

Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, Schedule IV, and Schedule V controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances and the prescribing, ordering, administering, furnishing, and dispensing of dangerous drugs by all practitioners authorized to prescribe, order, administer, furnish, or dispense those dangerous drugs.

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

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

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party, unless authorized by, or pursuant to, state and federal privacy and security laws and regulations. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(B) Notwithstanding subparagraph (A), a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances or do not prescribe, order, administer, furnish,

or dispense dangerous drugs shall not be provided data obtained from CURES.

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

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

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

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

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

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

(5) Quantity of the controlled substance or dangerous drug dispensed.

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

(7) Number of refills ordered.

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

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(11) Description of the diagnosis, condition, or purpose for which the prescription was issued.

(12) The directions for use.

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

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

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

(h) For purposes of this section, "dangerous drug" has the same meaning as defined in Section 4022 of the Business and Professions Code.

~~SEC. 5.~~

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1336
Author: Morrell
Bill Date: April 2, 2018, Amended
Subject: Public Health: End of Life Option Act
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would amend the End of Life Option Act (Act). This bill would increase the reporting requirements to include the patient's motivating reason, the area of practice of each physician, and the number of patients who received a mental health assessment.

BACKGROUND

ABX2 15 (Eggman, Chapter 1) established the Act in California, which became effective on June 9, 2016, and will remain in effect until January 1, 2026. This Act gives a mentally competent, adult California resident who has a terminal disease the legal right to ask for and receive a prescription from his or her physician to hasten death, as long as required criteria is met.

The California Department of Public Health (CDPH) published the California End of Life Option Act 2016 Data Report that included statistics required by the Act. The summary statistics are: 191 individuals had prescriptions written in 2016, 111 ingested the drug in 2016, 21 did not ingest the drug and subsequently died of the underlying illness, and 59 individuals had undetermined outcomes.

ANALYSIS

This bill would amend the Act and require the attending physician to request that the qualified individual inform the physician orally or in writing as to the motivating reason or reasons behind the individual's decision to request the aid-in-dying drug. The question used to gather this information must allow for the selection of multiple choices, at a minimum, to include the following choices:

- Pain or the fear of pain.
- Concern about being a burden to others.
- Loss of autonomy.
- Sense of hopelessness.

This bill would also require CDPH's annual report to include all of the information collected. This bill would add to the information collected by CDPH for the report to include the

motivating reasons behind a patient's decision to request the aid-in-dying drug, the area of practice of each physician, and the number of patients who received a mental health assessment.

This bill would require the Medical Board of California (Board) to make the changes to the attending physician checklist and compliance form, so it captures the information required by this bill.

According to the author's office, the existing CDPH report is limited and provides an incomplete picture of how the Act is working. The author believes the information required by this bill is critical in enabling policy makers to properly assess the performance of the Act.

This bill would include more information in the annual report published by CDPH on the Act. More information may give a better picture on how the Act is working in California. Board staff suggests the Board take a neutral position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN SENATE APRIL 2, 2018

SENATE BILL No. 1336

Introduced by Senator Morrell

February 16, 2018

An act to amend Sections ~~443.5, 443.19,~~ *443.19* and 443.22 of the Health and Safety Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1336, as amended, Morrell. Public health: End of Life Option Act.

Existing law, the End of Life Option Act, authorizes an adult who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease, as defined, to make a request for an aid-in-dying drug for the purpose of ending his or her life. Prior to prescribing an aid-in-dying drug, existing law requires the attending physician to make certain determinations and verify, immediately before writing the prescription for an aid-in-dying drug, that the qualified individual is making an informed decision. Existing law requires the State Department of Public Health to create a report with information collected from attending physician followup forms and to post that report to its Internet Web site. Existing law requires that information to include, among other things, the underlying illness of the qualified individual. Existing law authorizes the Medical Board of California to update the attending physician checklists and forms required under these provisions.

~~Prior to prescribing an aid-in-dying drug, this bill would require an attending physician to request that a qualified individual inform the physician orally or in writing as to the motivating reason or reasons for receiving an aid-in-dying drug, as specified. The bill would require that~~

~~information to be included in the report of the department described above. The bill would further require that report to~~ *This bill would require the report described above to further* include ~~additional information about each attending physician and the length of time that he or she provided care to a patient, and~~ *the areas of practice of each physician who wrote a prescription for an aid-in-dying drug, the motivating reason or reasons behind a patient's decision to request the aid-in-dying drug, as specified, and* the number of patients who received a mental health specialist ~~assessment.~~ *assessment prior to receiving the aid-in-dying drug.* The bill would require the Medical Board of California to make any necessary changes to the applicable forms to conform with these requirements.

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 443.5 of the Health and Safety Code is amended to read:~~

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

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

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

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

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

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

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

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

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

~~(A) His or her medical diagnosis and prognosis.~~

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

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

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

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

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

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

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

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

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

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

~~(D) Participating in a hospice program.~~

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

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

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

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

~~(9) For purposes of paragraph (7) of subdivision (b) of Section 443.19, request that the qualified individual inform the physician~~

~~orally or in writing as to the motivating reason or reasons behind the individual's decision to request the aid-in-dying drug. The question used to gather this information shall allow for the selection of multiple choices pursuant to, at a minimum, the following possible choices:~~

~~(A) Pain or the fear of pain.~~

~~(B) Concern about being a burden to others.~~

~~(C) Loss of autonomy.~~

~~(D) Sense of hopelessness.~~

~~(10) Confirm that all requirements are met and all appropriate steps are carried out in accordance with this part before writing a prescription for an aid-in-dying drug.~~

~~(11) Fulfill the record documentation required under Sections 443.8 and 443.19.~~

~~(12) Complete the attending physician checklist and compliance form, as described in Section 443.22, include it and the consulting physician compliance form in the individual's medical record, and submit both forms to the State Department of Public Health.~~

~~(13) Give the qualified individual the final attestation form, with the instruction that the form be filled out and executed by the qualified individual within 48 hours prior to the qualified individual choosing to self-administer the aid-in-dying drug.~~

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

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

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

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

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

~~(2) With the qualified individual's written consent, contacting a pharmacist, informing the pharmacist of the prescriptions, and delivering the written prescriptions personally, by mail, or electronically to the pharmacist, who may dispense the drug to the qualified individual, the attending physician, or a person expressly~~

~~designated by the qualified individual and with the designation delivered to the pharmacist in writing or verbally.~~

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

~~(d) An attending physician shall not be precluded from prescribing an aid-in-dying drug pursuant to this part under circumstances in which the qualified individual chooses not to provide an answer to the question asked pursuant to paragraph (9) of subdivision (a).~~

~~SEC. 2.~~

SECTION 1. Section 443.19 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

(5) The number of physicians who wrote prescriptions for aid-in-dying ~~drugs, and the specialty or specialties of each physician.~~ *drugs and the areas of practice of each physician.*

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

(A) Age at death.

(B) Education level.

(C) Race.

(D) Sex.

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

(F) Underlying illness.

(7) The motivating reason or reasons behind a patient's decision to request the aid-in-dying drug pursuant to ~~paragraph (9) of subdivision (a) of Section 443.5.~~ *the responses given to question 15 of the attending physician followup form described in Section 443.22.*

(8) The number of patients who received a mental health specialist assessment prior to receiving the aid-in-dying drug.

~~(9) The length of time the attending physician has provided care to the patient prior to prescribing the aid-in-dying drug.~~

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

~~SEC. 3.~~

SEC. 2. Section 443.22 of the Health and Safety Code is amended to read:

443.22. (a) (1) The Medical Board of California may update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, based on those provided in subdivision (b). Upon completion, the State Department of Public Health shall publish the updated forms on its Internet Web site.

(2) The Medical Board of California shall make changes to the forms referenced in paragraph (1) as necessary so the forms capture

the information needed to fulfill the reporting requirement in subdivision (b) of Section 443.19.

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

PRINTER PLEASE NOTE: TIP-IN MATERIAL TO BE INSERTED

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 1426
Author:	Stone
Bill Date:	March 22, 2018, Amended
Subject:	Pharmacists: Authority to Prescribe and Dispense Dangerous Drugs and Devices
Sponsor:	Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would give the Board of Pharmacy (BOP) the authority to modify the list of drugs that an advanced practice pharmacist may furnish, pursuant to a diagnosis by a health care practitioner with prescribing authority.

