LEGISLATIVE COMMITTEE MEETING

AGENDA

MemorialCare Health System
17360 Brookhurst Street, 3rd Floor
Aliso Assembly Room
Fountain Valley, CA 92708
(714) 377-2900

May 9, 2019

THIS MEETING WILL IMMEDIATELY FOLLOW THE CONCLUSION OF THE EDUCATION/LICENSESING COMMITTEE MEETING

Thursday, May 9, 2019

8.0 Call to Order/Roll Call/Establishment of a Quorum/Approval of Minutes

8.0.1 Review and Vote on Whether to Approve Previous Meeting Minutes:
➢ March 14, 2019

8.1 Discussion of Bills of Interest to the Board of Registered Nursing (Board) and Possible Vote to Recommendation that the Board Adopt or Modify Positions on Bills Introduced during the 2019-2020 Legislative Session:

➢ AB 8 (Chu) Pupil health: mental health professionals
➢ AB 62 (Fong) State government: Fi$Cal: transparency
➢ AB 63 (Fong) State government
➢ AB 193 (Patterson) Professions and vocations
➢ AB 239 (Salas) Community colleges: registered nursing programs
➢ AB 241 (Kamlager-Dove) Implicit bias: continuing education: requirements.
➢ AB 251 (Patterson) Personal income taxes: credit: family caregiver
➢ AB 312 (Cooley) State government: administrative regulations: review
➢ AB 329 (Rodriguez) Hospitals: assaults and batteries
➢ AB 358 (Low) Sexual assault: medical examination
➢ AB 362 (Eggman) Controlled substances: overdose prevention program
➢ AB 389 (Arambula) Substance use disorder treatment: peer navigators
➢ AB 476 (Blanca Rubio) Department of Consumer Affairs: task force: foreign-trained professionals
➢ AB 496 (Low) Business and Professions
➢ AB 535 (Brough) Personal income taxes: credit: professional license fees
➢ AB 538 (Berman) Sexual assault: forensic examinations and reporting
➢ AB 544 (Kiley) Professions and vocations: inactive license fees and accrued and unpaid renewal fees
➢ **AB 613** (Low) Professions and vocations: regulatory fees

➢ **AB 714** (Wood) Opioid prescription drugs: prescribers

➢ **AB 732** (Bonta) County jails: pregnant inmates

➢ **AB 743** (Eduardo Garcia) Pupil health: medication assistance: written physician statement

➢ **AB 768** (Brough) Professions and vocations

➢ **AB 822** (Irwin) Phlebotomy

➢ **AB 845** (Maienschein) Continuing education: physicians and surgeons: nurses: maternal mental health

➢ **AB 862** Professions and vocations: license revocation and suspension: student loan default.

➢ **AB 890** (Wood) Nurse practitioners

➢ **AB 931** (Boerner Horvath) State and local boards and commissions: representation: appointments

➢ **AB 993** (Nazarian) Health care coverage: HIV specialists

➢ **AB 1051** (Smith) Community colleges: temporary faculty members: clinical nursing faculty

➢ **AB 1145** (Cristina Garcia) Child abuse: reportable conduct

➢ **AB 1264** (Petrie-Norris) Healing arts licensees: self-administered hormonal contraceptives

➢ **AB 1271** (Diep) Licensing examinations: report

➢ **AB 1364** (Blanca Rubio) Nursing: schools and programs: analysis

➢ **AB 1444** (Flora) Physicians and surgeons and registered nurses: loan repayment grants

➢ **AB 1490** (Carrillo) Medical assistants

➢ **AB 1514** (Patterson) Deaf and Disabled Telecommunications Program

➢ **AB 1529** (Low) Telephone medical advice services

➢ **AB 1544** (Gipson) Community Paramedicine or Triage to Alternate Destination Act

➢ **AB 1592** (Bonta) Athletic trainers

➢ **AB 1622** (Carrillo) Family physicians

➢ **AB 1676** (Maienschein) Health care: mental health

➢ **SB 24** (Leyva) Public health: public university student health centers: abortion by medication techniques

➢ **SB 53** (Wilk) Open meetings

➢ **SB 207** (Hurtado) Medi-Cal: asthma preventive services

➢ **SB 223** (Hill) Pupil health: administration of medicinal cannabis: schoolsites

➢ **SB 227** (Leyva) Health and care facilities: inspections and penalties

➢ **SB 305** (Hueso) Access to Cannabis in Healthcare Facilities Act

➢ **SB 322** (Bradford) Health facilities: inspections: employee reporting

➢ **SB 425** (Hill) Health care practitioners: licensee’s file: probationary physician’s and surgeon’s certificate: unprofessional conduct


➢ **SB 567** (Caballero) Workers compensation: hospital workers

➢ **SB 601** (Morrell) State agencies: licenses: fee waiver

➢ **SB 697** (Caballero) Physician assistants: practice agreements: supervision

➢ **SB 700** (Roth) Business and professions: noncompliance with support orders and tax delinquencies
8.2 Public Comment for Items Not on the Agenda; Items for Future Agendas

NOTE: The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting. (Government Code, Sections 11125 and 11125.7(a)).

8.3 Adjournment

NOTICE:

All times are approximate and subject to change. Items may be taken out of order to maintain a quorum, accommodate a speaker, or for convenience. The meeting may be canceled without notice. For verification of the meeting, call (916) 574-7600 or access the Board’s Web Site at http://www.rn.ca.gov. Action may be taken on any item listed on this agenda, including information only items. Board members who are not members of this committee may attend meetings as observers only, and may not participate or vote.

Public comments will be taken on agenda items at the time the item is heard. Total time allocated for public comment may be limited. The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the Administration Unit at (916) 574-7600 or email webmasterbrn@dca.ca.gov or send a written request to the Board of Registered Nursing Office at 1747 North Market Blvd., Suite 150, Sacramento, CA 95834. (Hearing impaired: California Relay Service: TDD phone # (800) 326-2297. Providing your request at least five (5) business days before the meeting will help to ensure the availability of the requested accommodation.
DATE: March 14, 2019
TIME: 12:20 p.m.
LOCATION: Sutter Health
Big Sur/Manchester Room
2700 Gateway Oaks Drive
Sacramento, California 95833

MEMBERS PRESENT: Trande Phillips, Acting Chairperson
Imelda Ceja-Butkiewicz
Michael Jackson

MEMBERS ABSENT: Donna Gerber

STAFF PRESENT: Dr. Joseph Morris, Executive Officer
Stacie Berumen, Assistant Executive Officer
Thelma Harris, Chief of Legislation
Ann Salisbury, Legal Counsel

8.0 Call to Order, Roll Call, Establishment of a Quorum, and Approval of Minutes:
Trande Phillips called the meeting to order at 12:20 following the conclusion of the
Education/Licensing Committee.

8.0.1 Review and Vote on Whether to Approve Previous Meeting’s Minutes:
➢ January 10, 2019

| Motion: Approve the Minutes of January 10, 2019, by Trande Phillips |
| Second: Imelda Ceja-Butkiewicz |
| TP: Yes | I C-B: Yes | MJ: Abstain |

8.1 Discussion of Bills of Interest to the Board of Registered Nursing(Board) and
Recommendation that the Board Adopt or Modify positions on the Bills Introduced
during the 2019-2020 Legislative Session
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AB 1051 (Smith) Community colleges: temporary faculty members: clinical nursing faculty
AB 1145 (Cristina Garcia) Child abuse: reportable conduct
AB 1271 (Diep) Licensing examinations: report
AB 1364 (Blanca Rubio) Nursing: schools and programs: analysis
AB 1490 (Carrillo) Medical assistants
AB 1529 (Low) Telephone medical advice services
AB 1544 (Gipson) Community Paramedicine or Triage to Alternate Destination Act
AB 1622 (Carrillo) Family physicians
AB 1676 (Maienschein) Health care: mental health

SB 53 (Wilk) Open meetings
SB 207 (Hurtado) Medi-Cal: asthma preventive services
SB 223 (Hill) Pupil health: administration of medicinal cannabis: schoolsites
SB 227 (Leyva) Health and care facilities: inspections and penalties
SB 305 (Hueso) Access to Cannabis in Healthcare Facilities Act
SB 322 (Bradford) Health facilities: inspections: employee reporting
SB 425 (Hill) Health care practitioners: licensee’s file: probationary physician’s and surgeon’s certificate: unprofessional conduct
SB 601 (Morrell) State agencies: licenses: fee waiver
SB 697 (Caballero) Physician assistants: scope of practice
SB 700 (Roth) Business and professions: noncompliance with support orders and tax delinquencies

Public Comment:
Garrett Chan, HealthImpact re AB 890
B.J. Bartelson, CHA re AB 890
Saskia Kim, CNA re ABs 193, 312, 1544 and SB 322

<table>
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<tr>
<th>Motion:</th>
<th>Trande Phillips: Adopt a Watch position for the listed bills</th>
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<tr>
<td>Second:</td>
<td>Michael Jackson</td>
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<td>TP:</td>
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8.2 Public Comment for Items Not on the Agenda; Items for a Future Agenda
Saskia Kim, CNA re: ABs 241, 822, 1014 and SB 567

The meeting adjourned at 12:35 p.m.

Submitted by: __________________________ Approved by:_______________________________
Kay Weinkam, Nursing Education Consultant/ Trande Phillips, Acting Chair
Legislative Liaison Legislative Committee
BOARD OF REGISTERED NURSING

LEGISLATIVE COMMITTEE MEETING MINUTES

DATE: January 10, 2019
TIME: 2:54 p.m.-3:01 p.m.
LOCATION: California State University- San Bernardino
Santos Manuel Student Union (SMSU)- Rm 215-218
5500 University Parkway
San Bernardino, California 92407

MEMBERS PRESENT: Donna Gerber, Chairperson
Imelda Ceja-Butkiewicz
Michael Jackson

MEMBERS ABSENT: Barbara Yaroslavsky
Trande Phillips

STAFF PRESENT: Dr. Joseph Morris, Executive Officer
Stacie Berumen, Assistant Executive Officer
Ann Salisbury, Legal Counsel

8.1 Call to Order, Roll Call, Establishment of a Quorum, and Approval of Minutes:
Donna Gerber called the meeting to order at 2:52 p.m. following the conclusion of the Board meeting.
Ms. Gerber as Vice President appointed Michael Jackson to the Committee for today’s meeting in order
that a quorum be present.

8.1.1 Review and Approve Minutes: October 11, 2018

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<th>Motion: Approve the Minutes of October 11, 2018, by Imelda Ceja-Butkiewicz</th>
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<td>Second: Donna Gerber</td>
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<td>DG: Yes</td>
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8.2 Summary of Accomplishments: Goals and Objectives for the 2017-2018 Legislative Session
Information only. No public comment.

8.3 Discussion and Possible Action Regarding Revising or Recommending Goals and Objective for the 2019-2020 Legislative Session
Motion: Approve recommending the goals and objectives as revised to the full board, by Imelda Ceja-Butkiewicz

Second: Michael Jackson

DG: Yes | IC-B: Yes | MJ: Yes

No public comment.

8.4 Summary of Relevant Legislation Chaptered in 2018

Information only. No public comment.

8.5 Discuss Bills of Interest to the Board of Registered Nursing (Board) and Recommend that the Board Adopt or Modify positions on the Bills Introduced during the 2019-2020 Legislative Session

- AB 8 (Chu) Pupil health: mental health professionals
- AB 62 (Fong) State government: FinCal: transparency
- SB 24 (Leyva) Public health: public university student health centers: abortion by medication techniques

Bills were presented to the committee. No action was taken.

8.6 Public Comment for Items Not on the Agenda

No public comment.

The meeting adjourned at 3:01 p.m.

Submitted by: Kay Weinkam, Nursing Education Consultant/ Legislative Liaison

Approved by: Trande Phillips, Acting Chair

Trande Phillips, Acting Chair
Legislative Committee
# 2019-2020 Goals and Objectives

**GOAL 1:** Keep the Board of Registered Nursing informed about pertinent legislation that may affect nursing practice, education, nurses' roles in the delivery of health care, and administrative functions of the Board.

**OBJECTIVE: 1.1** Analyze legislative proposals and make position recommendations to the Board at each Board meeting.

**GOAL 2:** Monitor current legislation on behalf of the Board.

**OBJECTIVE: 2.1** Advocate for or against legislation as directed by the Board.

**OBJECTIVE: 2.2** Review and suggest appropriate amendments as necessary.

**OBJECTIVE: 2.3** Provide testimony to the Legislature, on behalf of the Board.

**OBJECTIVE: 2.4** Facilitate the Chair and Committee members advising the legislature regarding specific legislation.

**GOAL 3:** Serve as a resource to other Board committees on legislative and regulatory matters.

**OBJECTIVE: 3.1** Assist other Board committees in reviewing legislative and regulatory proposals.

**GOAL 4:** Enhance the Board's process to proactively identify legislation that potentially impacts nursing and the Board.

**OBJECTIVE: 4.1** Evaluate resources, e.g. Internet, new legislative publications, etc., as sources of pertinent legislative information.

**OBJECTIVE: 4.2** Maintain consistent dialogue with the Department of Consumer Affairs’ Legislative Unit, legislators, and their staff.

**OBJECTIVE: 4.3** Advise staff and legislators during the sunset review process related to the Board’s sunset date of January 1, 2022.

**GOAL 5:** Monitor legislation and regulations to ensure protection of the existing RN duty of patient advocacy.
AGENDA ITEM: 8.1
DATE: May 9, 2019

ACTIONS REQUESTED: Discuss Bills of Interest to the Board of Registered Nursing (Board) and Possible Action Regarding Adoption or Modification of Positions on the Bills Introduced during the 2019-2020 Legislative Session

REQUESTED BY: Donna Gerber, Chair, Legislative Committee

BACKGROUND: Bills of interest for the 2019-2020 legislative session are listed on the attached table.

**Bold** denotes a new bill for Committee or Board consideration, is one that has been amended since the last Committee or Board meeting, or is one about which the Board has taken a position and may wish to discuss further and restate or modify its position.

An analysis of and the bill text for these bills are included for further review.

NEXT STEPS: Present recommendations to the Board

FINANCIAL IMPLICATIONS, IF ANY: As reflected by the proposed legislation

PERSON TO CONTACT: Kay Weinkam, M.S., RN, CNS (916) 574-7600
## JANUARY

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### DEADLINES

- **Jan. 1**: Statutes take effect (Art. IV, Sec. 8(c)).
- **Jan. 7**: Legislature reconvenes (J.R. 51(a)(1)).
- **Jan. 10**: Budget must be submitted by Governor (Art. IV, Sec. 12(a)).
- **Jan. 21**: Martin Luther King, Jr. Day.
- **Jan. 25**: Last day to submit bill requests to the Office of Legislative Counsel.

## FEBRUARY

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- **Feb. 18**: Presidents' Day.
- **Feb. 22**: Last day for bills to be introduced (J.R. 61(a)(1), J.R. 54(a)).

## MARCH

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- **Mar. 29**: Cesar Chavez Day observed.

## APRIL

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- **Apr. 11**: Spring Recess begins upon adjournment (J.R. 51(a)(2)).
- **Apr. 22**: Legislature reconvenes from Spring Recess (J.R. 51(a)(2)).
- **Apr. 26**: Last day for policy committees to meet and report to fiscal committees non-fiscal bills introduced in their house (J.R. 61(a)(2)).

## MAY

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- **May 3**: Last day for policy committees to meet and report to the floor non-fiscal bills introduced in their house (J.R. 61(a)(3)).
- **May 10**: Last day for policy committees to meet prior to June 3 (J.R. 61(a)(4)).
- **May 17**: Last day for fiscal committees to meet and report to the floor bills introduced in their house (J.R. 61(a)(5)). Last day for fiscal committees to meet prior to June 3 (J.R. 61(a)(6)).
- **May 27**: Memorial Day.
- **May 28-31**: Floor session only. No committee may meet for any purpose except Rules Committee, bills referred pursuant to A.R. 77.2, and Conference Committees (J.R. 61(a)(7)).
- **May 31**: Last day for each house to pass bills introduced in that house (J.R. 61(a)(8)).

*Holiday schedule subject to final approval by Rules Committee.*
### 2019 TENTATIVE LEGISLATIVE CALENDAR

Compiled by the Office of the Assembly Chief Clerk and the Office of the Secretary of the Senate

Revised 10-31-18

**JUNE**

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June 3  Committee meetings may resume (J.R. 61(a)(9)).

June 15 Budget Bill must be passed by midnight (Art. IV, Sec. 12(c)(3)).

**JULY**

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July 4  Independence Day.

July 10 Last day for policy committees to hear and report fiscal bills to fiscal committees (J.R. 61(a)(10)).

July 12 Last day for policy committees to meet and report bills (J.R. 61(a)(11)).

**AUGUST**

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Aug. 12  Legislature reconvenes from Summer Recess (J.R. 51(a)(3)).

Aug. 30 Last day for fiscal committees to meet and report bills (J.R. 61(a)(12)).

**SEPTEMBER**

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</table>

Sept. 2  Labor Day.

Sept. 3-13  **Floor session only.** No committees may meet for any purpose, except Rules Committee, bills referred pursuant to A.R. 77.2, and Conference Committees (J.R. 61(a)(13)).

Sept. 6  Last day to amend bills on the floor (J.R. 61(a)(14)).

Sept. 13 Last day for any bill to be passed (J.R. 61(a)(15)). **Interim Recess** begins upon adjournment (J.R. 51(a)(4)).

**IMPORTANT DATES OCCURRING DURING INTERIM RECESS**

2019

*Oct. 13  Last day for Governor to sign or veto bills passed by the Legislature on or before Sept. 13 and in the Governor's possession after Sept. 13 (Art. IV, Sec. 10(b)(1)).

2020

*Jan.  1  Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 6  Legislature reconvenes (J.R. 51(a)(4)).

*Holiday schedule subject to final approval by Rules Committee.
<table>
<thead>
<tr>
<th>BILL #</th>
<th>AUTHOR/ BILL SPONSOR</th>
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<th>COMM POSITION (date)</th>
<th>BOARD POSITION (date)</th>
<th>BILL STATUS as of April 29, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB 8</td>
<td>Chu</td>
<td>Public health: mental health professionals</td>
<td>Information 1/10/19</td>
<td>Information 2/14/19</td>
<td>Assembly APPR</td>
</tr>
<tr>
<td>AB 62</td>
<td>Fong</td>
<td>State government: FI$Cal: transparency</td>
<td>Information 1/10/19</td>
<td>Watch 4/11/19</td>
<td>Assembly A&amp;AR</td>
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<tr>
<td>AB 63</td>
<td>Fong</td>
<td>State government</td>
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<tr>
<td>AB 193</td>
<td>Patterson</td>
<td>Professions and vocations</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Assembly B&amp;P</td>
</tr>
<tr>
<td>AB 239</td>
<td>Salas</td>
<td>Community colleges: registered nursing programs</td>
<td>Watch 3/14/19</td>
<td>Support 4/11/19</td>
<td>Senate Rules</td>
</tr>
<tr>
<td>AB 241</td>
<td>Kamlager-Dove</td>
<td>Implicit bias: continuing education: requirements</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Assembly APPR</td>
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<tr>
<td>AB 251</td>
<td>Patterson</td>
<td>Personal income taxes: credit: family caregiver</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Assembly APPR</td>
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<tr>
<td>AB 312</td>
<td>Cooley</td>
<td>State government: administrative regulations: review</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Assembly APPR</td>
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<tr>
<td>AB 329</td>
<td>Rodriguez</td>
<td>Hospitals: assaults and batteries</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Assembly APPR</td>
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<tr>
<td>AB 358</td>
<td>Low</td>
<td>Sexual assault forensic medical examination kits: databases</td>
<td>Watch 3/14/19</td>
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<td>AB 362</td>
<td>Eggman/ DPA; HRC</td>
<td>Controlled substances: overdose prevention program</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Assembly 3rd Reading</td>
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<td>AB 389</td>
<td>Santiago/ ACEP-California</td>
<td>Substance use disorder treatment: peer navigators</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Assembly Health</td>
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<tr>
<td>AB 476</td>
<td>Blanca Rubio/ CHIRLA</td>
<td>Department of Consumer Affairs: task force: foreign-trained professionals</td>
<td>Watch 3/14/19</td>
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<td>Assembly APPR</td>
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<td>AB 496</td>
<td>Low</td>
<td>Business and professions</td>
<td>Watch 3/14/19</td>
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<td>AB 535</td>
<td>Brough</td>
<td>Personal income taxes: credit: professional license fees</td>
<td>Watch 3/14/19</td>
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<td>Assembly REV&amp;TAX</td>
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<tr>
<td>AB 538</td>
<td>Berman/ CSAFEA</td>
<td>Sexual assault: forensic examinations and reporting</td>
<td>Watch 3/14/19</td>
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<td>AB 544</td>
<td>Kiley</td>
<td>Professions and vocations: inactive license fees and accrued and unpaid renewal fees</td>
<td>Watch 3/14/19</td>
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<td>Assembly APPR</td>
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<td>AB 714</td>
<td>Wood</td>
<td>Opioid prescription drugs: prescribers</td>
<td>Watch 3/14/19</td>
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<td>AB 732</td>
<td>Bonta</td>
<td>County jails: prisons: incarcerated pregnant persons</td>
<td>Watch 3/14/19</td>
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<td>AB 743</td>
<td>Eduardo Garcia</td>
<td>Pupil health: self-administration of prescribed asthma medication</td>
<td>Watch 3/14/19</td>
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<td>AB 768</td>
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<td>AB 822</td>
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<td>Continuing education: physicians and surgeons: nurses: maternal mental health</td>
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<td>AB 862</td>
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<td>Nurse practitioners: scope of practice: unsupervised practice</td>
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<td>Health care coverage: HIV specialists</td>
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<td>AB 1051</td>
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<td>Healing arts licensees: self-administered hormonal contraceptives</td>
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<td>Public health: public university student health centers: abortion by medication techniques</td>
<td>Information 1/10/19</td>
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<td>SB 53</td>
<td>Wilk</td>
<td>Open meetings</td>
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<td>SB 207</td>
<td>Hurtado/ Children Now, et al</td>
<td>Medi-Cal: asthma preventive services</td>
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<td>SB 223</td>
<td>Hill</td>
<td>Pupil health: administration of medicinal cannabis: schoolsites</td>
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<td>SB 227</td>
<td>Leyva/ CalifSC-SEIU</td>
<td>Health and care facilities: inspections and penalties</td>
<td>Watch 3/14/19</td>
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<td>Senate APPR</td>
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<td>SB 305</td>
<td>Hueso</td>
<td>Compassionate Access to Medical Cannabis Act or Ryan’s Law</td>
<td>Watch 3/14/19</td>
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<td>Senate 3rd Reading</td>
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<td>SB 322</td>
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<tr>
<td>SB 425</td>
<td>Hill</td>
<td>Health care practitioners: licensee’s file: probationary physician’s and surgeon’s certificate: unprofessional conduct</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
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<td>SB 567</td>
<td>Caballero/ CNA; NNU</td>
<td>Workers’ compensation: hospital employees</td>
<td>Support 4/11/19</td>
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<td>Senate L,PE&amp;R</td>
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<td>SB 601</td>
<td>Morrell/ R Street Institute</td>
<td>State agencies: licenses: fee waiver</td>
<td>Watch 3/14/19</td>
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<td>Senate APPR</td>
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<tr>
<td>SB 697</td>
<td>Caballero/ CAPA</td>
<td>Physician assistants: practice agreement: supervision</td>
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<td>SB 700</td>
<td>Roth</td>
<td>Business and professions: noncompliance with support orders and tax delinquencies</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Senate Rules</td>
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To view the bill text, use Control then click
BILL ANALYSIS

AUTHOR: Fong
BILL NUMBER: AB 63
SPONSOR: Fong
BILL STATUS: Assembly Committee on Appropriations
SUBJECT: State government
DATE LAST AMENDED: April 3, 2009

SUMMARY:

Existing law requires state agencies to make available on the Internet a plain-language form through which individuals can register complaints or comments relating to the performance of those agencies.

ANALYSIS:

This bill would require:

- If the agency furnishes information or renders services to the public, or engages in any other state program or activity that involves public contact, that the plain-language form made available on the Internet pursuant to these provisions to utilize an A, B, C, D, and F grading system that individuals can use to rate their experience based upon the performance of the agency.

- Individuals to be given the option whether to display their complaint, comment, or grade publicly among other complaints, comments, and grades posted publicly on an agency’s Internet website by other individuals.

BOARD POSITION: Not previously considered

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Not previously considered

SUPPORT: None on file

OPPOSE: None on file
An act to amend Section 8331 of the Government Code, relating to state government.

LEGISLATIVE COUNSEL’S DIGEST

AB 63, as amended, Fong. State government.
Existing law requires state agencies to make available on the internet a plain-language form through which individuals can register complaints or comments relating to the performance of those agencies.
This bill would require, if the agency furnishes information or renders services to the public, or engages in any other state program or activity that involves public contact, that the plain-language form made available on the internet pursuant to these provisions to utilize an A, B, C, D, and F grading system that individuals can use to rate their experience based upon the performance of the agency. The bill would require individuals to be given the option whether to display their complaint, comment, or grade publicly among other complaints, comments, and grades posted publicly on an agency’s internet website by other individuals.
The people of the State of California do enact as follows:

SECTION 1. Section 8331 of the Government Code is amended to read:
8331. (a) (1) State agencies shall make available on the Internet, commencing July 1, 2001, unless otherwise authorized by the Department of Information Technology pursuant to Executive Order D-3-99, a plain-language form through which individuals can register complaints or comments relating to the performance of that agency. The agency shall provide instructions on filing the complaint electronically, or on the manner in which to complete and mail the complaint form to the state agency, or both, consistent with whichever method the agency establishes for the filing of complaints.

(2) If the agency directly furnishes information or renders services to the public, including, but not limited to, providing public safety, protection, or prevention services, administering state benefits, implementing public programs, managing public resources or facilities, or holding public hearings, or engages in any other state program or activity that involves public contact, the plain-language form made available on the internet pursuant to this section shall utilize an A, B, C, D, and F grading system that individuals can use to rate their experience based upon the performance of the agency.

(3) Complaints, comments, and, if applicable, the A through F grades received by the agency shall be made publicly available on the agency’s internet website. Individuals shall have the option whether to display their complaint, comment, or grade publicly among other complaints, comments, and grades made or given by other individuals posted on the agency’s internet website.

(b) Any printed complaint form used by a state agency as part of the process of receiving a complaint against any licensed individual or corporation subject to regulation by that agency shall be made available by the agency on the Internet, commencing July 1, 2001, unless otherwise authorized by the Department of Information Technology pursuant to Executive Order D-3-99. The agency shall provide instructions on filing the complaint electronically, or on the manner in which to complete and mail the complaint form to the state agency, or both, consistent
with whichever method the agency establishes for the filing of complaints.

(c) State agencies making a complaint form available on the Internet shall, to the extent feasible, do both of the following:

1. Advise individuals calling the state agency to lodge a complaint of both of the following:
   
   (A) The availability of the complaint form on the Internet.
   
   (B) That many public libraries provide Internet access.

2. Include on the Internet the location at which this information may be accessed in the telephone directory in order that citizens will be aware that they may contact the state agency via the Internet or by telephone.

(d) Public libraries, to the extent permitted through donations and other means, may do each of the following:

1. Provide Internet access to their patrons.

2. Advertise that they provide Internet access.

(e) Notwithstanding subdivision (a) of Section 11000, state agency as used in this section includes the California State University.
SUMMARY:

Note: The bill also contains similar provisions for continuing education requirements for physicians’ assistants and for physicians and surgeons.

Existing law, the Nursing Practice Act, regulates the practice of nursing by the Board of Registered Nursing. The act requires persons licensed by the board to complete specified courses of instruction, including instruction regarding alcoholism and substance dependency and spousal abuse.

ANALYSIS:

Note: The bill adds a new section to the Nursing Practice Act.

The board shall adopt regulations to require that, on and after January 1, 2022, the continuing education curriculum for all licensees under this chapter includes a minimum of eight hours of instruction regarding understanding implicit bias and the promotion of bias-reducing strategies to address how unintended biases in decision making may contribute to health care disparities by shaping behavior and producing differences in treatment along lines of race, ethnicity, gender, or other characteristics.

This instruction shall also include testing both before and after the course of instruction and the results of this testing shall remain private and be used only for self-assessment. A licensee shall meet the requirements of this section by the licensee’s next license renewal date and each subsequent renewal date thereafter.

Amended analysis as of 4/4:

The amended bill contains Legislative findings and declarations regarding implicit bias. The bill:

• deletes the requirement for a minimum of eight hour of instruction;
• deletes “gender” from the included characteristics and adds gender identity, sexual orientation, and socioeconomic status to the list of characteristics that may produce differences in treatment;

• no longer require pre- and post-instruction testing.

**BOARD POSITION:** Watch (4/11/19)

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Not previously considered

**SUPPORT:**
American Federation of State, County and Municipal Employees
Anti-Recidivism Coalition
APLA Health
California Black Health Network
California Black Women’s Health Project
California Health Executives Association of California
California LGBTQ Health and Human Services Network
California Voices for Progress
Courage Campaign
Disability Rights California
Equal Justice Society
Hathaway-Sycamores Maternal Mental Health Now
Perinatal Mental Health Care
Planned Parenthood Affiliates of California
Santa Cruz County Community Coalition to Overcome Racism
San Francisco AIDS Foundation
United Domestic Workers/AFSCME Local 3930

**OPPOSE:**
Board of Registered Nursing
California Nurses Association
An act to amend Sections 2190.1 and 3524.5 of, and to add Section 2736.5 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL’S DIGEST


Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under the act, a physician and surgeon is required to demonstrate satisfaction of continuing education requirements, including cultural and linguistic competency in the practice of medicine, as specified.

This bill, by January 1, 2022, would require the curriculum for continuing education for a physician and surgeon to include specified instruction and testing in the understanding and reducing of implicit bias in medical treatment.

Existing law, the Nursing Practice Act, regulates the practice of nursing by the Board of Registered Nursing. The act requires persons licensed by the board to complete specified courses of instruction,
including instruction regarding alcoholism and substance dependency and spousal abuse.

This bill would require the Board of Registered Nursing, by January 1, 2022, to adopt regulations requiring the curriculum for continuing education for its licensees to include specified instruction and testing in the understanding and reducing of implicit bias in treatment.

Existing law, the Physician Assistant Practice Act, authorizes the Physician Assistant Board to require a licensee to complete not more than 50 hours of continuing education every two years as a condition of license renewal.

This bill would require the Physician Assistant Board, by January 1, 2022, to adopt regulations requiring the curriculum for continuing education for its licensees to include specified instruction and testing in the understanding and reducing of implicit bias in treatment.


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

1. SECTION 1. The Legislature finds and declares all of the following:
2. (a) Implicit bias, meaning the attitudes or internalized stereotypes that affect our perceptions, actions and decisions in an unconscious manner, exists, and often contributes to unequal treatment of people based on race, ethnicity, gender identity, sexual orientation, ability, and other characteristics.
3. (b) Implicit bias contributes to health disparities by affecting the behavior of physicians and surgeons, nurses, physician assistants, and other healing arts licensees.
4. (c) Evidence of racial and ethnic disparities in health care is remarkably consistent across a range of illnesses and health care services. Racial and ethnic disparities remain even after adjusting for socioeconomic differences, insurance status, and other factors influencing access to health care.
5. (d) African American women are three to four times more likely than white women to die from pregnancy-related causes nationwide. African American patients often are prescribed less pain medication than white patients who present the same complaints, and African American patients with signs of heart
problems are not referred for advanced cardiovascular procedures as often as white patients with the same symptoms.