BACKGROUND

SB 493 (Hernandez, Chapter 469, Statutes of 2013) allowed pharmacists to furnish medication, order and interpret tests, furnish self-administered hormonal contraceptives, furnish prescription medications not requiring a diagnosis recommended by the Centers for Disease Control and Prevention for individuals traveling outside the United States, independently initiate and administer vaccines, and furnish prescription nicotine replacement products and smoking cessation services. This bill required the BOP and the Medical Board of California (Board) to develop standardized procedures or protocols for the furnishing of self-administered hormonal contraceptives and nicotine replacement products. This bill also established an Advanced Practice Pharmacist (APP) recognition. The Board supported SB 493.

ANALYSIS:

This bill would require the BOP to establish, by regulation, a formulary of dangerous drugs and devices, as recommended by the Public Health and Pharmacy Formulary Advisory Committee, that an advanced practice pharmacist may furnish to a patient pursuant to a diagnosis by a health care practitioner who has prescribing authority and who is qualified to make the diagnosis.

This bill would require the BOP to convene a Public Health and Pharmacy Formulary Advisory Committee (Committee) consisting of seven members appointed by the Governor, for the purpose of advising BOP in promulgating regulations to establish a formulary of drugs and devices that an advanced practice pharmacist may furnish. This bill would require the Committee to consist of the following members:

- Two physicians and surgeons licensed to practice medicine.
- Two advanced practice registered nurses who have prescriptive authority and who are

licensed by the Board of Registered Nursing (BRN).

- Three pharmacists licensed by BOP, at least one of whom is employed as a community pharmacist and one of whom is employed as a health system pharmacist.
- The Board and BRN may each submit a list of up to three names to the Governor to be considered for membership on the Committee for each of the vacancies required to be filled by a licensee of each board

This bill would specify the term limits and that the Committee can elect a chairperson. This bill would require the Committee to recommend to BOP for adoption by regulation, a formulary of drugs and devices that an advanced practice pharmacist may furnish to a patient pursuant to a diagnosis by a health care practitioner qualified to make the diagnosis. This bill would require the Committee to periodically review the formulary and recommend revisions to BOP for adoption by regulation. This bill would allow a pharmacist to request that the Committee recommend adding a drug or device to the formulary by submitting a request on a form prescribed by BOP.

According to the author, this bill would alleviate the need to go back to the Legislature each time there is a necessity to add a specific dangerous drug or drug category to the list that pharmacists may furnish on their own authority.

The Board supported SB 493 in 2013 because it narrowly expanded the furnishing scope of a pharmacist. It only allowed pharmacists to furnish self-administered hormonal contraceptives in accordance with standardized procedures, allowed pharmacists to furnish prescription medications not requiring a diagnosis and recommended by the Centers for Disease Control and Prevention for individuals traveling outside the United States, and allowed pharmacists to furnish nicotine replacement products and provide smoking cessation services. This bill would allow BOP to add through the regulatory process any dangerous drug or device to the list of what an advanced practice pharmacist can furnish, with a diagnosis only. Although this bill does create the Committee made up of various professionals, the Committee provides advice only to BOP. Board staff is recommending that the Board take an oppose position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Oppose

AMENDED IN SENATE MARCH 22, 2018

SENATE BILL **No. 1426**

Introduced by Senator Stone

February 16, 2018

An act *to add Sections 4069 and 4069.1 to the Business and Professions Code,* relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1426, as amended, Stone. Pharmacists: authority to prescribe and dispense dangerous drugs and devices.

Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy, and generally prohibits a pharmacist from dispensing a dangerous drug or dangerous device except upon the prescription of an authorized prescriber. Existing law, notwithstanding that prohibition, authorizes a pharmacist to furnish certain dangerous drugs and devices, including nicotine replacement products, certain vaccines, and self-administered hormonal contraceptives, without a prescription in accordance with specified protocols and conditions. *Existing law authorizes a pharmacist recognized by the board as an advanced practice pharmacist to perform specified tasks, including initiating, adjusting, or discontinuing drug therapy in a specified manner.*

This bill would ~~express the intent of the Legislature to enact legislation that would~~ require the ~~California State Board of Pharmacy~~ *board* to convene a Public Health and Pharmacy Formulary Advisory Committee to advise the board in promulgating regulations to establish a formulary of drugs and devices that ~~a~~ *an advanced practice* pharmacist may ~~prescribe and dispense~~ *furnish* to a ~~patient, and to promulgate regulations establishing~~ *patient. The bill would require the board to establish* a

formulary of dangerous drugs and devices that ~~a pharmacy~~ *an advanced practice pharmacist* may ~~prescribe and dispense~~ *furnish* to a ~~patient.~~ *patient, and would authorize an advanced practice pharmacist to furnish a dangerous drug or dangerous device included on the formulary to a patient pursuant to a diagnosis by a health care practitioner.*

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

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

SECTION 1. Section 4069 is added to the Business and Professions Code, to read:

4069. (a) Notwithstanding any other law, an advanced practice pharmacist may, in addition to the tasks authorized by Section 4052.6, furnish a dangerous drug or dangerous device included on the formulary established under subdivision (b) pursuant to a diagnosis by a health care practitioner who has prescribing authority and is qualified to make the diagnosis.

(b) The board shall establish by regulation a formulary of dangerous drugs and dangerous devices, as recommended by the Public Health and Pharmacy Formulary Advisory Committee established pursuant to Section 4069.1, that an advanced practice pharmacist may furnish to a patient pursuant to a diagnosis by a health care practitioner who has prescribing authority and who is qualified to make the diagnosis.

SEC. 2. Section 4069.1 is added to the Business and Professions Code, to read:

4069.1. (a) The board shall convene a Public Health and Pharmacy Formulary Advisory Committee consisting of seven members appointed by the Governor for the purpose of advising the board in promulgating regulations to establish a formulary of drugs and devices that an advanced practice pharmacist may furnish to a patient pursuant to Section 4069.

(b) The committee shall consist of the following members:

(1) Two physicians and surgeons licensed to practice medicine.

(2) Two advanced practice registered nurses, as defined in Section 2725.5, who have prescriptive authority and who are licensed by the Board of Registered Nursing.

(3) Three pharmacists licensed by the board, at least one of whom is employed as a community pharmacist and one of whom is employed as a health system pharmacist.

(4) The Medical Board of California, the Board of Registered Nursing, and the board may each submit to the Governor a list of up to three names of individuals to be considered for membership for each of the vacancies required to be filled by licensees of each board.

(c) The term of each member of the committee shall be two years. A member whose term has expired shall continue to serve until a successor is appointed. If a vacancy occurs, a person who is a representative of the same state agency as the departing member shall serve for the remainder of the term.

(d) The committee shall elect one of its members to serve as chairperson.

(e) The committee shall recommend to the board for adoption by regulation of the board a formulary of drugs and devices that an advanced practice pharmacist may furnish to a patient pursuant to a diagnosis by a health care practitioner qualified to make the diagnosis. The committee shall periodically review the formulary and recommend the revisions to the board for adoption by regulation.

(f) A pharmacist may request that the committee recommend adding a drug or device to the formulary by submitting to the committee a request form prescribed by the board. The addition to the formulary of a drug or device under this subdivision shall be considered a revision to the formulary that the committee may recommend to the board for adoption by regulation.

~~SECTION 1. It is the intent of the Legislature to enact legislation that would do both of the following:~~

~~(a) Require the California State Board of Pharmacy to convene a Public Health and Pharmacy Formulary Advisory Committee, that includes representatives from the Medical Board of California, the Board of Registered Nursing, and the California State Board of Pharmacy, for the purpose of advising the California State Board of Pharmacy in promulgating regulations to establish a formulary of dangerous drugs and devices that a pharmacist may prescribe and dispense to a patient.~~

~~(b) Require the California State Board of Pharmacy to establish by regulation a formulary of dangerous drugs and devices~~

~~recommended by the Public Health and Pharmacy Formulary Advisory Committee that a pharmacist may prescribe and dispense to a patient that may include postdiagnostic drugs and devices such as diabetic testing supplies, emergency refills of insulin, albuterol inhalers, epinephrine autoinjectors, discharge medications for transitions of care, rapid strep tests, and spacers.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1448
Author: Hill
Bill Date: April 9, 2018, Amended
Subject: Healing Arts Licensees: Probation Status: Disclosure
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require, on and after July 1, 2019, physicians and surgeons, osteopathic physicians and surgeons, podiatrists, acupuncturists, chiropractors and naturopathic doctors to notify patients of their probationary status before seeing a patient for the first time, as specified.

BACKGROUND

The Medical Board of California's (Board's) Manual of Model Disciplinary Orders and Disciplinary Guidelines currently require a licensee to provide a copy of the disciplinary decision and accusation to the Chief of Staff or Chief Executive Officer at every hospital where privileges or membership are extended to the licensee. A copy of the decision or accusation must also be provided at any facility where the licensee engages in the practice of medicine, and to the Chief Executive Officer at every malpractice insurance carrier that extends malpractice insurance coverage to the licensee. Under optional condition 25 in the Board's Disciplinary Guidelines, the Board may require a licensee to provide written notification to patients in circumstances where the licensee is required to have a third-party chaperone present during the consultation, examination, or treatment by the licensee. Notification to patients may also be required if optional condition 26, regarding prohibited practice, is included in the licensee's probationary order.

The Board's website currently includes disciplinary information for all physicians, including if the physician is currently, or has been, on probation. This information is posted on the Board's website indefinitely. In addition, the Board has a call center that members of the public can contact to obtain any public disciplinary information for Board licensees, including probationary status and history.

The Board supported the probation notification requirements in SB 798. This bill would have required probation notification for cases when the legal conclusions of an administrative law judge find or in a stipulated settlement the licensee admits, or if no admissions, the accusation or the statement of issues charges, that the licensee is implicated in sexual misconduct, drug or alcohol abuse during practice, criminal conviction involving the practice of medicine, if the licensee has previously been ordered on probation or had his or her license revoked, and any violation constituting a threat to public health and safety where the Board believes notification is appropriate. This language was removed from SB 798 due to opposition.

ANALYSIS

This bill would require, on and after July 1, 2019, the Board to require a licensee on probation, pursuant to a probationary order made on or after July 1, 2019, before a patient's first visit following the probationary order, to provide the patient or the patient's guardian or health care surrogate, with a separate disclosure that includes the following:

- The licensee's probationary status.
- The length of the probation and the end date.
- All practice restrictions placed on the licensee by the Board.
- The Board's telephone number.
- An explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the Board's online license information website.

This bill would specify that a licensee required to provide a disclosure shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of the disclosure.

This bill would specify that a licensee on probation is not required to provide a disclosure if any of the following applies:

- The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.
- The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.
- The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.
- The licensee does not have a direct treatment relationship with the patient.

This bill would require the Board, on and after July 1, 2019, to provide the following information for licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the Board's website:

- For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.
- For probation imposed by an adjudicated decision of the Board, the causes for probation stated in the final probationary order.
- For a licensee granted a probationary license, the causes by which a probationary license was imposed.
- The length of the probation and end date.
- All practice restrictions placed on the license by the Board.

The probationary status of a physician is public information and available on the Board's

website. Ensuring that patients are informed promotes the Board's mission of consumer protection. The language in this bill is very similar to SB 798, which the Board supported, but SB 798 only required patient notification for specified cases, this bill would require probation notification for all physicians on probation.

FISCAL: This bill will likely result in more cases going to hearing because physicians will not want to agree to probation if they have to notify their patients. Board staff is estimating that cases that result in stipulated settlements of three years of probation or less will go to hearing instead of settling. The cost difference between the average cost for proposed decisions for the Attorney General's Office (AG) and the Office of Administrative Hearings (OAH), minus the average for stipulated settlements for the AG and OAH is approximately $38,000 per case. The Board is estimating that it has approximately 45 stipulated settlements per year for probation for three years or less, which is a total cost of $1,710,000 per year.

SUPPORT: None on file

OPPOSITION: None on file

AMENDED IN SENATE APRIL 9, 2018

SENATE BILL **No. 1448**

Introduced by Senator Hill

February 16, 2018

~~An act to amend Section 11600 of the Health and Safety Code, relating to public health.~~ *An act to add Sections 1007, 2228.1, 2228.5, 2459.4, 3663.5, and 4962 to the Business and Professions Code, relating to healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1448, as amended, Hill. ~~Controlled substances: educational programs.~~ *Healing arts licensees: probation status: disclosure.*

Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. Existing law establishes the California Board of Podiatric Medicine within the Medical Board of California for the licensing, regulation, and discipline of podiatrists. Existing law, the Osteopathic Act, enacted by an initiative measure, establishes the Osteopathic Medical Board of California for the licensing and regulation of osteopathic physicians and surgeons and requires the Osteopathic Medical Board of California to enforce specified provisions of the Medical Practice Act with respect to its licensees. Existing law, the Naturopathic Doctors Act, establishes the Naturopathic Medicine Committee within the Osteopathic Medical Board of California for the licensing and regulation of naturopathic doctors. Existing law, the Chiropractic Act, enacted by an initiative measure, establishes the State Board of Chiropractic Examiners for the licensing and regulation of chiropractors. Existing law, the Acupuncture Licensure Act, establishes the Acupuncture Board for the licensing and regulation of

acupuncturists. Existing law authorizes each of these regulatory entities to discipline its licensee by placing her or him on probation, as specified.

This bill, on and after July 1, 2019, would require those regulatory boards to require a licensee to provide a separate disclosure, as specified, to a patient or a patient's guardian or health care surrogate before the patient's first visit if the licensee is on probation pursuant to a probationary order made on and after July 1, 2019. The bill would also require those regulatory boards to provide specified information relating to licensees on probation on the regulatory entity's online license information Internet Web site.

~~The California Uniform Controlled Substances Act requires the Attorney General, the California State Board of Pharmacy, and other agencies to carry out educational programs designed to prevent and deter misuse and abuse of controlled substances. Existing law authorizes, in connection with these programs, the Attorney General to take certain actions, including, among others, promoting better recognition of the problems of misuse and abuse of controlled substances within the regulated industry and among interested groups and organizations.~~

~~This bill would also specifically require the Medical Board of California and the Osteopathic Medical Board of California to carry out those educational programs.~~

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

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

SECTION 1. This act shall be known, and may be cited, as the Patient's Right to Know Act of 2018.

SEC. 2. Section 1007 is added to the Business and Professions Code, to read:

1007. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation and the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the

probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) "Board" for purposes of this section means the State Board of Chiropractic Examiners.

SEC. 3. Section 2228.1 is added to the Business and Professions Code, to read:

2228.1. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation and the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has

expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

SEC. 4. Section 2228.5 is added to the Business and Professions Code, to read:

2228.5. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation and the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

(f) For purposes of this section:

(1) "Board" means the California Board of Podiatric Medicine.

(2) "Licensee" means a person licensed by the California Board of Podiatric Medicine.

SEC. 5. Section 2459.4 is added to the Business and Professions Code, to read:

2459.4. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation and the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's

guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) A violation of this section shall not be punishable as a crime.

(f) For purposes of this section:

(1) "Board" means the Osteopathic Medical Board of California.

(2) "Licensee" means a person licensed by the Osteopathic Medical Board of California.

SEC. 6. Section 3663.5 is added to the Business and Professions Code, to read:

3663.5. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the committee shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation and the probation end date, all practice restrictions placed on the licensee by the committee, the committee's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the committee's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the committee shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the committee's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has

expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the committee, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the committee.

(e) A violation of this section shall not be punishable as a crime.

SEC. 7. Section 4962 is added to the Business and Professions Code, to read:

4962. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation and the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) A violation of this section shall not be punishable as a crime.