(e) Implicit gender bias also impacts treatment decisions and outcomes. Women are less likely to survive a heart attack when they are treated by a male physician and surgeon. LGBTQ and gender-nonconforming patients are less likely to seek timely medical care because they experience disrespect and discrimination from health care staff, with one out of five transgender patients nationwide reporting that they were outright denied medical care due to bias.

(f) The Legislature intends to provide specified healing arts licensees with strategies for understanding and reducing the impact of their biases in order to reduce disparate outcomes and ensure that all patients receive fair treatment and quality health care.

SECTION 1.
SEC. 2. Section 2190.1 of the Business and Professions Code is amended to read:

2190.1. (a) The continuing medical education standards of Section 2190 may be met by educational activities that meet the standards of the board and that serve to maintain, develop, or increase the knowledge, skills, and professional performance that a physician and surgeon uses to provide care, or to improve the quality of care provided to patients. These may include, but are not limited to, educational activities that meet any of the following criteria:

(1) Have a scientific or clinical content with a direct bearing on the quality or cost-effective provision of patient care, community or public health, or preventive medicine.

(2) Concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine.

(3) Concern bioethics or professional ethics.

(4) Are designed to improve the physician-patient relationship.

(b) (1) On and after July 1, 2006, all continuing medical education courses shall contain curriculum that includes cultural and linguistic competency in the practice of medicine.

(2) Notwithstanding the provisions of paragraph (1), a continuing medical education course dedicated solely to research or other issues that does not include a direct patient care component or a course offered by a continuing medical education provider
that is not located in this state is not required to contain curriculum
that includes cultural and linguistic competency in the practice of
medicine.
(3) Associations that accredit continuing medical education
courses shall develop standards before July 1, 2006, for compliance
with the requirements of paragraph (1). The associations may
update these standards, as needed, in conjunction with an advisory
group that has expertise in cultural and linguistic competency
issues.
(4) A physician and surgeon who completes a continuing
education course meeting the standards developed pursuant to
paragraph (3) satisfies the continuing education requirement for
cultural and linguistic competency.
(c) In order to satisfy the requirements of subdivision (b),
continuing medical education courses shall address at least one or
a combination of the following:
(1) Cultural competency. For the purposes of this section,
“cultural competency” means a set of integrated attitudes,
knowledge, and skills that enables a health care professional or
organization to care effectively for patients from diverse cultures,
groups, and communities. At a minimum, cultural competency is
recommended to include the following:
(A) Applying linguistic skills to communicate effectively with
the target population.
(B) Utilizing cultural information to establish therapeutic
relationships.
(C) Eliciting and incorporating pertinent cultural data in
diagnosis and treatment.
(D) Understanding and applying cultural and ethnic data to the
process of clinical care, including, as appropriate, information
pertinent to the appropriate treatment of, and provision of care to,
the lesbian, gay, bisexual, transgender, and intersex communities.
(2) Linguistic competency. For the purposes of this section,
“linguistic competency” means the ability of a physician and
surgeon to provide patients who do not speak English or who have
limited ability to speak English, direct communication in the
patient’s primary language.
(3) A review and explanation of relevant federal and state laws
and regulations regarding linguistic access, including, but not
limited to, the federal Civil Rights Act (42 U.S.C. Sec. 1981, et
seq.), Executive Order 13166 of August 11, 2000, of the President of the United States, and the Dymally-Alatorre Bilingual Services Act (Chapter 17.5 (commencing with Section 7290) of Division 7 of Title 1 of the Government Code).

(d) On and after January 1, 2022, all continuing medical education courses shall contain curriculum that includes a minimum of eight hours of instruction regarding the understanding of implicit bias and the promotion of bias-reducing strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender, gender identity, sexual orientation, socioeconomic status, or other characteristics. This instruction shall also include testing both before and after the course of instruction and the results of this testing shall remain private and be used only for self-assessment. A physician and surgeon shall meet the requirements of this subdivision by the physician and surgeon’s next license renewal date and each subsequent renewal date thereafter.

(e) Notwithstanding subdivision (a), educational activities that are not directed toward the practice of medicine, or are directed primarily toward the business aspects of medical practice, including, but not limited to, medical office management, billing and coding, and marketing shall not be deemed to meet the continuing medical education standards for licensed physicians and surgeons.

(f) Educational activities that meet the content standards set forth in this section and are accredited by the California Medical Association or the Accreditation Council for Continuing Medical Education may be deemed by the Division of Licensing to meet its continuing medical education standards.

SEC. 2.
SEC. 3. Section 2736.5 is added to the Business and Professions Code, to read:

2736.5. The board shall adopt regulations to require that, on and after January 1, 2022, the continuing education curriculum for all licensees under this chapter includes a minimum of eight hours of instruction regarding the understanding of implicit bias and the promotion of bias-reducing strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in treatment along
lines of race, ethnicity, **gender**, **gender identity**, **sexual orientation**, socioeconomic status, or other characteristics. This instruction shall also include testing both before and after the course of instruction and the results of this testing shall remain private and be used only for self-assessment. A licensee shall meet the requirements of this section by the licensee’s next license renewal date and each subsequent renewal date thereafter.

**SEC. 3.**

**SEC. 4.** Section 3524.5 of the Business and Professions Code is amended to read:

3524.5. (a) The board may require a licensee to complete continuing education as a condition of license renewal under Section 3523 or 3524. The board shall not require more than 50 hours of continuing education every two years. The board shall, as it deems appropriate, accept certification by the National Commission on Certification of Physician Assistants (NCCPA), or another qualified certifying body, as determined by the board, as evidence of compliance with continuing education requirements. (b) The board shall adopt regulations to require that, on and after January 1, 2022, the continuing education curriculum for all licensees under this chapter includes a minimum of eight hours of instruction regarding the understanding of implicit bias and the promotion of bias-reducing strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in treatment along lines of race, ethnicity, **gender**, **gender identity**, **sexual orientation**, socioeconomic status, or other characteristics. This instruction shall also include testing both before and after the course of instruction and the results of this testing shall remain private and be used only for self-assessment. A licensee shall meet the requirements of this subdivision by the licensee’s next license renewal date and each subsequent renewal date thereafter.

REVISIONS:

Heading—Line 2.
This bill, for each taxable year beginning on or after January 1, 2020, and before January 1, 2025, would:

- allow a credit against those personal income taxes in an amount equal to 50% of the amount paid or incurred by a family caregiver during the taxable year for eligible expenses related to the care of an eligible family member, not to exceed $5,000.

- limit the aggregate amount of these credits to be allocated in each calendar year to $150,000,000 as well as any unused credit amount, if any, allocated in the preceding calendar year.

- require the Franchise Tax Board to allocate and certify these tax credits to taxpayers on a first-come-first-served basis.

- make these provisions operative on the effective date of any budget measure specifically appropriating funds to the Franchise Tax Board for its costs to administer these provisions.

The bill would require an eligible family member to be certified by a physician, registered nurse, advanced practice registered nurse, or physician assistant, under penalty of perjury, as being an individual with long-term care needs and would require the family caregiver to retain, and make available to the Franchise Tax Board upon request, that certification.

**BOARD POSITION:** Watch (4/11/19)

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Not previously considered

**SUPPORT:**
American Association of Retired Persons California
Association of Regional Center Agencies
California Association for Health Services at Home
National Multiple Sclerosis Society

**OPPOSE:**
California Tax Reform Association
California Teachers Association
An act to add and repeal Section 17056.1 of the Revenue and Taxation Code, relating to taxation, to take effect immediately, tax levy.

LEGISLATIVE COUNSEL'S DIGEST

AB 251, as amended, Patterson. Personal income taxes: credit: family caregiver.

The Personal Income Tax Law allows various credits against the taxes imposed by that law.

This bill, for each taxable year beginning and on or after January 1, 2020, and before January 1, 2025, would allow a credit against those taxes in an amount equal to 50% of the amount paid or incurred by a family caregiver during the taxable year for eligible expenses related to the care of an eligible family member, not to exceed $5,000. The bill would limit the aggregate amount of these credits to be allocated in each calendar year to $150,000,000 as well as any unused credit amount, if any, allocated in the preceding calendar year. The bill would require the Franchise Tax Board to allocate and certify these tax credits to taxpayers on a first-come-first-served basis. The bill would make these provisions operative on the effective date of any budget measure specifically appropriating funds to the Franchise Tax Board for its costs to administer these provisions.
The bill would require an eligible family member to be certified by a physician, registered nurse, advanced practice registered nurse, or physician assistant, under penalty of perjury, as being an individual with long-term care needs and would require the family caregiver to retain, and make available to the Franchise Tax Board upon request, that certification. By expanding the scope of the crime of perjury, this bill would impose a state-mandated local program.

The bill would make specified findings detailing the goals, purposes, and objectives of the above-described tax credit, performance indicators for determining whether the credit meets those goals, purposes, and objectives, and data collection requirements.

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 take effect immediately as a tax levy.


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

1. SECTION 1. The Legislature finds and declares all of the following:
   (a) At any given time, an estimated 4.4 million Californians provide varying degrees of unreimbursed care to adults with limitations in daily activities. The total value of the unpaid care provided to individuals in need of long-term services and support amounts to an estimated $57 billion every year, based on 2013 data. While most caregivers are asked to assist an individual with basic activities of daily living, including mobility, eating, and dressing, many are expected to perform complex tasks on a daily basis, including administering multiple medications, providing wound care, and operating medical equipment.
   (b) Caregivers are increasingly contributing more time, more energy, and more money to support their loved ones. The rising costs of healthcare, the limitations to Medicare and other insurance coverage, the increased number of years that caregivers are providing care, and improved longevity have all put pressure on
Caregivers to dip into their own finances to help pay for various elements of care.

(c) For many caregivers, these out-of-pocket expenses can add up. A recent AARP study, “Family Caregiving and Out-of-Pocket Costs: 2016 Report,” showed that caregivers, on average, contribute $6,954 to their loved one’s care. For caregivers earning at or below the average median income level, those contributions have a significant impact.

(d) Numerous studies have found that caregivers feel stressed by the financial burden of caregiving. Two in five caregivers have noted that this stress is moderate to high. Furthermore, this strain is exacerbated the longer that someone provides care, the more intense the care burden, whether the care recipient has a mental health condition, and whether other help is involved.

(e) In order to successfully address the challenges of a surging population of older adults and others living with chronic conditions, who have significant needs for long-term services and support, the state must develop methods to enable caregivers to continue to support their loved ones at home and in the community, and avoid unnecessary costs to the state’s healthcare system.

SEC. 2. It is the intent of the Legislature to create a tax credit for certain expenses incurred by a family caregiver for the care and support of an eligible family member.

SEC. 3. Section 17056.1 is added to the Revenue and Taxation Code, to read:

17056.1. (a) For each taxable year beginning on or after January 1, 2020, and before January 1, 2025, there shall be allowed as a credit against the “net tax,” as defined in Section 17039, an amount equal to 50 percent of the amount paid or incurred by a family caregiver during the taxable year for eligible expenses, not to exceed five thousand dollars ($5,000), regardless of the type of return filed.

(b) For the purposes of this section:

(1) (A) “Eligible family member” means, with respect to any taxable year, an individual who is the spouse of the family caregiver or who bears a relationship, as defined in Section 152(d)(2) of the Internal Revenue Code, relating to relationship, with the family caregiver, and who has been certified, under penalty of perjury, before the due date for filing the return of tax for the taxable year,
not subject to extensions, by a physician, as defined in Section 1861(r) of the Social Security Act, a registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, an advanced practice registered nurse, as defined in Section 2725.5 of the Business and Professions Code, or a physician assistant, as defined in Section 3501 of the Business and Professions Code, as being an individual with long-term care needs described in subparagraph (C) for a period that meets both of the following requirements:

(i) Is at least 180 consecutive days.

(ii) A portion of that period occurs within the taxable year.

(B) “Eligible family member” shall not include either of the following:

(i) An individual otherwise meeting the requirements of subparagraph (A) unless, within the 39 1/2-month period ending on that due date for the filing of the return of tax, or another period that the Franchise Tax Board prescribes, a physician, registered nurse, advanced practice registered nurse, or physician assistant, as those terms are defined in subparagraph (A), has certified, under penalty of perjury, that the individual meets those requirements.

(ii) An individual who has a monthly federal adjusted gross income of more than two thousand dollars ($2,000) for an individual or three thousand dollars ($3,000) for a joint return.

(C) An individual is described in this paragraph to have long-term care needs if that individual meets any of the following requirements:

(i) The individual is at least six years of age and meets either of the following requirements:

(I) The individual is unable to perform, without substantial assistance from another individual, at least three activities of daily living, as defined in Section 7702B(c)(2)(B) of the Internal Revenue Code, relating to activities of daily living, due to a loss of functional capacity.

(II) The individual requires substantial supervision to protect that individual from threats to health and safety due to severe cognitive impairment and meets either of the following additional requirements:

(ia) Is unable to perform at least one activity of daily living, as defined in Section 7702B(c)(2)(B) of the Internal Revenue Code, relating to activities of daily living.
(ib) To the extent provided by the Franchise Tax Board, in consultation with the Secretary of California Health and Human Services, is unable to engage in age-appropriate activities.

(ii) The individual is at least two years of age but less than six years of age and is unable, due to a loss of functional capacity, to perform, without substantial assistance from another individual, at least two of the following activities: eating, transferring, or mobility.

(iii) The individual is under two years of age and requires specific durable medical equipment by reason of a severe health condition or requires a skilled practitioner trained to address the individual’s condition to be available if the individual’s parents or guardians are absent.

(2) (A) “Family caregiver” means an individual who meets both all of the following requirements:

(i) Incurs uncompensated expenses directly related to the care of an eligible family member.

(ii) Provides care to one or more eligible family members during the taxable year.

(iii) Has an annual federal adjusted gross income of one hundred seventy thousand dollars ($170,000) or less for an individual or two hundred fifty thousand dollars ($250,000) or less for a joint return for the taxable year in which the credit is claimed.

(B) In the case of a joint return, “family caregiver” includes the individual and the individual’s spouse.

(3) “Eligible expenses” includes all of the following that are directly related to assisting a family caregiver in providing care for an eligible family member in the state:

(A) The total amount expended by the family caregiver to retrofit an existing residence, provided that the retrofitting of the existing residence is designed to improve accessibility, or to provide universal visitability.

(B) Purchases or leases of equipment that is necessary to assist an eligible family member in carrying out one or more activities of daily living.

(C) Goods, services, or support that assists the family caregiver in providing care to an eligible family member, including, but not limited to, expenditures related to hiring a home care aide or personal care attendant, respite care, adult day care, transportation,
legal and financial services, and for assistive technology to care
for the eligible family member.
(c) Only one family caregiver may be allowed the credit
provided by this section in a taxable year with respect to any one
eligible family member.
(d) If the credit allowed by this section exceeds the “net tax,”
the excess may be carried over to reduce the “net tax” in the
following taxable year, and succeeding two years if necessary,
until the credit is exhausted.
(e) (1) No credit shall be allowed under this section to a family
caregiver with respect to any eligible family member unless the
family caregiver includes the name and taxpayer identification
number of the eligible family member, and the identification
number of the physician, registered nurse, advanced
practice registered nurse, or physician assistant certifying that
eligible family member, on the return of tax for the taxable year.
(2) The denial of any credit under paragraph (1) may be made
pursuant to Section 19051.
(f) The family caregiver shall retain the physician certification
required by paragraph (1) of subdivision (b) and shall make that
certification available to the Franchise Tax Board upon request.
(g) (1) The Franchise Tax Board may adopt regulations
necessary or appropriate to carry out the purposes of this section.
(2) Chapter 3.5 (commencing with Section 11340) of Part 1 of
Division 3 of Title 2 of the Government Code shall not apply to
any standard, criterion, procedure, determination, rule, notice, or
guideline established or issued by the Franchise Tax Board.
(h) Any deduction otherwise allowed under this part for any
amount paid or incurred by the taxpayer upon which the credit is
based shall be reduced by the amount of the credit allowed under
this section.
(i) The aggregate amount of credits that may be allocated
pursuant to this section shall be an amount equal to the sum of the
following:
(1) One hundred fifty million dollars ($150,000,000) in credits
for each calendar year.
(2) The unused credit amount, if any, allocated in the preceding
calendar year.
(j) For the purposes of this section, the Franchise Tax Board
shall do both of the following:
(1) On or after January 1, 2020, and before January 1, 2025, allocate and certify tax credits to taxpayers on a first-come-first-served basis by determining and designating applicants who meet the requirements of this section.

(2) Once the credits allocated exceed the limit established in subdivision (i), the Franchise Tax Board shall cease to allocate and certify tax credits to taxpayers.

(k) This section shall become operative on the effective date of any budget measure specifically appropriating funds to the Franchise Tax Board for its costs to administer this section.

(l) This section is repealed on December 1, 2025.

SEC. 4. For purposes of complying with Section 41 of the Revenue and Taxation Code, the Legislature finds and declares the following with respect to Section 17056.1 of the Revenue and Taxation Code:

(a) The specific goals, purposes, and objectives that the tax credit allowed by this act will achieve are as follows:

(1) Relieving part of the significant financial burden that family caregivers face for out-of-pocket expenses they often cannot afford.

(2) Reducing the number of family caregivers who require loans to cover the costs of caring for an eligible family member.

(3) Providing flexibility for family caregivers to care for loved ones themselves.

(b) Detailed performance indicators for the Legislature to use in determining whether the tax credit allowed by this act meets those goals, purposes, and objectives are as follows:

(1) The number of people receiving the credit.

(2) The number of family caregivers who are able to financially manage taking care of their loved one full time as a result of receiving the credit.

(c) The Legislative Analyst shall, on an annual basis beginning January 1, 2021, collaborate with the Franchise Tax Board to review the effectiveness of the tax credit allowed by Section 17056.1 of the Revenue and Taxation Code. The review shall include, but not be limited to, an analysis of the demand for the tax credit and the economic impact of the tax credit.

(d) The data collection requirements for determining whether the tax credit is meeting, failing to meet, or exceeding those specific goals, purposes, and objectives are as follows:
(1) To assist the Legislature in determining whether the tax credit allowed by this act meets the goals, purposes, and objectives specified in subdivision (a), and in carrying out their duties under subdivision (c), the Legislative Analyst may request information from the Franchise Tax Board.

(2) The Franchise Tax Board shall provide any data requested by the Legislative Analyst pursuant to this subdivision.

SEC. 4.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 5.

SEC. 6. This act provides for a tax levy within the meaning of Article IV of the California Constitution and shall go into immediate effect.
BILL ANALYSIS

AUTHOR: Eggman
BILL NUMBER: AB 362

SPONSOR: Drug Policy Alliance
Harm Reduction Coalition
BILL STATUS: Assembly 3rd Reading

SUBJECT: Controlled substances: overdose prevention program
DATE LAST AMENDED: April 25, 2019

SUMMARY:

Existing law makes it a crime:

- to possess specified controlled substances or paraphernalia.

- to use or be under the influence of specified controlled substances.

- to visit or be in any room where specified controlled substances are being unlawfully used with knowledge that the activity is occurring, or to open or maintain a place for the purpose of giving away or using specified controlled substances.

- for a person to rent, lease, or make available for use any building or room for the purpose of storing or distributing any controlled substance.

Existing law authorizes forfeiture of property used for specified crimes involving controlled substances.

ANALYSIS:

This bill would:

- until January 1, 2026, authorize the City and County of San Francisco to approve entities to operate overdose prevention programs that satisfy specified requirements, including, among other things, the provision of a hygienic space supervised by healthcare professionals, as defined, where adults who use drugs can consume preobtained drugs, sterile consumption supplies, and access to referrals to substance use disorder treatment.

- require the City and County of San Francisco, prior to authorizing an overdose prevention program in its jurisdiction, to provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting.
• require any entity operating a program to provide an annual report to the city and county, as specified.

• exempt a person from, among other things, civil liability, professional discipline, or existing criminal sanctions, solely for actions or conduct on the site of an overdose prevention program for adults authorized by the city and county.

Amended analysis as of 3/20:

The bill would add employees of the City and County of San Francisco acting in the course and scope of employment to the list of those persons exempt from, among other things, civil liability, professional discipline, or existing criminal sanctions, solely for actions, conduct, or omissions on the site of an overdose prevention program for adults authorized by the city and county.

Amended analysis as of 4/25:

This bill would:
• restrict operation of the program to persons 18 years of age and older

• exempt a person from, among other things, civil liability, professional discipline, or existing criminal sanctions, solely for actions, conduct, or omissions on the site of in compliance with an overdose prevention program for adults authorized by the city and county.

BOARD POSITION: Watch (4/11/19)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (3/14/19)

SUPPORT:
Drug Policy Alliance (Co-Sponsor)
Harm Reduction Coalition (Co-Sponsor)
Access Support Network
Aids Legal Referral Panel
Alcohol Justice
American Academy of HIV Medicine California/Hawaii Steering Committee American Civil Liberties Union of California
Any Positive Change Inc.
APLA Health
Asian American Drug Abuse Program, Inc.
Asian Americans Advancing Justice California
C.O.R.E. Medical Clinic, Inc.
Ca Association Of Alcohol And Drug Executives, Inc
California Association of Alcohol and Drug Program Executives, Inc. California Consortium of Addiction Programs and Professionals California Medical Association
California Psychiatric Association
California Public Defenders Association
California Society of Addiction Medicine
California State Council of Service Employees
City and County of San Francisco - City Attorney's Office
Coalition on Homelessness, San Francisco
Community Aid and Resources – UCSC
Community Housing Partnership
Consumer Attorneys of California
Courage Campaign
Democratic Socialists of America, San Francisco, Healthcare Committee Dolores Street Community Services
Drug Policy Action
Ella Baker Center for Human Rights
Face to Face
Friends Committee on Legislation of California
Glide Foundation
Harvey Milk LGBTQ Democratic Club
Health Officers Association of California
Healthright 360
HIV Education and Prevention Project of Alameda County
Hive
Homeless Health Care Los Angeles
Indivisible SF
Larkin Street Youth Services
Legal Services for Prisoners with Children
National Association of Social Workers, California Chapter
National Health Law Program
Office of the Mayor, San Francisco
PRC
Saint Francis Foundation
San Francisco AIDS Foundation
San Francisco Community Clinic Consortium
San Francisco Community Health Center
San Francisco Drug Users' Union
San Francisco Public Defender's Office
Shanti Project
St. Anthony Foundation
Tarzana Treatment Centers, Inc.
Tenderloin Neighborhood Development Corporation
Tenderloin People's Congress
The Spahr Center Transitions Clinic Network
UCSF Alliance Health Project

OPPOSE:
Association of Deputy District Attorneys
California Association of Code Enforcement Officers
California College and University Police Chiefs Association California Correctional Supervisors Organization, Inc.
California Narcotic Officers’ Association
California Police Chiefs Association
California State Sheriffs’ Association
Congress of Racial Equality International
Faith Based Coalition
Los Angeles County Professional Peace Officers Association
An act to add and repeal Section 11376.6 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL’S DIGEST

AB 362, as amended, Eggman. Controlled substances: overdose prevention program.

Existing law makes it a crime to possess specified controlled substances or paraphernalia. Existing law makes it a crime to use or be under the influence of specified controlled substances. Existing law additionally makes it a crime to visit or be in any room where specified controlled substances are being unlawfully used with knowledge that the activity is occurring, or to open or maintain a place for the purpose of giving away or using specified controlled substances. Existing law makes it a crime for a person to rent, lease, or make available for use any building or room for the purpose of storing or distributing any controlled substance. Existing law authorizes forfeiture of property used for specified crimes involving controlled substances.

This bill would, until January 1, 2026, authorize the City and County of San Francisco to approve entities to operate overdose prevention programs for persons 18 years of age or older that satisfy specified
requirements, including, among other things, the provision of providing a hygienic space supervised by health care professionals, as defined, where adults people who use drugs can consume preobtained drugs, use providing sterile consumption supplies, and access to providing access or referrals to substance use disorder treatment. The bill would require the City and County of San Francisco, prior to authorizing an overdose prevention program in its jurisdiction, to provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The bill would require any entity operating a program to provide an annual report to the city and county, as specified. The bill would exempt a person from, among other things, civil liability, professional discipline, or existing criminal sanctions, solely for actions, conduct, or omissions on the site of in compliance with an overdose prevention program for adults authorized by the city and county.

This bill would make legislative findings and declarations as to the necessity of a special statute for the City and County of San Francisco.


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

SECTION 1. Section 11376.6 is added to the Health and Safety Code, to read:

11376.6. (a) Notwithstanding any other law, the City and County of San Francisco may approve entities within its jurisdiction to establish and operate overdose prevention programs for persons 18 years of age or older that satisfy the requirements set forth in subdivision (c).

(b) Prior to approving an entity within its jurisdiction pursuant to subdivision (a), the City and County of San Francisco shall provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The notice of the meeting to the public shall be sufficient to ensure adequate participation in the meeting by the public. The meeting shall be noticed in accordance with all state laws and local ordinances, and as local officials deem appropriate.

(c) In order for an entity to be approved to operate an overdose prevention program pursuant to this section, the entity shall demonstrate that it will, at a minimum:
(1) Provide a hygienic space supervised by health care professionals where people who use drugs can consume preobtained drugs. For purposes of this paragraph, “health care professional” includes, but is not limited to, a physician, physician assistant, nurse practitioner, licensed vocational nurse, registered nurse, psychiatrist, psychologist, licensed clinical social worker, licensed professional clinical counselor, mental health provider, social service provider, or substance use disorder provider, trained in overdose recognition and reversal pursuant to Section 1714.22 of the Civil Code.

(2) Provide sterile consumption supplies, collect used hypodermic needles and syringes, and provide secure hypodermic needle and syringe disposal services.

(3) Administer first aid, if needed, monitor participants for potential overdose, and provide treatment as necessary to prevent fatal overdose.

(4) Provide access or referrals to substance use disorder treatment services, medical services, mental health services, and social services.

(5) Educate participants on the risks of contracting HIV and viral hepatitis.

(6) Provide overdose prevention education and access to or referrals to obtain naloxone hydrochloride or another overdose reversal medication approved by the United States Food and Drug Administration.

(7) Educate participants regarding proper disposal of hypodermic needles and syringes.

(8) Provide reasonable security of the program site.

(9) Establish operating procedures for the program, made available to the public either through an internet website or upon request, that are publicly noticed, including, but not limited to, standard hours of operation, a minimum number of personnel required to be onsite during those hours of operation, the licensing and training standards for staff present, an established maximum number of individuals who can be served at one time, and an established relationship with the nearest emergency department of a general acute care hospital, as well as eligibility criteria for program participants.

(10) Train staff members to deliver services offered by the program.
(11) Establish a good neighbor policy that facilitates communication from and to local businesses and residences, to the extent they exist, to address any neighborhood concerns and complaints.

(12) Establish a policy for informing local government officials and neighbors about the approved entity’s complaint procedures, and the contact number of the director, manager, or operator of the approved entity.

(d) An entity operating an overdose prevention program under this section shall provide an annual report to the city and county, that shall include all of the following:

1. The number of program participants.
2. Aggregate information regarding the characteristics of program participants.
3. The number of hypodermic needles and syringes distributed for use onsite.
4. The number of overdoses experienced and the number of overdoses reversed onsite.
5. The number of persons referred to drug treatment.
6. The number of individuals directly and formally referred to other services and the type of service.

(e) Notwithstanding any other law, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, clients or participants, and employees of the City and County of San Francisco acting in the course and scope of employment, shall not be arrested, charged, or prosecuted pursuant to Section 11350, 11364, 11365, 11366, 11366.5, or 11377, or subdivision (a) of Section 11550, including for attempt, aiding and abetting, or conspiracy to commit a violation of any of those sections, or have their property subject to forfeiture, or otherwise be penalized solely for actions, conduct, or omissions on the site of an overdose prevention program approved by the City and County of San Francisco, or for conduct relating to the approval of an entity to operate an overdose prevention program, or the inspection, licensing, or other regulation of an overdose prevention program approved by the City and County of San Francisco pursuant to subdivision (a).

(f) Notwithstanding any other law, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, clients or participants, and employees of the City and
County of San Francisco acting in the course and scope of employment shall not be subject to civil, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability, or have their property subject to forfeiture, solely for actions, conduct, or omissions on the site of an overdose prevention program approved by the City and County of San Francisco or for conduct relating to the approval of an entity to operate an overdose prevention program, or the inspection, licensing, or other regulation of an overdose prevention program approved by the City and County of San Francisco pursuant to subdivision (a).

(g) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

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 of the unique needs of the City and County of San Francisco.
The bill was originally introduced with the subject “Prescriptions.” It was amended March 21 to become this bill.

Existing law provides for:

- the licensure and regulation of professions and vocations by various boards within the Department of Consumer Affairs.

- the payment of a fee for the renewal of certain licenses, certificates, or permits in an inactive status, and, for certain licenses, certificates, and permits that have expired, requires the payment of all accrued fees as a condition of reinstatement of the license, certificate, or permit.

ANALYSIS:

This bill would:

- limit the maximum fee for the renewal of a license in an inactive status to no more than 50% of the renewal fee for an active license.

- prohibit a board from requiring payment of accrued and unpaid renewal fees as a condition of reinstating an expired license or registration.

BOARD POSITION: Watch (4/11/19)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Not previously considered

SUPPORT:

OPPOSE:
Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board
An act to amend Sections 4073 of the Business and Professions Code, relating to healing arts. An act to amend Sections 121.5, 462, 703, 1006.5, 1718, 1718.3, 1936, 2427, 2456.3, 2535.2, 2538.54, 2646, 2734, 2892.1, 2984, 3147, 3147.7, 3524, 3774, 3775.5, 4545, 4843.5, 4901, 4966, 4989.36, 4999.104, 5070.6, 5600.2, 5680.1, 6796, 6980.28, 7076.5, 7417, 7672.8, 7725.2, 7729.1, 7881, 7883, 8024.7, 8802, 9832, 9832.5, 9884.5, 19170.5, and 19290 of the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL’S DIGEST

AB 544, as amended, Brough. Prescriptions—Professions and vocations: inactive license fees and accrued and unpaid renewal fees. Existing law provides for the licensure and regulation of professions and vocations by various boards within the Department of Consumer Affairs. Existing law provides for the payment of a fee for the renewal of certain licenses, certificates, or permits in an inactive status, and, for certain licenses, certificates, and permits that have expired, requires the payment of all accrued fees as a condition of reinstatement of the license, certificate, or permit.

This bill would limit the maximum fee for the renewal of a license in an inactive status to no more than 50% of the renewal fee for an active license. The bill would also prohibit a board from requiring payment of accrued and unpaid renewal fees as a condition of reinstating an expired license or registration.
The Pharmacy Law provides for the licensure and regulation of pharmacists and pharmacies by the California State Board of Pharmacy, which is within the Department of Consumer Affairs, and authorizes a pharmacist filling a prescription order for a drug product prescribed by its brand or trade name to select another drug product with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name of those drug products having the same active chemical ingredients, as specified.

This bill would make a nonsubstantive change to that provision.


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

SECTION 1. Section 121.5 of the Business and Professions Code is amended to read:

121.5. (a) Except as otherwise provided in this code, the application of delinquency fees or accrued and unpaid renewal fees for the renewal of expired licenses or registrations shall not apply to licenses or registrations that have lawfully been designated as inactive or retired.

(b) Notwithstanding any other law, a board shall not require a person to pay accrued and unpaid renewal fees as a condition of reinstating an expired license or registration.