~~SECTION 1. Section 11600 of the Health and Safety Code is amended to read:~~

~~11600. The Attorney General, the Board of Pharmacy, the Medical Board of California, the Osteopathic Medical Board of California, and other agencies shall carry out educational programs designed to prevent and deter misuse and abuse of controlled substances. In connection with these programs, the Attorney General may do all of the following:~~

~~(a) Promote better recognition of the problems of misuse and abuse of controlled substances within the regulated industry and among interested groups and organizations.~~

~~(b) Assist the regulated industry and interested groups and organizations in contributing to the reduction of misuse and abuse of controlled substances.~~

~~(c) Consult with interested groups and organizations to aid them in solving administrative and organizational problems.~~

~~(d) Assist in the education and training of state and local law enforcement officials in their efforts to control misuse and abuse of controlled substances.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1495
Author: Committee on Health
Bill Date: April 10, 2018, Amended
Subject: Health
Sponsor: Author

DESCRIPTION OF LEGISLATION:

This bill would make technical and clarifying changes to SB 512 from last year, regarding non-United States Food and Drug Administration (FDA) approved stem cell therapies. This bill would specify that the stem cell therapies that require a notice do not include therapies that meet the criteria of the Code of Federal Regulations, Title 21, Sections 1271.10 and 1271.15, which are those that do not require FDA premarket review or clearance, but are still regulated by the FDA, or those that qualify for an exception, as specified. This bill also contains other technical clean up not related to the Medical Board of California (Board).

BACKGROUND

SB 512 (Hernandez, Chapter 428, Statutes of 2017) required health care practitioners that perform a stem cell therapy not approved by the FDA, to communicate this to his or her patients on a notice displayed in his or her office. This bill required the Board to report citations issued and discipline imposed, with regard to violations by licensees who provide stem cell therapies, in its Annual Report beginning with the 2018-19 Annual Report. The Board took a neutral position on this bill.

ANALYSIS

This bill is a clean-up bill to SB 512 from last year. SB 512 was meant to apply to experimental stem cell therapies. The way the language was written it also applied to some therapies that qualified for an exception with the FDA, and also to some therapies that are already regulated by the FDA. This bill makes technical and clarifying changes to ensure that the notice requirements only apply to non-FDA approved, experimental therapies. As such, Board staff suggests that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN SENATE APRIL 10, 2018

SENATE BILL No. 1495

Introduced by Committee on Health (Senators Hernandez (Chair), Leyva, Mitchell, Monning, Newman, Nguyen, Nielsen, Pan, and Roth)

February 28, 2018

An act to amend Section 684 of the Business and Professions Code, to amend ~~Section 1797.188~~ *Sections 1797.188 and 101080* of the Health and Safety Code, and to amend Sections 4300, 4301, 4311, ~~and 4313 of, and~~ *4313, 5349, 5651, and 5897 of,* to add Section 4005.8 to, *to repeal Sections 5651.2 and 5666 of, and to repeal and add Section 5650 of,* the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1495, as amended, Committee on Health. Health.

(1) Existing law provides for the licensure and regulation of various health care practitioners by boards within the Department of Consumer Affairs. Existing law requires licensed health care practitioners who perform stem cell therapies that are not approved by the United States Food and Drug Administration (FDA) to communicate to their patients specified information regarding the therapies in a notice and in writing prior to providing the initial stem cell therapy. Under existing law, for these purposes, a "stem cell therapy" is a therapy involving the use of HCT/Ps, defined as human cells, tissues, or cellular- or tissue-based products in accordance with specified federal law. Under existing law, these requirements do not apply to a health care practitioner who has obtained approval for an investigational new drug or device from the FDA for the use of HCT/Ps.

This bill would exclude from the definition of "stem cell therapy" those therapies involving HCT/Ps that meet specified criteria pursuant to, or that qualify for an exception under, federal law. The bill would require only health care practitioners who perform a stem cell therapy that is subject to FDA regulation, and that is not FDA-approved, to provide the notice and writing to their patients. The bill would exempt from these requirements a health care practitioner who has obtained clearance for an investigational new drug, or an investigational device exemption, from the FDA.

(2) Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, establishes the Emergency Medical Services Authority. The authority is responsible for the coordination and integration of all statewide activities concerning emergency medical services.

The act requires health facilities to notify prehospital emergency medical care personnel who have provided emergency medical or rescue services, and have been exposed to a person afflicted with a reportable communicable disease or condition, that they have been exposed. If the affected prehospital emergency medical care person has not provided the health facility infection control officer, as defined, with his or her name and telephone number, existing law requires the health facility infection control officer to immediately notify the designated officer of the employer of the prehospital emergency medical care person and the county health officer under specified circumstances. Otherwise, existing law requires the health facility infection control officer to notify the prehospital emergency medical care person consistent with certain state regulations.

This bill would instead require the health facility infection control officer, in the latter circumstance, to notify the designated officer, not the prehospital emergency medical care person, consistent with those regulations.

(3) Existing law authorizes a local health officer to declare a local health emergency under specified circumstances, including when the release or escape of a hazardous waste or medical waste is an immediate threat to the public health, or upon an imminent and proximate threat of the introduction of certain diseases, chemical agents, toxins, or radioactive agents. Existing law authorizes the local health emergency to remain in effect for 7 days unless the board of supervisors or city council ratifies the local health emergency for a longer period of time. Existing law thereafter requires the board of supervisors or city council

to review the need for continuing that local health emergency at least every 14 days.

This bill would instead require the board of supervisors or city council to review the need for continuing that local health emergency at least every 30 days.

~~(3)~~

(4) Existing law provides the State Department of State Hospitals with jurisdiction over the execution of laws relating to care and treatment of persons with mental health disorders under the custody of the department. Existing law provides that the Chief, Deputy Chief, supervising investigators, and investigators of the Office of Protective Services of the department are peace officers whose authority extends to any place in the state for the purpose of performing their primary duty or when making an arrest, as specified.

This bill would designate the Chief of the Office of Protective Services of the department as the deputy director of the office, with oversight of all protective service components within the department's law enforcement and fire protection services. The bill would require that the deputy director be an experienced law enforcement officer, as specified.

Existing law requires the Director of State Hospitals to appoint and define the duties of the clinical director and the hospital administrator for each state hospital. Existing law requires the Director of State Hospitals to appoint either the clinical director or the hospital administrator to be the hospital director.

This bill would additionally require the Director of State Hospitals to appoint and define the duties of the chief of police services and the hospital director for each state hospital, and would repeal the above provision requiring the appointment of the clinical director or hospital administrator as hospital director. The bill would make conforming changes to related provisions.

Existing law requires the hospital administrator to be responsible for preserving the peace in the hospital buildings and grounds and authorizes him or her to arrest persons, as specified.

This bill would transfer that duty and that authority to the chief of police services at the hospital, and would require the chief of police services to be an experienced law enforcement officer, as specified.

Existing law authorizes the hospital administrator of each state hospital to designate, as a police officer, one or more of the bona fide employees of the hospital. Under existing law, the hospital administrator

and each of those police officers have the powers and authority conferred by law upon peace officers, as specified. Existing law prohibits those police officers from receiving compensation, as specified.

This bill would repeal the authority of the hospital administrator to designate hospital employees as police officers. The bill would replace the hospital administrator with the chief of police services for purposes of peace officer powers, and would remove the prohibition on compensation of the police officers. The bill would further make conforming changes to related provisions and would add that the chief of police services and the hospital police officers are required to help ensure integration of treatment, safety, and security, as directed by the hospital director.

(5) Existing law, the Bronzan-McCorquodale Act, contains provisions governing the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law requires the board of supervisors of each county, or boards of supervisors of counties acting jointly, to adopt, and submit to the Director of Health Care Services in the form and according to the procedures specified by the director, a proposed annual county mental health services performance contract for mental health services in the county or counties. Existing law requires the State Department of Health Care Services to develop and implement the requirements, format, procedure, and submission dates for the preparation and submission of the proposed performance contract. Existing law requires the Director of Health Care Services, or his or her designees, to review each proposed county mental health services performance contract to determine that it complies with specified requirements.

This bill would repeal those provisions relating to an annual county mental health services performance contract, and would instead require the department and each county to have a performance contract for community mental health services, the Mental Health Services Act, the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other federal grants or county mental health programs for the term of 3 years, as specified. The bill would authorize the department to extend the term of the contract for 2 one-year periods, as specified. The bill would further authorize the department to amend the contract at any time during the term of the contract, as specified.

Existing law requires the proposed annual county mental health services performance contract to include specified provisions, and authorizes the county to choose to include contract provisions for other state-directed mental health managed programs within the performance contract.

This bill would delete that authorization and would instead authorize the department to include contract provisions for other federal grants or county mental health programs in the performance contract. The bill would also delete obsolete provisions and make related, conforming changes.

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

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

SECTION 1. Section 684 of the Business and Professions Code is amended to read:

684. (a) For the purpose of this section:

(1) "FDA" means the United States Food and Drug Administration.