SEC. 2. Section 462 of the Business and Professions Code is amended to read:

462. (a) Any of the boards, bureaus, commissions, or programs within the department may establish, by regulation, a system for an inactive category of licensure for persons who are not actively engaged in the practice of their profession or vocation.

(b) The regulation shall contain the following provisions:

(1) The holder of an inactive license issued pursuant to this section shall not engage in any activity for which a license is required.

(2) An inactive license issued pursuant to this section shall be renewed during the same time period in which an active license is renewed. The holder of an inactive license need not comply with any continuing education requirement for renewal of an active license.
(3) The renewal fee for a license in an active status shall apply also for a renewal of a license in an inactive status, unless a lesser renewal fee is specified by the board. Status shall be no more than 50 percent of the renewal fee for a license in an active status.

(4) In order for the holder of an inactive license issued pursuant to this section to restore his or her the license to an active status, the holder of an inactive license shall comply with all the following:

(A) Pay the renewal fee.

(B) If the board requires completion of continuing education for renewal of an active license, complete continuing education equivalent to that required for renewal of an active license, unless a different requirement is specified by the board.

(C) This section shall not apply to any healing arts board as specified in Section 701.

SEC. 3. Section 703 of the Business and Professions Code is amended to read:

703. (a) An inactive healing arts license or certificate issued pursuant to this article shall be renewed during the same time period at which an active license or certificate is renewed. In order to renew a license or certificate issued pursuant to this article, the holder thereof need not comply with any continuing education requirement for renewal of an active license or certificate.

(b) The Notwithstanding any other law, the renewal fee for a license or certificate in an active inactive status shall apply also for renewal of a license or certificate in an inactive status, unless a lower fee has been established by the issuing board. be no more than 50 percent of the renewal fee for a license in an active status.

SEC. 4. Section 1006.5 of the Business and Professions Code is amended to read:

1006.5. Notwithstanding any other law, the amount of regulatory fees necessary to carry out the responsibilities required by the Chiropractic Initiative Act and this chapter are fixed in the following schedule:

(a) Fee to apply for a license to practice chiropractic: three hundred seventy-one dollars ($371).

(b) Fee for initial license to practice chiropractic: one hundred eighty-six dollars ($186).

(c) Fee to renew an active or inactive license to practice chiropractic: three hundred thirteen dollars ($313).
(d) Fee to renew an inactive license to practice chiropractic: no more than 50 percent of the renewal fee for an active license.

(e) Fee to apply for approval as a continuing education provider: eighty-four dollars ($84).

(f) Biennial continuing education provider renewal fee: fifty-six dollars ($56).

(g) Fee to apply for approval of a continuing education course: fifty-six dollars ($56) per course.

(h) Fee to apply for a satellite office certificate: sixty-two dollars ($62).

(i) Fee to renew a satellite office certificate: thirty-one dollars ($31).

(j) Fee to apply for a license to practice chiropractic pursuant to Section 9 of the Chiropractic Initiative Act: three hundred seventy-one dollars ($371).

(k) Fee to apply for a certificate of registration of a chiropractic corporation: one hundred eighty-six dollars ($186).

(l) Fee to renew a certificate of registration of a chiropractic corporation: thirty-one dollars ($31).

(m) Fee to file a chiropractic corporation special report: thirty-one dollars ($31).

(n) Fee to apply for approval as a referral service: five hundred fifty-seven dollars ($557).

(o) Fee for an endorsed verification of licensure: one hundred twenty-four dollars ($124).

(p) Fee for replacement of a lost or destroyed license: fifty dollars ($50).
(q) Fee for replacement of a satellite office certificate: fifty dollars ($50).

(r) Fee for replacement of a certificate of registration of a chiropractic corporation: fifty dollars ($50).

(s) Fee to restore a forfeited or canceled license to practice chiropractic: double the annual renewal fee specified in subdivision (c).

(t) Fee to apply for approval to serve as a preceptor: thirty-one dollars ($31).

(u) Fee to petition for reinstatement of a revoked license: three hundred seventy-one dollars ($371).

(v) Fee to petition for early termination of probation: three hundred seventy-one dollars ($371).

(w) Fee to petition for reduction of penalty: three hundred seventy-one dollars ($371).

SEC. 5. Section 1718 of the Business and Professions Code is amended to read:

1718. Except as otherwise provided in this chapter, an expired license may be renewed at any time within five years after its expiration on filing of application for renewal on a form prescribed by the board, and payment of all accrued renewal and delinquency fees. If the license is renewed more than 30 days after its expiration, the licensee, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date provided in Section 1715 which next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 6. Section 1718.3 of the Business and Professions Code is amended to read:
1718.3. (a) A license which is not renewed within five years
after its expiration may not be renewed, restored, reinstated, or
reissued thereafter, but the holder of the license may apply for and
obtain a new license if the following requirements are satisfied:
(1) No fact, circumstance, or condition exists which would
justifying denial of licensure under Section 480.
(2) The person pays all of the fees which would be
required of him or her if the person were then applying
for the license for the first time and all renewal and delinquency
fees which have accrued since the date on which he or she last
renewed his or her license.
(3) The person takes and passes the examination, if
any, which would be required of him or her if the person were then applying
for the license for the first time, or
otherwise establishes to the satisfaction of the board that with due
regard for the public interest, he or she is qualified to
practice the profession or activity in which he or she seeks to be licensed.
(b) The board may impose conditions on any license issued
pursuant to this section, as it deems necessary.
(c) The board may by regulation provide for the waiver or refund
of all or any part of the examination fee in those cases in which a
license is issued without an examination under this section.

SEC. 7. Section 1936 of the Business and Professions Code is
amended to read:
1936. Except as otherwise provided in this article, an expired
license may be renewed at any time within five years after its
expiration by filing an application for renewal on a form prescribed
by the hygiene board and payment of all renewal and
delinquency fees. If the license is renewed after its expiration, the
licensee, as a condition precedent of renewal, shall also pay the
delinquency fee prescribed by this article. Renewal under this
section shall be effective on the date on which the application is
filed, on the date on which the renewal fee is paid, or on the date
on which the delinquency fee, if any, is paid, whichever last occurs.
If so renewed, the license shall continue in effect until the
expiration date provided in Section 1935 that next occurs after the
effective date of the renewal.

SEC. 8. Section 2427 of the Business and Professions Code is
amended to read:
2427. (a) Except as provided in Section 2429, a license which has expired may be renewed at any time within five years after its expiration on filing an application for renewal on a form prescribed by the licensing authority and payment of all accrued renewal fees and any other fees required by Section 2424. If the license is not renewed within 30 days after its expiration, the licensee, as a condition precedent to renewal, shall also pay the prescribed delinquency fee, if any. Except as provided in Section 2424, renewal under this section shall be effective on the date on which the renewal application is filed, on the date on which the renewal fee or accrued renewal fees are paid, or on the date on which the delinquency fee or the delinquency fee and penalty fee, if any, are paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date set forth in Section 2422 or 2423 which next occurs after the effective date of the renewal, when it shall expire and become invalid if it is not again renewed.

(b) Notwithstanding subdivision (a), the license of a doctor of podiatric medicine which has expired may be renewed at any time within three years after its expiration on filing an application for renewal on a form prescribed by the licensing authority and payment of all accrued renewal fees and any other fees required by Section 2424. If the license is not renewed within 30 days after its expiration, the licensee, as a condition precedent to renewal, shall also pay the prescribed delinquency fee, if any. Except as provided in Section 2424, renewal under this section shall be effective on the date on which the renewal application is filed, on the date on which the renewal fee or accrued renewal fees are paid, or on the date on which the delinquency fee or the delinquency fee and penalty fee, if any, are paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date set forth in Section 2422 or 2423 which next occurs after the effective date of the renewal, when it shall expire and become invalid if it is not again renewed.

SEC. 9. Section 2456.3 of the Business and Professions Code is amended to read:

2456.3. Except as provided in Section 2429, a license which has expired may be renewed at any time within five years after its expiration by filing an application for renewal on a form prescribed by the board and payment of all accrued renewal fees and
any other fees required by Section 2455. Except as provided in 
Section 2456.2, renewal under this section shall be effective on 
the date on which the renewal application is filed, on the date on 
which the renewal fee or accrued renewal fees are paid, or on 
the date on which the delinquency fee or the delinquency fee and 
penalty fee, if any, are paid, whichever last occurs. If so renewed, 
the license shall continue in effect through the expiration date set 
forth in Section 2456.1 which next occurs after the effective date 
of the renewal.

SEC. 10. Section 2535.2 of the Business and Professions Code 
is amended to read:

2535.2. Except as provided in Section 2535.3, a license that 
has expired may be renewed at any time within five years after its 
expiration upon filing of an application for renewal on a form 
prescribed by the board and payment of all accrued and unpaid 
renewal fees: the renewal fee. If the license is not renewed on or 
before its expiration, the licensee, as a condition precedent to 
renewal, shall also pay the prescribed delinquency fee. Renewal 
under this section shall be effective on the date on which the 
application is filed, on the date on which all the renewal fees are 
fee is paid, or on the date on which the delinquency fee is paid, 
whichever last occurs. If so renewed, the license shall continue in 
effect through the expiration date provided in Section 2535, after 
the effective date of the renewal, when it shall expire and become 
invalid if it is not again renewed.

SEC. 11. Section 2538.54 of the Business and Professions Code 
is amended to read:

2538.54. Except as otherwise provided in this article, an expired 
license may be renewed at any time within three years after its 
expiration upon filing of an application for renewal on a form 
prescribed by the board and payment of all accrued and unpaid 
renewal fees: the renewal fee. If the license is renewed after its 
expiration the licensee, as a condition precedent to renewal, shall 
also pay the delinquency fee prescribed by this article. Renewal 
under this section shall be effective on the date on which the 
application is filed, on the date on which the renewal fee is paid, 
or on the date on which the delinquency fee, if any, is paid, 
whichever last occurs. If so renewed, the license shall continue in 
effect through the date provided in Section 2538.53 which next
occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 12. Section 2646 of the Business and Professions Code is amended to read:

2646. A license that has expired may be renewed at any time within five years after its expiration by applying for renewal as set forth in Section 2644. Renewal under this section shall be effective on the date on which the renewal application is filed, on the date on which the renewal fee or accrued renewal fees are paid, or on the date on which the delinquency fee and penalty fee, if any, are paid, whichever last occurs. A renewed license shall continue in effect through the expiration date set forth in Section 2644 that next occurs after the effective date of the renewal, at which time it shall expire and become invalid if it is not so renewed.

SEC. 13. Section 2734 of the Business and Professions Code is amended to read:

2734. Upon application in writing to the board and payment of the fee not to exceed 50 percent of the biennial renewal fee, a licensee may have his license placed in an inactive status for an indefinite period of time. A licensee whose license is in an inactive status may not practice nursing. However, such a licensee does not have to comply with the continuing education standards of Section 2811.5.

SEC. 14. Section 2892.1 of the Business and Professions Code is amended to read:

2892.1. Except as provided in Sections 2892.3 and 2892.5, an expired license may be renewed at any time within four years after its expiration upon filing of an application for renewal on a form prescribed by the board, payment of all accrued and unpaid renewal fees, the renewal fee, and payment of any fees due pursuant to Section 2895.1.

If the license is renewed more than 30 days after its expiration, the licensee, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which all the renewal fees are paid, or on the date on which the delinquency fee is paid, whichever last occurs. If so renewed, the license shall continue in effect through the date provided in Section 2892 which next occurs after the
effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 15. Section 2984 of the Business and Professions Code is amended to read:

2984. Except as provided in Section 2985, a license that has expired may be renewed at any time within three years after its expiration on filing of an application for renewal on a form prescribed by the board and payment of all accrued and unpaid renewal fees. If the license is renewed after its expiration, the licensee, as a condition precedent to renewal, shall also pay the prescribed delinquency fee, if any. Renewal under this section shall be effective on the date on which the application is filed, on the date on which all the renewal fees are paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date provided in Section 2982 which next occurs after the effective date of the renewal, when it shall expire and become invalid if it is not again renewed.

SEC. 16. Section 3147 of the Business and Professions Code is amended to read:

3147. (a) Except as otherwise provided by Section 114, an expired optometrist license may be renewed at any time within three years after its expiration, and a retired license issued for less than three years may be reactivated to active status, by filing an application for renewal or reactivation on a form prescribed by the board, paying all accrued and unpaid renewal fees or reactivation fees determined by the board, paying any delinquency fees prescribed by the board, and submitting proof of completion of the required number of hours of continuing education for the last two years, as prescribed by the board pursuant to Section 3059. Renewal or reactivation to active status under this section shall be effective on the date on which all of those requirements are satisfied. If so renewed or reactivated to active status, the license shall continue as provided in Sections 3146 and 3147.5.

(b) Expired statements of licensure, branch office licenses, and fictitious name permits issued pursuant to Sections 3070, 3077, and 3078, respectively, may be renewed at any time by filing an application for renewal, paying all accrued and unpaid renewal fees.
fees, the renewal fee, and paying any delinquency fees prescribed
by the board.

SEC. 17. Section 3147.7 of the Business and Professions Code
is amended to read:
3147.7. The provisions of Section 3147.6 shall not apply to a
person holding a license that has not been renewed within three
years of expiration, if the person provides satisfactory proof that
he or she holds an active license from another state and
meets all of the following conditions:
(a) Is not subject to denial of a license under Section 480.
(b) Applies in writing for restoration of the license on a form
prescribed by the board.
(c) Pays all accrued and unpaid the renewal fees fee and any
delinquency fees prescribed by the board.
(d) Submits proof of completion of the required number of hours
of continuing education for the last two years.
(e) Takes and satisfactorily passes the board’s jurisprudence
examination.

SEC. 18. Section 3524 of the Business and Professions Code
is amended to read:
3524. A license or approval that has expired may be renewed
at any time within five years after its expiration by filing an
application for renewal on a form prescribed by the board or
Medical Board of California, as the case may be, and payment of
all accrued and unpaid renewal fees: the renewal fee. If the license
or approval is not renewed within 30 days after its expiration, the
licensed physician assistant and approved supervising physician,
as a condition precedent to renewal, shall also pay the prescribed
delinquency fee, if any. Renewal under this section shall be
effective on the date on which the application is filed, on the date
on which all the renewal fees are fee is paid, or on the date on
which the delinquency fee, if any, is paid, whichever occurs last.
If so renewed, the license shall continue in effect through the
expiration date provided in Section 3522 or 3523 which next occurs
after the effective date of the renewal, when it shall expire, if it is
not again renewed.

SEC. 19. Section 3774 of the Business and Professions Code
is amended to read:
3774. On or before the birthday of a licensed practitioner in
every other year, following the initial licensure, the board shall
mail to each practitioner licensed under this chapter, at the latest
date furnished by the licensed practitioner to the executive
officer of the board, a notice stating the amount of the renewal fee
and the date on which it is due. The notice shall state that failure
to pay the renewal fee on or before the due date and submit
evidence of compliance with Sections 3719 and 3773 shall result
in expiration of the license.
Each license not renewed in accordance with this section shall
expire but may within a period of three years thereafter be
reinstated upon payment of all accrued and unpaid the renewal
fees and penalty fees required by this chapter. The board may also
require submission of proof of the applicant’s qualifications, except
that during the three-year period no examination shall be required
as a condition for the reinstatement of any expired license that has
lapsed solely by reason of nonpayment of the renewal fee.
SEC. 20. Section 3775.5 of the Business and Professions Code
is amended to read:
3775.5. The fee for an inactive license shall be the same as no
more than 50 percent of the renewal fee for an active license for
the practice of respiratory care as specified in Section 3775.
SEC. 21. Section 4545 of the Business and Professions Code
is amended to read:
4545. Except as provided in Section 4545.2, a license that has
expired may be renewed at any time within four years after its
expiration on filing an application for renewal on a form prescribed
by the board, payment of all accrued and unpaid renewal fees, the
renewal fee, and payment of all fees required by this chapter. If
the license is renewed more than 30 days after its expiration, the
holder, as a condition precedent to renewal, shall also pay the
delinquency fee prescribed by this chapter. Renewal under this
section shall be effective on the date on which the application is
filed, on the date on which the renewal fee is paid, or on the date
on which the delinquency fee, if any, is paid, whichever last occurs.
If so renewed, the license shall continue in effect through the date
provided in Section 4544 which next occurs after the effective date
of the renewal, when it shall expire if it is not again renewed.
A certificate which was forfeited for failure to renew under the
law in effect before October 1, 1961, shall, for the purposes of this
article, be considered to have expired on the date that it became
forfeited.
SEC. 22. Section 4843.5 of the Business and Professions Code is amended to read:

4843.5. Except as otherwise provided in this article, an expired certificate of registration may be renewed at any time within five years after its expiration on filing of an application for renewal on a form prescribed by the board, and payment of all accrued and unpaid renewal fees. If the certificate of registration is renewed more than 30 days after its expiration, the registrant, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this article. Renewal under this section shall be effective on the date on which the application is filed, on the date all renewal fees are paid, or on the date on which the delinquency fee, if any, is paid, whichever occurs last.

SEC. 23. Section 4901 of the Business and Professions Code is amended to read:

4901. Except as otherwise provided in this chapter, an expired license or registration may be renewed at any time within five years after its expiration on filing of an application for renewal on a form prescribed by the board, and payment of all accrued and unpaid renewal fees. If the license or registration is renewed more than 30 days after its expiration, the licensee or registrant, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date all renewal fees are paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license or registration shall continue in effect through the expiration date provided in Section 4900 that next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 24. Section 4966 of the Business and Professions Code is amended to read:

4966. Except as provided in Section 4969, a license that has expired may be renewed at any time within three years after its expiration by filing of an application for renewal on a form provided by the board, paying all accrued and unpaid renewal fees, the renewal fee, and providing proof of completing continuing education requirements. If the license is not renewed prior to its expiration, the acupuncturist, as a condition precedent to renewal,
shall also pay the prescribed delinquency fee. Renewal under this
section shall be effective on the date on which the application is
filed, on the date on which the renewal fee is paid, or on the date
the delinquency fee is paid, whichever occurs last. If so renewed,
the license shall continue in effect through the expiration date
provided in Section 4965, after the effective date of the renewal,
when it shall expire and become invalid if it is not again renewed.

SEC. 25. Section 4989.36 of the Business and Professions Code
is amended to read:

4989.36. A licensee may renew a license that has expired at
any time within three years after its expiration date by taking all
of the actions described in Section 4989.32 and by paying all
unpaid prior renewal fees and delinquency fees. the delinquency
fee.

SEC. 26. Section 4999.104 of the Business and Professions
Code is amended to read:

4999.104. Licenses issued under this chapter that have expired
may be renewed at any time within three years of expiration. To
renew an expired license described in this section, the licensee
shall do all of the following:

(a) File an application for renewal on a form prescribed by the
board.

(b) Pay all fees that would have been paid if the license had not
become delinquent.

(c) Pay all the delinquency fees.

(d) Certify compliance with the continuing education
requirements set forth in Section 4999.76.

(e) Notify the board whether he or she the licensee has been
convicted, as defined in Section 490, of a misdemeanor or felony,
or whether any disciplinary action has been taken by any regulatory
or licensing board in this or any other state, subsequent to the
licensee’s last renewal.

SEC. 27. Section 5070.6 of the Business and Professions Code
is amended to read:

5070.6. Except as otherwise provided in this chapter, an expired
permit may be renewed at any time within five years after its
expiration upon the filing of an application for renewal on a form
prescribed by the board, payment of all accrued and unpaid renewal fees the renewal fee, and providing evidence satisfactory to the board of compliance as required by Section 5070.5. If the permit is renewed after its expiration, its holder, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the accrued renewal fees are fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the permit shall continue in effect through the date provided in Section 5070.5 that next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 28. Section 5600.2 of the Business and Professions Code is amended to read:

5600.2. Except as otherwise provided in this chapter, a license which has expired may be renewed at any time within five years after its expiration on filing of application for renewal on a form prescribed by the board, and payment of all accrued and unpaid renewal fees the renewal fee. If a license is renewed more than 30 days after its expiration, the licenseholder, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date provided in this chapter which next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 29. Section 5680.1 of the Business and Professions Code is amended to read:

5680.1. Except as otherwise provided in this chapter, a license that has expired may be renewed at any time within five years after its expiration on filing of an application for renewal on a form prescribed by the board, and payment of all accrued and unpaid renewal fees the renewal fee. If the license is renewed more than 30 days after its expiration, the licenseholder, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which all the renewal fees are fee is paid, or on the date on which the
delinquency fee, if any, is paid, whichever last occurs. If so
renewed, the license shall continue in effect through the date
provided in Section 5680 that next occurs after the effective date
of the renewal, when it shall expire if it is not again renewed.

SEC. 30. Section 6796 of the Business and Professions Code
is amended to read:

6796. Except as otherwise provided in this article, certificates
of registration as a professional engineer and certificates of
authority may be renewed at any time within five years after
expiration on filing of application for renewal on a form prescribed
by the board and payment of the renewal fee. If the certificate is renewed more than 60 days
after its expiration, the certificate holder, as a condition precedent
to renewal, shall also pay the delinquency fee prescribed by this
chapter. Renewal under this section shall be effective on the date
on which the application is filed, on the date on which the renewal
fee is paid, or on the date on which the delinquency fee, if any, is
paid, whichever last occurs.

The expiration date of a certificate renewed pursuant to this
section shall be determined pursuant to Section 6795.

SEC. 31. Section 6980.28 of the Business and Professions Code
is amended to read:

6980.28. A locksmith license not renewed within three years
following its expiration may not be renewed thereafter. Renewal
of the license within three years, or issuance of an original license
thereafter, shall be subject to payment of any and all fines assessed by the chief or the director which are not pending
appeal and all other applicable fees.

SEC. 32. Section 7076.5 of the Business and Professions Code
is amended to read:

7076.5. (a) A contractor may inactivate his or her license
by submitting a form prescribed by the registrar accompanied by
the current active license certificate. When the current license
certificate has been lost, the licensee shall pay the fee prescribed
by law to replace the license certificate. Upon receipt of an
acceptable application to inactivate, the registrar shall issue an
inactive license certificate to the contractor. The holder of an
inactive license shall not be entitled to practice as a contractor until
his or her license is reactivated.
(b) Any licensed contractor who is not engaged in work or activities which require a contractor’s license may apply for an inactive license.

(c) Inactive licenses shall be valid for a period of four years from their due date.

(d) During the period that an existing license is inactive, no bonding requirement pursuant to Section 7071.6, 7071.8 or 7071.9 or qualifier requirement pursuant to Section 7068 shall apply. An applicant for license having met the qualifications for issuance may request that the license be issued inactive unless the applicant is subject to the provisions of Section 7071.8.

(e) The board shall not refund any of the renewal fee which a licensee may have paid prior to the inactivation of his or her license.

(f) An inactive license shall be renewed on each established renewal date by submitting the renewal application and paying the inactive renewal fee.

(g) An inactive license may be reactivated by submitting an application acceptable to the registrar, by paying the full renewal fee or no more than 50 percent of the renewal fee for an active license, and by fulfilling all other requirements of this chapter. No examination shall be required to reactivate an inactive license.

(h) The inactive status of a license shall not bar any disciplinary action by the board against a licensee for any of the causes stated in this chapter.

SEC. 33. Section 7417 of the Business and Professions Code is amended to read:

7417. Except as otherwise provided in this article, a license that has expired for failure of the licensee to renew within the time fixed by this article may be renewed at any time within five years following its expiration upon application and payment of all accrued and unpaid renewal fees and delinquency fees. If the license is renewed after its expiration, the licensee, as a condition precedent to renewal, shall also pay the delinquency fee and meet current continuing education requirements, if applicable, prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, or on the date on which the accrued renewal fees are paid, or on the date on which the delinquency fee, if any, is paid, whichever occurs last. If so renewed, the license shall continue in effect through the expiration
date provided in this article which next occurs following the
effective date of the renewal, when it shall expire if it is not again
renewed.

SEC. 34. Section 7672.8 of the Business and Professions Code
is amended to read:
7672.8. All cremated remains disposer registrations shall expire
at midnight on September 30 of each year. A person desiring to
renew his or her registration shall file an application for
renewal on a form prescribed by the bureau accompanied by the
required fee. A registration that has expired may be renewed within
five years of its expiration upon payment of all accrued and unpaid
renewal fees. The bureau shall not renew the
registration of any person who has not filed the required annual
report until he or she has filed a complete annual report
with the department.

SEC. 35. Section 7725.2 of the Business and Professions Code
is amended to read:
7725.2. Except as otherwise provided in this chapter, a license
that has expired may be renewed at any time within five years after
its expiration on filing of an application for renewal on a form
prescribed by the bureau and payment of all accrued and unpaid
renewal fees. The license shall not be renewed unless
the person has filed a complete annual report with the department.

SEC. 36. Section 7729.1 of the Business and Professions Code
is amended to read:
7729.1. The amount of fees prescribed for a license or
certificate of authority under this act is that fixed by the following
provisions of this article. Any license or certificate of authority
provided under this act that has expired may be renewed within
five years of its expiration upon payment of all accrued and unpaid
renewal and regulatory fees: the renewal fee.
SEC. 37. Section 7881 of the Business and Professions Code
is amended to read:
7881. Except as otherwise provided in this article, certificates
of registration as a geologist or as a geophysicist, or certified
specialty certificates, may be renewed at any time within five years
after expiration on filing an application for renewal on a form
prescribed by the board and payment of all accrued and unpaid
renewal fees: the renewal fee. If the certificate is renewed more
than 30 days after its expiration, the certificate holder, as a
condition precedent to renewal, shall also pay the delinquency fee
prescribed by this chapter. Renewal under this section shall be
effective on the date on which the application is filed, on the date
on which all the renewal fees are paid, or on the date on
which the delinquency fee, if any, is paid, whichever last occurs.
If so renewed, the certificate shall continue in effect through the
date provided in Section 7880 that next occurs after the effective
date of the renewal, when it shall expire if it is not again renewed.
SEC. 38. Section 7883 of the Business and Professions Code
is amended to read:
7883. A revoked certificate is subject to expiration as provided
in this article, but it may not be renewed. If it is reinstated after its
expiration, the holder of the certificate, as a condition precedent
to its reinstatement, shall pay a reinstatement fee in an amount
equal to the renewal fee in effect on the last regular date before
the date on which it is reinstated, plus all accrued and unpaid
renewal fees reinstated and the delinquency fee, if any, accrued
at the time of its revocation.
SEC. 39. Section 8024.7 of the Business and Professions Code
is amended to read:
8024.7. The board shall establish an inactive category of
licensure for persons who are not actively engaged in the practice
of shorthand reporting.
(a) The holder of an inactive license issued pursuant to this
section shall not engage in any activity for which a license is
required.
(b) An inactive license issued pursuant to this section shall be
renewed during the same time period in which an active license
is renewed. The holder of an inactive license is exempt from any
continuing education requirement for renewal of an active license.
(c) The renewal fee for a license in an active status shall apply
also for a renewal of a license in an inactive status, unless a lesser
renewal fee is specified by the board. be no more than 50 percent
of the renewal fee for a license in an active status.
(d) In order for the holder of an inactive license issued pursuant
to this section to restore his or her license to an active status,
the holder of an inactive license shall comply with both of the
following:
(1) Pay the renewal fee.
(2) If the board requires completion of continuing education for
renewal of an active license, complete continuing education
equivalent to that required for renewal of an active license, unless
a different requirement is specified by the board.
SEC. 40. Section 8802 of the Business and Professions Code
is amended to read:
8802. Except as otherwise provided in this article, licenses
issued under this chapter may be renewed at any time within five
years after expiration on filing of application for renewal on a form
prescribed by the board and payment of all accrued and unpaid
renewal fees. The renewal fee. If the license is renewed more than
30 days after its expiration, the licensee, as a condition precedent
to renewal, shall also pay the delinquency fee prescribed by this
chapter. Renewal under this section shall be effective on the date
on which the application is filed, on the date on which the renewal
fee is paid, or on the date on which the delinquency fee, if any, is
paid, whichever last occurs. If so renewed, the license shall
continue in effect through the date provided in Section 8801 which
next occurs after the effective date of the renewal, when it shall
expire if it is not again renewed.
SEC. 41. Section 9832 of the Business and Professions Code
is amended to read:
9832. (a) Registrations issued under this chapter shall expire
no more than 12 months after the issue date. The expiration date
of registrations shall be set by the director in a manner to best
distribute renewal procedures throughout the year.
(b) To renew an unexpired registration, the service dealer shall,
on or before the expiration date of the registration, apply for
renewal on a form prescribed by the director, and pay the renewal fee prescribed by this chapter.

(c) To renew an expired registration, the service dealer shall apply for renewal on a form prescribed by the director, pay the renewal fee in effect on the last regular renewal date, and pay all accrued and unpaid the delinquency and renewal fees.

(d) Renewal is effective on the date that the application is filed, filed and the renewal fee is paid, and all delinquency fees are paid.

(e) For purposes of implementing the distribution of the renewal of registrations throughout the year, the director may extend by not more than six months, the date fixed by law for renewal of a registration, except that in that event any renewal fee that may be involved shall be prorated in a manner that no person shall be required to pay a greater or lesser fee than would have been required had the change in renewal dates not occurred.

SEC. 42. Section 9832.5 of the Business and Professions Code is amended to read:

9832.5. (a) Registrations issued under this chapter shall expire no more than 12 months after the issue date. The expiration date of registrations shall be set by the director in a manner to best distribute renewal procedures throughout the year.

(b) To renew an unexpired registration, the service contractor shall, on or before the expiration date of the registration, apply for renewal on a form prescribed by the director, and pay the renewal fee prescribed by this chapter.

(c) To renew an expired registration, the service contractor shall apply for renewal on a form prescribed by the director, pay the renewal fee in effect on the last regular renewal date, and pay all accrued and unpaid the delinquency and renewal fees.

(d) Renewal is effective on the date that the application is filed, filed and the renewal fee is paid, and all delinquency fees are paid.

(e) For purposes of implementing the distribution of the renewal of registrations throughout the year, the director may extend, by not more than six months, the date fixed by law for renewal of a registration, except that, in that event, any renewal fee that may be involved shall be prorated in such a manner that no person shall be required to pay a greater or lesser fee than would have been required had the change in renewal dates not occurred.

(f) This section shall remain in effect only until January 1, 2023, and as of that date is repealed.
SEC. 43. Section 9884.5 of the Business and Professions Code is amended to read:

9884.5. A registration that is not renewed within three years following its expiration shall not be renewed, restored, or reinstated thereafter, and the delinquent registration shall be canceled immediately upon expiration of the three-year period.

An automotive repair dealer whose registration has been canceled by operation of this section shall obtain a new registration only if he or she again meets the requirements set forth in this chapter relating to registration, is not subject to denial under Section 480, and pays the applicable fees.

An expired registration may be renewed at any time within three years after its expiration upon the filing of an application for renewal on a form prescribed by the bureau and the payment of all accrued renewal and delinquency fees. Renewal under this section shall be effective on the date on which the application is filed and all the renewal and delinquency fees are paid. If so renewed, the registration shall continue in effect through the expiration date of the current registration year as provided in Section 9884.3, at which time the registration shall be subject to renewal.

SEC. 44. Section 19170.5 of the Business and Professions Code is amended to read:

19170.5. (a) Except as provided in Section 19170.3, licenses issued under this chapter expire two years from the date of issuance. To renew his or her license, a licensee shall, on or before the date on which it would otherwise expire, apply for renewal on a form prescribed by the chief, and pay the fees prescribed by Sections 19170 and 19213.1. If a licensee fails to renew his or her license before its expiration, a delinquency fee of 20 percent, but not more than one hundred dollars ($100), notwithstanding the provisions of Section 163.5, shall be added to the renewal fee. If the renewal fee and delinquency fee are not paid within 90 days after expiration of a license, the licensee shall be assessed an additional penalty fee of 30 percent of the renewal fee.