(2) "HCT/Ps" means human cells, tissues, or cellular or tissue-based products, as defined in Section 1271.3 of Title 21 of the Code of Federal Regulations, as amended August 31, 2016, as published in the Federal Register (81 Fed. Reg. 60223).

(3) "Stem cell therapy" means a therapy involving the use of HCT/Ps, but shall not include a therapy involving HCT/Ps that meets the criteria set out in Section 1271.10 of Title 21 of the Code of Federal Regulations, as amended May 25, 2004, as published in the Federal Register (69 Fed. Reg. 29829), or that qualifies for any of the exceptions described in Section 1271.15 of Title 21 of the Code of Federal Regulations, as amended May 25, 2004, as published in the Federal Register (69 Fed. Reg. 29829).

(b) (1) A health care practitioner licensed under this division who performs a stem cell therapy that is subject to FDA regulation, but is not FDA-approved, shall communicate to a patient seeking stem cell therapy the following information in English:

"THIS NOTICE MUST BE PROVIDED TO YOU UNDER CALIFORNIA LAW. This health care practitioner performs one or more stem cell therapies that have not been approved by the

United States Food and Drug Administration. You are encouraged to consult with your primary care physician prior to undergoing a stem cell therapy."

(2) The information in paragraph (1) shall be communicated to the patient in all of the following ways:

(A) In a prominent display in an area visible to patients in the health care practitioner's office and posted conspicuously in the entrance of the health care practitioner's office. These notices shall be at least eight and one-half inches by 11 inches and written in no less than 40-point type.

(B) Prior to providing the initial stem cell therapy, a health care practitioner shall provide the patient with the notice described in paragraph (1) in writing. The notice shall be at least eight and one-half inches by 11 inches and written in no less than 40-point type.

(c) This section does not apply to a health care practitioner licensed under this division who has obtained approval or clearance for an investigational new drug, or an investigational device exemption, from the FDA for the use of HCT/Ps.

(d) (1) The licensing board having jurisdiction of the health care practitioner may cite and fine the health care practitioner, not to exceed one thousand dollars ($1,000) per violation of this section.

(2) No citation shall be issued and no fine shall be assessed upon the first complaint against a health care practitioner who violates this section.

(3) Upon a second or subsequent violation of this section, a citation and administrative fine not to exceed one thousand dollars ($1,000) per violation may be assessed.

(e) The Medical Board of California shall indicate in its annual report, commencing with the 2018–19 annual report, all of the following with regard to licensees who provide stem cell therapies:

(1) The number of complaints received.

(2) Any disciplinary actions taken.

(3) Any administrative actions taken.

SEC. 2. Section 1797.188 of the Health and Safety Code is amended to read:

1797.188. (a) As used in this section:

(1) "Prehospital emergency medical care person or personnel" means any of the following: an authorized registered nurse or mobile intensive care nurse, emergency medical technician-I, emergency medical technician-II, emergency medical technician-paramedic, lifeguard, firefighter, or peace officer, as defined or described by Sections 1797.56, 1797.80, 1797.82, 1797.84, 1797.182, and 1797.183, respectively, or a physician and surgeon who provides prehospital emergency medical care or rescue services.

(2) "Reportable communicable disease or condition" or "a communicable disease or condition listed as reportable" means those diseases prescribed by Subchapter 1 (commencing with Section 2500) of Chapter 4 of Title 17 of the California Code of Regulations, as may be amended from time to time.

(3) "Exposed" means at risk for contracting the disease, as defined by regulations of the state department.

(4) "Health facility" means a health facility, as defined in Section 1250, including a publicly operated facility.

(5) "Health facility infection control officer" means the official or officer who has been designated by the health facility to communicate with a designated officer, or his or her designee.

(6) "Designated officer" means the official or officer of an employer of a prehospital emergency medical care person or personnel who has been designated by the state's public health officer or the employer.

(7) "Urgency reporting requirement" means a disease required to be reported immediately by telephone or reported by telephone within one working day pursuant to subdivisions (h) and (i) of Section 2500 of Title 17 of the California Code of Regulations.

(b) In addition to the communicable disease testing and notification procedures applicable under Chapter 3.5 (commencing with Section 120260) of Part 1 of Division 105, all prehospital emergency medical care personnel, whether volunteers, partly paid, or fully paid, who have provided emergency medical or rescue services and have been exposed to a person afflicted with a communicable disease or condition listed as reportable, which can, as determined by the county health officer, be transmitted through physical or oral contact or secretions of the body, including blood, shall be notified that they have been exposed to the disease or condition in accordance with the following:

(1) If the prehospital emergency medical care person, who has rendered emergency medical or rescue services and believes that he or she may have been exposed to a person afflicted with a reportable communicable disease or condition in a manner that could result in transmission of a reportable communicable disease or condition, and provides the health facility infection control officer with his or her name and telephone number at the time the patient is transferred from that prehospital emergency medical care person to the admitting health facility; or the party transporting the person afflicted with the reportable communicable disease or condition provides that health facility with the name and telephone number of the prehospital emergency medical care person who provided the emergency medical or rescue services and believes he or she may have been exposed to a person afflicted with a reportable communicable disease or condition in a manner that could result in transmission of a communicable disease or condition, the health facility infection control officer, upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services is diagnosed as being afflicted with a reportable communicable disease or condition, and that the reportable communicable disease or condition may have been transmitted during the provision of emergency medical or rescue services, shall immediately notify the designated officer of the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the health facility infection control officer shall notify the designated officer consistent with Section 2500 of Title 17 of the California Code of Regulations. The health facility infection control officer shall also report the name and telephone number of the prehospital emergency medical care person to the county health officer. The designated officer shall immediately notify the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the

exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the designated officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations.

(2) If the prehospital emergency medical care person who has rendered emergency medical or rescue services and has been exposed to a person afflicted with a reportable communicable disease or condition, but has not provided the health facility infection control officer with his or her name and telephone number pursuant to paragraph (1), the health facility infection control officer, upon determining that the person to whom the prehospital emergency medical care person provided the emergency medical or rescue services is diagnosed as being afflicted with a reportable communicable disease or condition that may have been transmitted during provision of emergency medical or rescue services, shall immediately notify the designated officer of the employer of the prehospital emergency medical care person and the county health officer if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the health facility infection control officer shall notify the designated officer consistent with Section 2500 of Title 17 of the California Code of Regulations. The designated officer shall immediately notify the prehospital emergency medical care person if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition. Otherwise, the designated officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations.

(c) The county health officer shall immediately notify the prehospital emergency medical care person who has provided emergency medical or rescue services and has been exposed to a person afflicted with a communicable disease or condition listed as reportable, which can, as determined by the county health officer, be transmitted through oral contact or secretions of the body, including blood, if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the prehospital emergency medical care person and the blood of the person afflicted with the reportable communicable disease or condition, upon receiving the report from a health facility pursuant to paragraph (1) of subdivision (b). Otherwise, the county health officer shall notify the prehospital emergency medical care person consistent with Section 2500 of Title 17 of the California Code of Regulations. The county health officer shall not disclose the name of the patient or other identifying characteristics to the prehospital emergency medical care person.

(d) An employer of a prehospital emergency medical care person or personnel that maintains an Internet Web site shall post the title and telephone number of the designated officer in a conspicuous location on its Internet Web site accessible from the home page. A health facility that maintains an Internet Web site shall post the title and telephone number of the health facility infection control officer in a conspicuous location on its Internet Web site accessible from the home page.

(e) (1) The health facility infection control officer, or his or her designee, shall be available either onsite or on call 24 hours per day.

(2) The designated officer, or his or her designee, shall be available either onsite or on call 24 hours per day.

(f) An employer of a health facility infection control officer and an employer of a prehospital emergency medical care person or personnel shall inform those employees of this law as part of the Cal-OSHA Injury and Illness Prevention Program training required by paragraph (7) of subdivision (a) of Section 3203 of Title 8 of the California Code of Regulations.

(g) Nothing in this section shall be construed to authorize the further disclosure of confidential medical information by the health facility, the designated officer, or any prehospital emergency medical care personnel described in this section except as otherwise authorized by law.

(h) In the event of the demise of the person afflicted with the reportable communicable disease or condition, the health facility or county health officer shall notify the funeral director, charged with removing the decedent from the health facility, of the reportable communicable disease or condition prior to the release of the decedent from the health facility to the funeral director.

(i) Notwithstanding Section 1798.206, a violation of this section is not a misdemeanor.

SEC. 3. Section 101080 of the Health and Safety Code is amended to read:

101080. Whenever a release, spill, escape, or entry of waste occurs as described in paragraph (2) of subdivision (b) of Section 101075 and the director or the local health officer reasonably determines that the waste is a hazardous waste or medical waste, or that it may become a hazardous waste or medical waste because of a combination or reaction with other substances or materials, and the director or local health officer reasonably determines that the release or escape is an immediate threat to the public health, or whenever there is an imminent and proximate threat of the introduction of any contagious, infectious, or communicable disease, chemical agent, noncommunicable biologic agent, toxin, or radioactive agent, the director may declare a health emergency and the local health officer may declare a local health emergency in the jurisdiction or any area thereof affected by the threat to the public health. Whenever a local health emergency is declared by a local health officer pursuant to this section, the local health emergency shall not remain in effect for a period in excess of seven days unless it has been ratified by the board of supervisors, or city council, whichever is applicable to the jurisdiction. The board of supervisors, or city council, if applicable, shall review, at least every ~~14~~ *30* days until the local health emergency is terminated, the need for continuing the local health emergency and shall proclaim the termination of the local health emergency at the earliest possible date that conditions warrant the termination.

~~SEC. 3.~~

SEC. 4. Section 4005.8 is added to the Welfare and Institutions Code, to read:

4005.8. (a) The Deputy Director of the Office of Protective Services of the Department of State Hospitals has oversight of all protective service components within the department's law enforcement and fire protection services, including those at each state hospital. The deputy director shall be an experienced law enforcement officer who has completed the management training course prescribed by the Commission on Peace Officer Standards and Training, with extensive management experience directing uniformed peace officers and investigation officers.

(b) Wherever the term "Chief of the Office of Protective Services" is used in reference to the State Department of State Hospitals, the term shall be deemed to mean the Deputy Director of the Office of Protective Services of the State Department of State Hospitals.

~~SEC. 4.~~

SEC. 5. Section 4300 of the Welfare and Institutions Code is amended to read:

4300. As used in this chapter, "officers" of a state hospital means:

(a) Clinical director.

(b) Hospital administrator.

(c) Hospital director.

(d) Chief of police services at the hospital.

~~SEC. 5.~~

SEC. 6. Section 4301 of the Welfare and Institutions Code is amended to read:

4301. (a) The Director of State Hospitals shall appoint and define the duties, subject to the laws governing civil service, of the clinical director, the hospital administrator, the hospital director, and the chief of police services for each state hospital.

(b) The Director of State Hospitals shall appoint a program director for each program at a state hospital.

~~SEC. 6.~~

SEC. 7. Section 4311 of the Welfare and Institutions Code is amended to read:

4311. (a) The chief of police services at the hospital shall be responsible for preserving the peace in the hospital buildings and

grounds and may arrest or cause the arrest and appearance before the nearest magistrate for examination, of all persons who attempt to commit or have committed a public offense thereon.

(b) The chief of police services shall be an experienced law enforcement officer who has completed the management training course prescribed by the Commission on Peace Officer Standards and Training, with management experience directing uniformed peace officers and investigation officers.

~~SEC. 7.~~

SEC. 8. Section 4313 of the Welfare and Institutions Code is amended to read:

4313. The chief of police services and each hospital police officer have the powers and authority conferred by law upon peace officers listed in Section 830.38 of the Penal Code. When and as directed by the hospital director, the chief of police services and those police officers shall enforce the rules and regulations of the hospital, preserve peace and order on the premises thereof, protect and preserve the property of the state, and help ensure integration of treatment, safety, and security.

SEC. 9. Section 5349 of the Welfare and Institutions Code is amended to read:

5349. This article shall be operative in those counties in which the county board of supervisors, by resolution or through the county budget process, authorizes its application and makes a finding that no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of the implementation of this article. To the extent otherwise permitted under state and federal law, counties that elect to implement this article may pay for the provision of services under Sections 5347 and 5348 using funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund 2011, funds from the Mental Health Services Fund when included in county plans pursuant to Section 5847, and any other funds from which the Controller makes distributions to the counties for those purposes. Compliance with this section shall be monitored by the State Department of Health Care ~~Services as part~~

~~of its review and approval of county performance contracts.~~ *Services.*

SEC. 10. Section 5650 of the Welfare and Institutions Code is repealed.

~~5650. (a) The board of supervisors of each county, or boards of supervisors of counties acting jointly, shall adopt, and submit to the Director of Health Care Services in the form and according to the procedures specified by the director, a proposed annual county mental health services performance contract for mental health services in the county or counties.~~

~~(b) The State Department of Health Care Services shall develop and implement the requirements, format, procedure, and submission dates for the preparation and submission of the proposed performance contract.~~

SEC. 11. Section 5650 is added to the Welfare and Institutions Code, to read:

5650. (a) The State Department of Health Care Services and each county shall have a performance contract for community mental health services, the Mental Health Services Act, the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other federal grants or other county mental health programs.

(b) The department shall develop the county mental health services performance contract, which shall be effective for an initial period of three years. The department shall provide the three-year performance contract to the county by January 2 of the year the existing performance contract expires. The county shall adopt, execute, and return the performance contract by May 1 of the year the existing contract expires.

(c) The department may extend the term of the contract for two one-year periods. If the department extends the term of the performance contract, the department shall notify the county by January 2 of the year the existing performance contract expires. The county shall adopt, execute, and return the extension to the performance contract by May 1 of the year the existing contract expires.

(d) The department may amend the contract at any time during the term of the contract and the county shall have 90 days from receipt of an amendment to adopt, execute, and return the amendment to the department.

(e) For the purposes of this chapter, provisions of law referring to the county shall be construed to include counties, counties acting jointly, and cities receiving funds pursuant to Section 5701.5.

SEC. 12. Section 5651 of the Welfare and Institutions Code is amended to read:

5651. *(a) Counties shall comply with the terms of the county mental health services performance contract.*

(b) The ~~proposed annual~~ county mental health services performance contract shall include all of the ~~following:~~ *following provisions:*

~~(a) The following assurances:~~

(1) That the county ~~is in compliance~~ *shall comply* with the expenditure requirements of Section 17608.05.

(2) That the county shall provide services to persons receiving involuntary treatment as required by Part 1 (commencing with Section 5000) and Part 1.5 (commencing with Section 5585).

(3) That the county shall comply with all requirements necessary for Medi-Cal reimbursement for mental health treatment services and case management programs provided to Medi-Cal eligible individuals, including, but not limited to, the provisions set forth in Chapter 3 (commencing with Section 5700), and that the county shall submit cost reports and other data to the department in the form and manner determined by the State Department of Health Care Services.

(4) That the local mental health advisory board has reviewed and approved procedures ensuring citizen and professional involvement at all stages of the planning process pursuant to Section 5604.2.

(5) That the county shall comply with all provisions and requirements in law pertaining to patient rights.

(6) That the county shall comply with all requirements in federal law and ~~regulation~~ *regulation, and all agreements, certifications, assurances, and policy letters,* pertaining to federally funded mental health ~~programs.~~ *programs, including, but not limited to, the Projects for Assistance in Transition from Homelessness and Community Mental Health Services Block Grant programs.*

(7) That the county shall provide all data and information set forth in Sections 5610 and 5664.

(8) That the county, if it elects to provide the services described in Chapter 2.5 (commencing with Section 5670), shall comply

with guidelines established for program initiatives outlined in that chapter.

(9) ~~Assurances that~~ *That* the county shall comply with all applicable laws and regulations for all services delivered, including all laws, regulations, and guidelines of the Mental Health Services Act.

~~(b) Any contractual requirements needed for any program initiatives utilized by the county contained within this part. In addition, any county may choose to include contract provisions for other state directed mental health managed programs within this performance contract.~~

~~(c)~~

(10) The State Department of Health Care Services' ability to monitor the county's three-year program and expenditure plan and annual update pursuant to Section 5847.

~~(d)~~

(11) Other information determined to be necessary by the director, to the extent this requirement does not substantially increase county costs.

(c) The State Department of Health Care Services may include contract provisions for other federal grants or county mental health programs in this performance contract.