(b) Except as otherwise provided in this chapter, a licensee may renew an expired license within six years after expiration of the license by filing an application for renewal on a form prescribed...
by the bureau, and paying all accrued renewal, delinquent, the
renewal, delinquency, and penalty fees.

(c) A license that is not renewed within six years of its expiration
shall not be renewed, restored, reinstated, or reissued, but the holder
of the license may apply for and obtain a new license if both of
the following requirements are satisfied:

(1) No fact, circumstance, or condition exists which would
justify denial of licensure under Section 480.

(2) The licensee pays all the renewal, delinquency, and penalty
fees that have accrued since the date on which the license was last
renewed.

(d) The bureau may impose conditions on any license issued
pursuant to subdivision (c).

SEC. 45. Section 19290 of the Business and Professions Code
is amended to read:

19290. (a) Permits issued under this chapter expire two years
from the date of issuance. To renew a permit, a permittee shall,
on or before the date on which it would otherwise expire, apply
for renewal on a form prescribed by the chief, and continue to pay
the fees prescribed in Sections 19288 and 19288.1. Notwithstanding
Section 163.5, if a permittee fails to renew the permit before its
expiration, a delinquency fee of 20 percent of the most recent fee
paid to the bureau pursuant to Sections 19288 and 19288.1 shall
be added to the amount due to the bureau at the next fee interval.
If the renewal fee and delinquency fee are not paid within 90 days
after expiration of a permit, the permittee shall be assessed an
additional fee of 30 percent of the most recent fee paid to the
bureau pursuant to Sections 19288 and 19288.1.

(b) Except as otherwise provided in this chapter, a permittee
may renew an expired permit within two years after expiration of
the permit by filing an application for renewal on a form prescribed
by the bureau, and paying all accrued fees.

(c) A permit that is not renewed within two years of its
expiration shall not be renewed, restored, reinstated, or reissued,
but the holder of the expired permit may apply for and obtain a
new permit as provided in this chapter, upon payment of all fees
that accrued since the date the permit was last renewed.

(d) The bureau may impose conditions on any permit issued
pursuant to subdivision (c).
SECTION 1. Section 4073 of the Business and Professions Code is amended to read:
4073. (a) A pharmacist filling a prescription order for a drug product prescribed by its trade or brand name may select another drug product with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name as determined by the United States Adopted Names (USAN) and accepted by the federal Food and Drug Administration (FDA), of those drug products having the same active chemical ingredients.

(b) In no case shall a selection be made pursuant to this section if the prescriber personally indicates, either orally or in the prescriber’s own handwriting, “Do not substitute,” or words of similar meaning. Nothing in this subdivision shall prohibit a prescriber from checking a box on a prescription marked “Do not substitute”; provided that the prescriber personally initials the box or checkmark. To indicate that a selection shall not be made pursuant to this section for an electronic data transmission prescription as defined in subdivision (c) of Section 4040, a prescriber may indicate “Do not substitute,” or words of similar meaning, in the prescription as transmitted by electronic data, or may check a box marked on the prescription “Do not substitute.” In either instance, it shall not be required that the prohibition on substitution be manually initialed by the prescriber.

(c) Selection pursuant to this section is within the discretion of the pharmacist, except as provided in subdivision (b). The person who selects the drug product to be dispensed pursuant to this section shall assume the same responsibility for selecting the dispensed drug product as would be incurred in filling a prescription for a drug product prescribed by generic name. There shall be no liability on the prescriber for an act or omission by a pharmacist in selecting, preparing, or dispensing a drug product pursuant to this section. In no case shall the pharmacist select a drug product pursuant to this section unless the drug product selected costs the patient less than the prescribed drug product. Cost, as used in this subdivision, is defined to include any professional fee that may be charged by the pharmacist.

(d) This section shall apply to all prescriptions, including those presented by or on behalf of persons receiving assistance from the federal government or pursuant to the California Medical Assistance Program set forth in Chapter 7 (commencing with
Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

(e) When a substitution is made pursuant to this section, the use of the cost-saving drug product dispensed shall be communicated to the patient and the name of the dispensed drug product shall be indicated on the prescription label, except where the prescriber orders otherwise.
BILL ANALYSIS

AUTHOR: Eduardo Garcia  BILL NUMBER: AB 743

SPONSOR:  BILL STATUS: Assembly 3rd Reading

SUBJECT: Pupil health: self-administration of prescribed asthma medication  DATE LAST AMENDED: March 28, 2019

SUMMARY:

Existing law authorizes a school nurse, or other designated school personnel to assist any pupil who is required to take, during the regular school day, medication prescribed for the pupil by a physician and surgeon or ordered for a pupil by a physician assistant if the school district receives specified written statements from the physician and surgeon or physician assistant and from the parent, foster parent, or guardian of the pupil.

ANALYSIS:

This bill would require a school district to accept a written statement provided by a physician, surgeon, or physician assistant licensed another state or country.

Amended analysis as of 3/28:

The title of the bill changed from “Pupil health: medication assistance: written physician statement” to “Pupil health: self-administration of prescribed asthma medication.”

Existing law authorizes a pupil to carry and self-administer prescription inhaled asthma medication, if the school district receives a written statement from a physician or surgeon detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken, and confirming that the pupil is able to self-administer inhaled asthma medication.

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. Existing law requires a prepaid health plan operating lawfully under the laws of Mexico that elects to operate a health care service plan in this state to apply for licensure as a health care service plan.

The bill now:

- deletes the ability of a physician’s assistant to order a medication for a pupil
- require a school district to accept a written statement provided by a physician or surgeon relating to a pupil carrying and self-administering inhaled asthma medication, from a
physician or surgeon who is contracted with a prepaid health plan operating lawfully under the laws of Mexico that is licensed as a health care service plan in this state.

**Amended analysis as of 4/22:**

The bill would:
- require that written statement to be provided in both English and Spanish and to include the name and contact information for the physician or surgeon.
- provide that a school nurse or other school personnel shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for their acts or omissions relating to a pupil self-administering inhaled asthma medication in accordance with a written statement from such a physician or surgeon.
- provide that a school district shall not be subject to civil liability if a pupil self-administering inhaled asthma medication in accordance with a written statement from such a physician or surgeon suffers an adverse reaction.

**BOARD POSITION:** Watch (4/11/19)

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Watch (3/14/19)

**SUPPORT:**
Comite Civico Del Valle, Inc.

**OPPOSE:**
California School Nurses Organization
California Teachers Association
An act to amend Section 49423.1 of the Education Code, relating to pupil health.

LEGISLATIVE COUNSEL’S DIGEST


Existing law authorizes a school nurse or other designated school personnel to assist any pupil who is required to take, during the regular schoolday, medication prescribed for the pupil by a physician or surgeon if the school district receives specified written statements from the physician or surgeon and from the parent, foster parent, or guardian of the pupil. Existing law authorizes a pupil to carry and self-administer prescription inhaled asthma medication, if the school district receives (1) a written statement from a physician or surgeon detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken, and confirming that the pupil is able to self-administer inhaled asthma medication and (2) specified written statements from the parent, foster parent, or guardian of the pupil, including releasing the school district and school personnel from civil liability if the self-administering pupil suffers an adverse reaction by taking the asthma medication.
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. Existing law requires a prepaid health plan operating lawfully under the laws of Mexico that elects to operate a health care service plan in this state to apply for licensure as a health care service plan.

This bill would require a school district to accept a written statement provided by a physician or surgeon relating to a pupil carrying and self-administering inhaled asthma medication, from a physician or surgeon who is contracted with a prepaid health plan operating lawfully under the laws of Mexico that is licensed as a health care service plan in this state. The bill would require that written statement to be provided in both English and Spanish and to include the name and contact information for the physician or surgeon. The bill would provide that a school nurse or other school personnel shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for their acts or omissions relating to a pupil self-administering inhaled asthma medication in accordance with a written statement from such a physician or surgeon. The bill would also provide that a school district shall not be subject to civil liability if a pupil self-administering inhaled asthma medication in accordance with a written statement from such a physician or surgeon suffers an adverse reaction.


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

SECTION 1. This act shall be known, and may be cited, as the Clear Air for All Act.

SEC. 2. Section 49423.1 of the Education Code is amended to read:

49423.1. (a) Notwithstanding Section 49422, a pupil who is required to take, during the regular schoolday, medication prescribed for the pupil by a physician or surgeon, may be assisted by the school nurse or other designated school personnel or may carry and self-administer inhaled asthma medication if the school district receives the appropriate written statements specified in subdivision (b).
(b) (1) In order for a pupil to be assisted by a school nurse or other designated school personnel pursuant to subdivision (a), the school district shall obtain both a written statement from the physician or surgeon detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken and a written statement from the parent, foster parent, or guardian of the pupil requesting that the school district assist the pupil in the matters set forth in the statement of the physician or surgeon.

(2) (A) In order for a pupil to carry and self-administer prescription inhaled asthma medication pursuant to subdivision (a), the school district shall obtain both a written statement from the physician or surgeon detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken, and confirming that the pupil is able to self-administer inhaled asthma medication, and a written statement from the parent, foster parent, or guardian of the pupil consenting to the self-administration, providing a release for the school nurse or other designated school personnel to consult with the health care provider of the pupil regarding any questions that may arise with regard to the medication, and releasing the school district and school personnel from civil liability if the self-administering pupil suffers an adverse reaction by taking medication pursuant to this section.

(B) (i) A school district shall accept the written statement from a physician or surgeon, as specified in this paragraph, from a physician or surgeon who is contracted with a health plan licensed pursuant to Section 1351.2 of the Health and Safety Code. A written statement specified in this subparagraph shall be provided in both English and Spanish, and shall include the name and contact information for the physician or surgeon.

(ii) A school nurse or other school personnel shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for their acts or omissions relating to a pupil self-administering inhaled asthma medication in accordance with this subparagraph. A school district shall not be subject to civil liability if a pupil self-administering inhaled asthma medication in accordance with this subparagraph suffers an adverse reaction.

(3) The written statements specified in this subdivision shall be provided at least annually and more frequently if the medication,
dosage, frequency of administration, or reason for administration changes.

(c) A pupil may be subject to disciplinary action pursuant to
Section 48900 if the pupil uses inhaled asthma medication in a
manner other than as prescribed.
BOARD OF REGISTERED NURSING
LEGISLATIVE COMMITTEE
May 9, 2019

BILL ANALYSIS

AUTHOR: Irwin                   BILL NUMBER: AB 822

SPONSOR: Velano Vascular        BILL STATUS: Assembly Committee on Appropriations

SUBJECT: Phlebotomy             DATE LAST AMENDED: April 10, 2019

SUMMARY:

Existing law provides for the licensure and regulation of clinical laboratories and clinical laboratory personnel and health professionals by the State Department of Public Health and makes a violation of these provisions a crime.

Existing law authorizes an unlicensed person employed by a licensed clinical laboratory to perform venipuncture or skin puncture for the purpose of withdrawing blood or for clinical laboratory test purposes upon specific authorization from a licensed physician and surgeon, if that unlicensed person meets certain requirements.

Existing law requires an unlicensed person performing these duties to possess a valid and current certification as a certified phlebotomy technician issued by the department.

ANALYSIS:

This bill would specify that the tests an unlicensed person may perform under these provisions include following procedures and using devices for blood collection authorized by the clinical laboratory or other facility employing the person.

Amended analysis as of 4/10:

This bill would specify that the tests an unlicensed person may perform under these provisions include following procedures and using devices approved by the United States Food and Drug Administration for blood collection authorized by the clinical laboratory or other facility employing the person.

BOARD POSITION: Oppose (4/11/19)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Not previously considered
SUPPORT:
Velano Vascular, Inc. (sponsor)
American Congress of Obstetricians & Gynecologists - District IX
Center for Phlebotomy Education
Connecticut Center for Patient Safety
Infusion Therapy Strategies and Solutions
Kisses for Katie
Lynn Hadaway Associates
University Hospitals Cleveland Medical Center
One Individual

OPPOSE:
Aids Healthcare Foundation
California Labor Federation, AFL-CIO
California Nurses Association
California Teamsters Public Affairs Council
Engineers and Scientists of California Local 20, IFPTE AFL-CIO & CLC
United Food and Commercial Workers, Western States Council
United Nurses Associations of California/Union of Health Care Professionals
An act to amend Sections 1242 and 1246 of the Business and Professions Code, relating to phlebotomy.

LEGISLATIVE COUNSEL’S DIGEST

AB 822, as amended, Irwin. Phlebotomy.

Existing law provides for the licensure and regulation of clinical laboratories and clinical laboratory personnel and health professionals by the State Department of Public Health and makes a violation of these provisions a crime. Existing law authorizes an unlicensed person employed by a licensed clinical laboratory to perform venipuncture or skin puncture for the purpose of withdrawing blood or for clinical laboratory test purposes upon specific authorization from a licensed physician and surgeon, if that unlicensed person meets certain requirements. Existing law requires an unlicensed person performing these duties to possess a valid and current certification as a certified phlebotomy technician issued by the department.

This bill would specify that the tests an unlicensed person may perform under these provisions include following procedures and using devices approved by the United States Food and Drug Administration for blood collection authorized by the clinical laboratory or other facility employing the person.

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

SECTION 1. Section 1242 of the Business and Professions Code is amended to read:

1242. Any person duly licensed under the provisions of this chapter to perform tests called for in a clinical laboratory may perform skin tests for specific diseases, arterial puncture, venipuncture, or skin puncture for purposes of withdrawing blood or for clinical laboratory test purposes as defined by regulations established by the department and upon specific authorization from any person in accordance with the authority granted under any provisions of law relating to the healing arts. These tests may include following procedures and using devices for blood collection that are authorized by the clinical laboratory or other facility licensed under the Health and Safety Code employing the person.

SEC. 2. Section 1246 of the Business and Professions Code is amended to read:

1246. (a) Except as provided in subdivisions (b) and (c), and in Section 23158 of the Vehicle Code, an unlicensed person employed by a licensed clinical laboratory may perform venipuncture or skin puncture for the purpose of withdrawing blood or for clinical laboratory test purposes, or may follow procedures and use other devices approved by the United States Food and Drug Administration for blood collection that are authorized by the clinical laboratory or other facility licensed under the Health and Safety Code employing the person, upon specific authorization from a licensed physician and surgeon provided that the person meets both of the following requirements:

(1) The person works under the supervision of a person licensed under this chapter or of a licensed physician and surgeon or of a licensed registered nurse. A person licensed under this chapter, a licensed physician or surgeon, or a registered nurse shall be physically available to be summoned to the scene of the venipuncture within five minutes during the performance of those procedures.

(2) The person has been trained by a licensed physician and surgeon or by a clinical laboratory bioanalyst in the proper
procedure to be employed when withdrawing blood in accordance
with training requirements established by the department and has
a statement signed by the instructing physician and surgeon or by
the instructing clinical laboratory bioanalyst that the training has
been successfully completed.

(b) (1) On and after the effective date of the regulations
specified in paragraph (2), any unlicensed person employed by a
clinical laboratory performing the duties described in this section
shall possess a valid and current certification as a certified
phlebotomy technician issued by the department. However, an
unlicensed person employed by a clinical laboratory to perform
these duties pursuant to subdivision (a) on that date shall have until
January 1, 2007, to comply with this requirement, provided that
the person has submitted the application to the department on or
before July 1, 2006.

(2) The department shall adopt regulations for certification by
January 1, 2001, as a certified phlebotomy technician that shall
include all of the following:

(A) The applicant shall hold a valid, current certification as a
phlebotomist issued by a national accreditation agency approved
by the department, and shall submit proof of that certification when
applying for certification pursuant to this section.

(B) The applicant shall complete education, training, and
experience requirements as specified by regulations that shall
include, but not be limited to, the following:

(i) At least 40 hours of didactic instruction.