SEC. 13. Section 5651.2 of the Welfare and Institutions Code is repealed.

~~5651.2. For the 1991–92 fiscal year, each county shall, no later than October 1, 1991, submit to the department a simplified performance contract. The performance contract shall contain information that the department determines necessary for the provision and funding of mental health services provided for in law. The performance contract shall include, but not be limited to, assurances necessary to ensure compliance with federal law. In addition, the performance contract may include provisions governing reimbursement to the state for costs associated with state hospitals and institutions for mental disease.~~

SEC. 14. Section 5666 of the Welfare and Institutions Code is repealed.

~~5666. (a) The Director of Health Care Services, or his or her designee, shall review each proposed county mental health services performance contract to determine that it complies with the requirements of this division.~~

~~(b) The director or his or her designee shall require modifications in the proposed county mental health services performance contract which he or she deems necessary to bring the proposed contract into conformance with the requirements of this division.~~

~~(c) Upon approval by both parties, the provisions of the performance contract required by Section 5651 shall be deemed to be a contractual arrangement between the state and county.~~

SEC. 15. Section 5897 of the Welfare and Institutions Code is amended to read:

5897. (a) Notwithstanding any other state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. For purposes of this section, a county mental health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of those mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through the ~~annual~~ county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2.

(d) The department shall conduct program reviews of performance contracts to determine compliance. Each county performance contract shall be reviewed at least once every three years, subject to available funding for this purpose.

(e) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements. The department shall post on its Internet Web site any plans of correction requested and the related findings.

(f) Contracts awarded by the State Department of Health Care Services, the State Department of Public Health, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890), may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to those contracts.

(g) For purposes of Section 14712, the allocation of funds pursuant to Section 5892 ~~which~~ *that* are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

MBC TRACKER II BILLS
4/11/2018

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 11	McCarty	Early and Periodic Screening, Diagnosis, and Treatment Program	Sen. Health	01/10/18
AB 64	Bonta	Cannabis: Licensure and Regulation	Sen. Approps.	06/27/17
AB 183	Lackey	Bill of Rights for State Excluded Employees	Asm. Inactive	05/25/17
AB 186	Eggman	Controlled Substances: Safer Drug Consumption Program	Sen. Inactive	09/08/17
AB 224	Thurmond	Dentistry: Anesthesia and Sedation	Sen. B&P	05/30/17
AB 238	Steinorth	Emergency Response; Trauma Kits	Sen. Rules	02/21/18
AB 251	Bonta	Health and Care Facilities: Dialysis Clinics	Sen. Inactive	06/29/17
AB 254	Thurmond	Local Educational Agency Behavioral Health Pilot Program	Sen. Approps.	06/28/17
AB 263	Rodriguez	Emergency Medical Services Workers	Sen. Rules	06/21/17
AB 389	Salas	Cannabis: Consumer Guide	Sen. Approps.	07/05/17
AB 444	Ting	Medical Waste: Home Generated Medical Waste	Sen. Env. Quality	04/18/17
AB 451	Arambula	Health Facilities: Emergency Services and Care	Sen. Approps.	07/05/17
AB 479	Gonzalez Fletcher	Workers' Compensation: Permanent Disability	Senate	01/12/18
AB 514	Salas	Medical Waste: Pharmaceuticals	Sen. Env. Quality	04/17/17
AB 613	Nazarian	Healing Arts: Clinical Laboratories	Sen. Inactive	08/29/17
AB 767	Quirk-Silva	Master Business License Act	Sen. B&P	04/05/18
AB 827	Rubio	Department of Consumer Affairs: Task Force: Foreign-Trained Professionals	Sen. Approps.	04/03/17
AB 893	Garcia, E.	Public Health: Graduate Medical Education	Sen. Health	05/11/17
AB 937	Eggman	Health Care Decisions: Order of Priority	Sen. Health	05/03/17
AB 1098	McCarty	Child Death Investigations: Review Teams	Sen. Approps.	05/26/17
AB 1116	Grayson	Peer Support and Crisis Referral Services Act	Sen. Inactive	09/08/17
AB 1136	Eggman	Health Facilities: Residential Mental or Substance Use Disorder	Sen. Health	02/05/18
AB 1372	Levine	Crisis Stabilization Units: Psychiatric Patients	Sen. Inactive	06/13/17
AB 1445	Reyes	Public Contracting: Small Business Goal	Sen. Rules	04/18/17
AB 1659	Low	Healing Arts Boards: Inactive Licenses	Senate	01/03/18

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1753	Low	Controlled Substances: CURES Database	Asm. Public Safety	01/03/18
AB 1779	Nazarian	Sexual Orientation: Change Efforts	Asm. B&P	04/05/18
AB 1787	Salas	Reporting: Valley Fever	Asm. Approps	04/02/18
AB 1790	Salas	Clinics and Hospitals: Valley Fever	Asm. B&P	04/03/18
AB 1801	Nazarian	Newborns: Cytomegalovirus Public Education and Testing	Asm. Health	04/10/18
AB 1860	Limon	Health Care Coverage: Cancer Treatment	Asm. Health	01/10/18
AB 1880	Fong	Valley Fever Reporting	Asm. Health	03/01/18
AB 1881	Fong	Valley Fever Testing	Asm. Health	03/14/18
AB 1893	Maienschein	Maternal Mental Health: Federal Funding	Asm. 3rd Reading	04/09/18
AB 1955	Limon	Alzheimer's Disease and Dementia: Public Awareness Campaign	Asm. Aging & LTC	04/10/18
AB 1963	Waldron	Medi-Cal: Reimbursement: Opioid Addiction Treatment	Asm. Approps	02/20/18
AB 2018	Maienschein	Mental Health Workforce: Loan Repayment	Asm. Approps	04/05/18
AB 2029	Garcia, E.	Public Health	Asm. Health	
AB 2046	Daly	Workers' Compensation Insurance Fraud Reporting	Asm. Approps	04/05/18
AB 2085	Cooley	Retirement Systems: Surviving Spouse	Asm. PERSS	03/20/18
AB 2088	Santiago	Patient Records: Addenda	Assembly	
AB 2099	Gloria	Mental Health: Detention and Evaluation	Asm. 3rd Reading	04/02/18
AB 2122	Reyes	Medi-Cal: Blood Lead Screening Tests	Asm. Health	
AB 2143	Caballero	Mental Health: Licensed Mental Health Service Provider Ed. Prog.	Asm. Health	04/02/18
AB 2167	Chau	Information Privacy: Digital Health Feedback Systems	Asm. Health	03/23/18
AB 2182	Levine	Privacy: DCA: California Data Protection Authority	Asm. P&CP	03/15/18
AB 2196	Cooper	Public Employees' Retirement: Service Credit: Payments	Asm. PERSS	
AB 2198	Obernolte	State Government: FI$Cal: Transparency	Assembly	03/14/18
AB 2200	Patterson	Alcoholism or Drug Abuse Recovery or Treatment Facilities	Asm. Health	04/10/18
AB 2202	Gray	University of California: School of Medicine	Asm. Higher Ed.	

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2203	Gray	Medi-Cal: Primary Care Services	Asm. Health	
AB 2215	Kalra	Cannabis: Veterinarians: Animals	Asm. B&P	03/23/18
AB 2251	Melendez	State Agencies: Audits	Asm. A&AR	
AB 2256	Santiago	Law Enforcement Agencies: Opioid Antagonist	Asm. Public Safety	
AB 2264	Brough	Professions and Vocations: Fees	Asm. B&P	
AB 2275	Arambula	Medi-Cal Managed Care: Quality Assessment and Performance Improvement	Asm Health	04/09/18
AB 2287	Kiley	Mental Health Services Act	Asm. Health	
AB 2302	Baker	Child Abuse: Sexual Assault: Mandated Reporters	Asm. Public Safety	03/15/18
AB 2342	Burke	BRCA Gene Mutations: Screening, Counseling and Testing	Asm. Health	
AB 2384	Arambula	Medication Assisted Treatment	Asm. Health	
AB 2405	Patterson	Controlled Substances: Carfentanil	Asm. Public Safety	
AB 2423	Holden	Physical Therapists: Direct Access to Services	Asm. Approps	04/09/18
AB 2457	Irwin	Podiatry: Podiatric Medical Board of California	Assembly	04/02/18
AB 2476	Rubio	Health and Care Facilities	Asm. Approps	
AB 2481	Voepel	State Employees: Infant at Work Programs	Asm. Approps	04/10/18
AB 2576	Aguiar-Curry	Emergencies: Healthcare	Asm. Health	
AB 2587	Levine	Disability Compensation: Paid Family Leave	Assembly	04/02/18
AB 2643	Irwin	Dentistry: General Anesthesia: Health Care Coverage	Asm. Health	
AB 2653	Allen, T.	Health Care Coverage: Prescriptions	Asm. Health	03/23/18
AB 2668	Allen, T.	Pupil Immunizations: Pupils Not Immunized	Asm. Health	04/02/18
AB 2689	Gray	Contribution and Gift Ban: Senate Confirmation	Asm. E&R	03/14/18
AB 2777	Daly	State Employees: Travel Reimbursements	Asm. A&AR	
AB 2846	Gipson	Organ and Tissue Transplantation: Uninsured or Undocumented	Asm. Health	04/02/18
AB 2859	Caballero	Pharmacy: Safe Storage Products	Asm. Approps	04/02/18
AB 2861	Salas	Medi-Cal: Telehealth: Substance Use Disorder Services	Asm. Health	

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2935	Chau	Health Information Privacy: Digital Commercial Health Monitoring	Asm. P&CP	
AB 2941	Berman	Health Care Coverage: State of Emergency	Asm. Health	
AB 2958	Quirk	State Bodies: Meetings: Teleconference	Asm. Gov. Org.	
AB 2971	Calderon	State Agencies: Administrative Regulations: Review	Asm. A&AR	03/22/18
AB 2976	Quirk	Childhood Lead Poisoning Prevention	Asm. Health	03/15/18
AB 2983	Arambula	Health Care Facilities: Voluntary Psychiatric Care	Asm. Health	
AB 3087	Kalra	California Health Care Cost, Quality, and Equity Commission	Asm. Health	04/09/18
AB 3110	Mullin	Athletic Trainers	Asm. B&P	
AB 3148	Arambula	Health Care Affordability Assistance: Cost Sharing	Asm. Health	03/23/18
AB 3179	Salas	State Agencies: Bilingual Services: Punjabi	Asm. A&AR	
AB 3189	Cooper	Consent by Minors to Treatment for Intimate Partner Violence	Asm. Judiciary	03/15/18
ACA 23	Melendez	Legislative Committees: Prohibition on Holding Bills	Assembly	
ACR 158	Baker	Cancer Screen Week	Asm. Rules	02/27/18
ACR 203	Quirk-Silva	Donate Life/DMV Partnership Month	Sen. Rules	
HR 6	Burke	Relative to Women's Reproductive Health	Adopted	
HR 83	Caballero	Relative to Prescription Drug Abuse Awareness Month	Adopted	03/01/18
SB 21	Hill	Law Enforcement Agencies: Surveillance: Policies	Asm. Approps.	08/21/17
SB 43	Hill	Antimicrobial-Resistant Infection: Reporting	Asm. Health	04/05/17
SB 76	Nielsen	Excluded Employees: Arbitration	Asm. Inactive	06/29/17
SB 162	Allen	Cannabis: Marketing	Asm. Approps.	08/21/17
SB 199	Hernandez	The California Health Care Cost, Quality, and Equity Atlas	Asm. Approps.	03/30/17
SB 212	Jackson	Medical Waste	Asm. E.S.&T.M.	
SB 244	Lara	Privacy: Agencies: Personal Information	Asm. Inactive	09/08/17
SB 275	Portantino	Children, Adolescents, and Young Adults Alcohol and Drug Treatment and Recovery Act	Asm. Rules	

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BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 392	Bates	Dentistry: Report: Access to Care: Pediatric Dental Patients	Asm. B&P	05/26/17
SB 399	Portantino	Health Care Coverage: Pervasive Developmental Disorder/Autism	Assembly	01/22/18
SB 456	Pan	Medi-Cal Managed Care: FQHCs and Rural Health Clinics	Asm. Approps.	06/19/17
SB 501	Glazer	Dentistry: Anesthesia and Sedation: Report	Asm. Approps.	05/01/17
SB 538	Monning	Hospital Contracts	Asm. Health	05/26/17
SB 555	Morrell	Regulations: 5-year Review and Report	Sen. G.O.	
SB 562	Lara	The Healthy California Act	Assembly	05/26/17
SB 715	Newman	DCA: Regulatory Boards: Removal of Board Members	Asm. Inactive	04/25/17
SB 762	Hernandez	Healing Arts Licensee: License Activation Fee: Waiver	Asm. B&P	04/17/17
SB 783	Pan	State Employment: Unused Leave Buy-Back	Assembly	
SB 902	Bates	Alcoholism or Drug Abuse Recovery or Treatment Facilities	Sen. Health	04/09/18
SB 906	Beall	Medi-Cal: Mental Health Services	Sen. Approps.	01/17/18
SB 921	Morrell	State Agencies: Internet Websites: Disclosure of Financial Info.	Sen. G.O.	04/02/18
SB 945	Atkins	Breast and Cervical Cancer Treatment Program	Sen. Health	
SB 984	Skinner	State Boards and Commissions: Representation: Women	Sen. Judiciary	
SB 992	Hernandez	Alcoholism or Drug Abuse Recovery or Treatment Facilities	Sen. Health	04/02/18
SB 997	Monning	Health Care Service Plans: Physician to Enrollee Ratios	Sen. Approps.	
SB 1003	Roth	Respiratory Therapy	Sen. Approps.	
SB 1023	Hernandez	Reproductive Health Care Coverage	Sen. Health	03/12/18
SB 1034	Mitchell	Health Care: Mammograms	Sen. Health	
SB 1041	Leyva	Childhood Lead Poisoning Prevention	Sen. Approps.	04/09/18
SB 1047	Nielsen	Medi-Cal: Reimbursement Rates: Rural Counties	Sen. Rules	
SB 1060	Mendoza	Public Employees' Retirement Law: Employer Contributions	Sen. Rules	
SB 1123	Jackson	Disability Compensation: Paid Family Leave	Sen. L&IR	03/22/18
SB 1124	Leyva	Public Employees' Retirement System: Collective Bargaining	Sen. P.E. &R	03/22/18

MBC TRACKER II BILLS
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BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1149	Glazer	Public Employees' Retirement: Defined Contribution Program	Sen. P.E. &R	04/10/18
SB 1150	Jackson	Gender Discrimination	Sen. Judiciary	
SB 1180	Newman	California Disabled Veteran Business Enterprise Program	Sen. Vet. Affairs	03/19/18
SB 1229	Stone	Pharmacists: Opioid Medications: Consultation	Sen. B&P	04/09/18
SB 1241	Nguyen	Income Taxes: Credit: Healing Arts Licensees: Volunteers	Sen. Gov. & Fin.	04/02/18
SB 1244	Wieckowski	Public Records: Disclosure	Sen. Judiciary	03/21/18
SB 1264	Stone	Medi-Cal: Hypertension Medication Management Services	Sen. B&P	03/21/18
SB 1290	Bates	Substance Abuse Disorder Treatment	Sen. Health	03/22/18
SB 1297	Moorlach	Office of the State Operations	Sen. G.O.	04/02/18
SB 1303	Pan	Coroner: County Office of the Medical Examiner	Sen. Gov. & Fin.	03/22/18
SB 1322	Stone	Medi-Cal: Comprehensive Medication Management	Sen. Health	03/22/18
SB 1396	Galgiani	Accessible State Technology	Sen. G.O.	
SB 1423	Hernandez	Medi-Cal: Oral Interpretation Services	Sen. Rules	04/09/18
SCA 8	Moorlach	Public Employee Retirement Benefits	Sen. P.E. &R	
SCA 10	Moorlach	Public Employee Retirement Benefits	Sen. P.E. &R	
SCR 104	Hertzberg	National Nutrition Month	Assembly	02/27/18
SB 115	McGuire	Opioid Crisis	Sen. Approps.	04/09/18
SR 12	Atkins	Relative to Women's Reproductive Health	Adopted	
SR 26	Hernandez	Relative to the Patient Protection and Affordable Care Act	Adopted	03/09/17
SR 82	Gaines	Relative to Opioid Death Awareness Week	Sen. Inactive	