(ii) At least 40 hours of practical instruction.

(iii) At least 50 successful venipunctures.

However, an applicant who has been performing these duties
pursuant to subdivision (a) may be exempted from the requirements
specified in clauses (ii) and (iii), and from 20 hours of the 40 hours
didactic instruction as specified in clause (i), if the applicant
has at least 1,040 hours of work experience, as specified in
regulations adopted by the department.

It is the intent of the Legislature to permit persons performing
these duties pursuant to subdivision (a) to use educational leave
provided by their employers for purposes of meeting the
requirements of this section.

(C) Each certified phlebotomy technician shall complete at least
three hours per year or six hours every two years of continuing
education or training. The department shall consider a variety of programs in determining the programs that meet the continuing education or training requirement.

(D) The applicant has been found to be competent in phlebotomy by a licensed physician and surgeon or person licensed pursuant to this chapter.

(E) The applicant works under the supervision of a licensed physician and surgeon, licensed registered nurse, or person licensed under this chapter, or the designee of a licensed physician and surgeon or the designee of a person licensed under this chapter.

(3) The department shall adopt regulations establishing standards for approving training programs designed to prepare applicants for certification pursuant to this section. The standards shall ensure that these programs meet the state’s minimum education and training requirements for comparable programs.

(4) The department shall adopt regulations establishing standards for approving national accreditation agencies to administer certification examinations and tests pursuant to this section.

(5) The department shall charge fees for application for and renewal of the certificate authorized by this section of no more than one hundred dollars ($100) for a two-year period.

(c) (1) (A) A certified phlebotomy technician may perform venipuncture or skin puncture, or may follow other procedures and use devices approved by the United States Food and Drug Administration for blood collection that are authorized by the clinical laboratory or other facility licensed under the Health and Safety Code employing the technician, to obtain a specimen for nondiagnostic tests assessing the health of an individual, for insurance purposes, provided that the technician works under the general supervision of a physician and surgeon licensed under Chapter 5 (commencing with Section 2000). The physician and surgeon may delegate the general supervision duties to a registered nurse or a person licensed under this chapter, but shall remain responsible for ensuring that all those duties and responsibilities are properly performed. The physician and surgeon shall make available to the department, upon request, records maintained documenting when a certified phlebotomy technician has performed venipuncture or skin puncture pursuant to this paragraph.
(B) As used in this paragraph, general supervision requires the supervisor of the technician to determine that the technician is competent to perform venipuncture or skin puncture prior to the technician’s first blood withdrawal, and on an annual basis thereafter. The supervisor is also required to determine, on a monthly basis, that the technician complies with appropriate venipuncture or skin puncture policies and procedures approved by the medical director and required by state regulations. The supervisor, or another designated licensed physician and surgeon, registered nurse, or person licensed under this chapter, shall be available for consultation with the technician, either in person or through telephonic or electronic means, at the time of blood withdrawal.

(2) (A) Notwithstanding any other law, a person who has been issued a certified phlebotomy technician certificate pursuant to this section may draw blood following policies and procedures approved by a physician and surgeon licensed under Chapter 5 (commencing with Section 2000), appropriate to the location where the blood is being drawn and in accordance with state regulations, including by following procedures and using devices approved by the United States Food and Drug Administration for blood collection that are authorized by the clinical laboratory or other facility licensed under the Health and Safety Code employing that person. The blood collection shall be done at the request and in the presence of a peace officer for forensic purposes in a jail, law enforcement facility, or medical facility, with general supervision.

(B) As used in this paragraph, “general supervision” means that the supervisor of the technician is licensed under this code as a physician and surgeon, physician assistant, clinical laboratory bioanalyst, registered nurse, or clinical laboratory scientist, and reviews the competency of the technician before the technician may perform blood withdrawals without direct supervision, and on an annual basis thereafter. The supervisor is also required to review the work of the technician at least once a month to ensure compliance with venipuncture policies, procedures, and regulations. The supervisor, or another person licensed under this code as a physician and surgeon, physician assistant, clinical laboratory bioanalyst, registered nurse, or clinical laboratory scientist, shall be accessible to the location where the technician is working to
provide onsite, telephone, or electronic consultation, within 30 minutes when needed.

(d) The department may adopt regulations providing for the issuance of a certificate to an unlicensed person employed by a clinical laboratory authorizing only the performance of skin punctures for test purposes.
SUMMARY:

Existing law, the Nursing Practice Act:

- provides for the certification and regulation of nurse practitioners by the Board of Registered Nursing.
- authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including certifying disability after performing a physical examination and collaboration with a physician and surgeon.

ANALYSIS:

This bill would:

- authorize a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body to practice without the supervision of a physician and surgeon if the nurse practitioner meets specified requirements, including having practiced under the supervision of a physician and surgeon for an unspecified number of hours.
- authorize a nurse practitioner to perform specified functions in addition to any other practices authorized by law, including ordering and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and administering controlled substances.

Amended analysis as of 4/3:

The bill changed the subject from “Nurse practitioners” to “Nurse practitioners: scope of practice: unsupervised practice.”

The bill also cites two other existing laws.
The bill would now:

- authorize a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body recognized by the board who practices in certain settings to perform specified functions without supervision by a physician and surgeon, including ordering and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and administering controlled substances.

- authorize a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body recognized by the board to practice without supervision by a physician and surgeon in accordance with specified conditions and requirements if the nurse practitioner has successfully completed a transition to practice program, as defined by the bill, and a supervising physician and surgeon at the facility at which the nurse practitioner completed the transition to practice program attests to the board that the nurse practitioner is proficient in competencies established by the board by regulation.

Existing law makes it unlawful for specified healing arts practitioners, including physicians and surgeons, psychologists, and acupuncturists, to refer a person for certain services, including laboratory, diagnostic nuclear medicine, and physical therapy, if the physician and surgeon or their immediate family has a financial interest with the person or in the entity that receives the referral. A violation of those provisions is a misdemeanor and subject to specified civil penalties and disciplinary action.

This bill would make those provisions applicable to a nurse practitioner practicing pursuant to the bill’s provisions.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process and defines “licentiate” for those purposes.

This bill would include as a licentiate a nurse practitioner practicing pursuant to the bill’s provisions.

**Amended analysis as of 4/22:**

This bill adds Article 8.5 *Advanced Practice Registered Nurses* to the Nursing Practice Act.

This bill would now:

- establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members;

- authorize a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body recognized by the board who practices in certain settings or organizations to perform specified functions without supervision by a physician and surgeon, including ordering and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and administering controlled substances;

- authorize a nurse practitioner who holds an active certification issued by the board to practice without supervision by a physician and surgeon outside of specified settings or organizations in accordance with specified conditions and requirements if the nurse
practitioner meets specified education and other requirements, including completion of a transition to practice, as defined by the bill;

- The bill would authorize the board, upon application, to issue an inactive certificate.

**BOARD POSITION:** Oppose unless amended (4/11/19)

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Watch (3/14/19)

**SUPPORT:**
AARP
Alliance of Catholic Health Care, Inc.
American Nurses Association/California
Anthem Blue Cross
Association of California Healthcare Districts
Association of Community Human Service Agencies
California Alliance of Child and Family Services
California Association of Clinical Nurse Specialist
California Association for Health Services at Home
California Association for Nurse Practitioners
California Hospital Association
California Naturopathic Doctors Association
California State Council of Service Employees
Casa Pacifica
Congress of California Seniors
Engineers and Scientists of California Local 20, IFPTE AFL-CIO & CLC
Essential Access Health
Hathaway-Sycamores
Mental Health Association in California
Providence St. Joseph
Steinberg Institute
Western University of Health Sciences
Numerous individuals, including licensed NPs

**OPPOSE:**
California Chapter American College of Cardiology
California Chapter of the American College of Emergency Physicians
California Medical Association (unless amended)
California Prolife Council and Right to Life Federation (unless amended)
California Orthopedic Association
California Society of Plastic Surgeons
Physicians for Patient Protection
Numerous individuals, including licensed physician and surgeons

Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts that are in addition to other authorized practices, including certifying disability after performing a physical examination and collaboration with a physician and surgeon. A violation of the act is a misdemeanor.

This bill would establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members. The bill would authorize a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body
recognized by the board who practices in certain settings or organizations to perform specified functions without supervision by a physician and surgeon, including ordering and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and administering controlled substances.

The bill would also authorize a nurse practitioner who holds an active certification as a nurse practitioner from a national certifying body recognized issued by the board to practice without supervision by a physician and surgeon outside of specified settings or organizations in accordance with specified conditions and requirements if the nurse practitioner has successfully completed meets specified education and other requirements, including completion of a transition to practice program, practice, as defined by the bill, and a supervising physician and surgeon at the facility at which the nurse practitioner completed the transition to practice program attests to the board that the nurse practitioner is proficient in competencies established by the board by regulation. The bill would authorize the board, upon application, to issue an inactive certificate.

Existing law makes it unlawful for specified healing arts practitioners, including physicians and surgeons, psychologists, and acupuncturists, to refer a person for certain services, including laboratory, diagnostic nuclear medicine, and physical therapy, if the physician and surgeon or their immediate family has a financial interest with the person or in the entity that receives the referral. A violation of those provisions is a misdemeanor and subject to specified civil penalties and disciplinary action.

This bill would make those provisions applicable to a nurse practitioner practicing pursuant to the bill’s provisions.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process and defines “licentiate” for those purposes.

This bill would include as a licentiate a nurse practitioner practicing pursuant to the bill’s provisions.

Because the bill would expand the scope of crimes, the bill would impose a state-mandated local program.

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

This bill would provide that no reimbursement is required by this act for a specified reason.
The people of the State of California do enact as follows:

SECTION 1. Section 650.01 of the Business and Professions Code is amended to read:

650.01. (a) Notwithstanding Section 650, or any other provision of law, it is unlawful for a licensee to refer a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or their immediate family has a financial interest with the person or in the entity that receives the referral.

(b) For purposes of this section and Section 650.02, the following shall apply:

(1) “Diagnostic imaging” includes, but is not limited to, all X-ray, computed axial tomography, magnetic resonance imaging nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) A “financial interest” includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the licensee refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect financial relationship between a licensee and the referral recipient including, but not limited to, an arrangement whereby a licensee has an ownership interest in an entity that leases property to the referral recipient. Any financial interest transferred by a licensee to any person or entity or otherwise established in any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the licensee. For purposes of this paragraph, “direct or indirect payment” shall not include a royalty or consulting fee received by a physician and surgeon who has completed a recognized residency training program in orthopedics from a manufacturer or distributor as a result of their research and development of medical devices and techniques for that manufacturer or distributor. For purposes of

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this paragraph, “consulting fees” means those fees paid by the
manufacturer or distributor to a physician and surgeon who has
completed a recognized residency training program in orthopedics
only for their ongoing services in making refinements to their
medical devices or techniques marketed or distributed by the
manufacturer or distributor, if the manufacturer or distributor does
not own or control the facility to which the physician is referring
the patient. A “financial interest” shall not include the receipt of
capitation payments or other fixed amounts that are prepaid in
exchange for a promise of a licensee to provide specified health
care services to specified beneficiaries. A “financial interest” shall
not include the receipt of remuneration by a medical director of a
hospice, as defined in Section 1746 of the Health and Safety Code,
for specified services if the arrangement is set out in writing, and
specifies all services to be provided by the medical director, the
term of the arrangement is for at least one year, and the
compensation to be paid over the term of the arrangement is set
in advance, does not exceed fair market value, and is not
determined in a manner that takes into account the volume or value
of any referrals or other business generated between parties.

(3) For the purposes of this section, “immediate family” includes
the spouse and children of the licensee, the parents of the licensee,
and the spouses of the children of the licensee.

(4) “Licensee” means a physician, as defined in Section 3209.3
of the Labor Code, or a nurse practitioner practicing pursuant to
Section 2837.1 or 2837.2. 2837.104 or 2837.105.

(5) “Licensee’s office” means either of the following:

(A) An office of a licensee in solo practice.

(B) An office in which services or goods are personally provided
by the licensee or by employees in that office, or personally by
independent contractors in that office, in accordance with other
provisions of law. Employees and independent contractors shall
be licensed or certified when licensure or certification is required
by law.

(6) “Office of a group practice” means an office or offices in
which two or more licensees are legally organized as a partnership,
professional corporation, or not-for-profit corporation, licensed
pursuant to subdivision (a) of Section 1204 of the Health and Safety
Code, for which all of the following apply:
(A) Each licensee who is a member of the group provides
substantially the full range of services that the licensee routinely
provides, including medical care, consultation, diagnosis, or
treatment through the joint use of shared office space, facilities,
equipment, and personnel.

(B) Substantially all of the services of the licensees who are
members of the group are provided through the group and are
billed in the name of the group and amounts so received are treated
as receipts of the group, except in the case of a multispecialty
clinic, as defined in subdivision (l) of Section 1206 of the Health
and Safety Code, physician services are billed in the name of the
multispecialty clinic and amounts so received are treated as receipts
of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice
are distributed in accordance with methods previously determined
by members of the group.

(c) It is unlawful for a licensee to enter into an arrangement or
scheme, such as a cross-referral arrangement, that the licensee
knows, or should know, has a principal purpose of ensuring
referrals by the licensee to a particular entity that, if the licensee
directly made referrals to that entity, would be in violation of this
section.

(d) No claim for payment shall be presented by an entity to any
individual, third party payer, or other entity for a good or service
furnished pursuant to a referral prohibited under this section.

(e) No insurer, self-insurer, or other payer shall pay a charge or
lien for any good or service resulting from a referral in violation
of this section.

(f) A licensee who refers a person to, or seeks consultation from,
an organization in which the licensee has a financial interest, other
than as prohibited by subdivision (a), shall disclose the financial
interest to the patient, or the parent or legal guardian of the patient,
in writing, at the time of the referral or request for consultation.

(1) If a referral, billing, or other solicitation is between one or
more licensees who contract with a multispecialty clinic pursuant
to subdivision (l) of Section 1206 of the Health and Safety Code
or who conduct their practice as members of the same professional
corporation or partnership, and the services are rendered on the
same physical premises, or under the same professional corporation
or partnership name, the requirements of this subdivision may be
met by posting a conspicuous disclosure statement at the registration area or by providing a patient with a written disclosure statement.

(2) If a licensee is under contract with the Department of Corrections or the California Youth Authority, and the patient is an inmate or parolee of either respective department, the requirements of this subdivision shall be satisfied by disclosing financial interests to either the Department of Corrections or the California Youth Authority.

(g) A violation of subdivision (a) shall be a misdemeanor. The Medical Board of California shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), or (e) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California or other appropriate governmental agency.

(h) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(i) This section shall become operative on January 1, 1995.

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

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

(1) (A) “Peer review” means both of the following:

(i) A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following:

(I) Determine whether a licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, to determine the parameters of that practice.
(II) Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.

(ii) Any other activities of a peer review body as specified in subparagraph (B).

(B) “Peer review body” includes:

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

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

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

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

(2) “Licentiate” means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, physician assistant, or nurse practitioner practicing pursuant to Section 2837.1 or 2837.2; 2837.104 or 2837.105. “Licentiate” also includes a person authorized to practice medicine pursuant to Section 2113 or 2168.

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

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

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

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

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

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

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

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

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

(c) If a licentiate takes any action listed in paragraph (1), (2), or (3) after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that their application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the
renewal thereof, shall file an 805 report with the relevant agency within 15 days after the licentiate takes the action.

(1) Resigns or takes a leave of absence from membership, staff privileges, or employment.

(2) Withdraws or abandons their application for staff privileges or membership.

(3) Withdraws or abandons their request for renewal of staff privileges or membership.

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

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

(f) A copy of the 805 report, and a notice advising the licentiate of their right to submit additional statements or other information, electronically or otherwise, pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report. The notice shall also advise the licentiate that information submitted electronically will be publicly disclosed to those who request the information.

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

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

If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the
license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension. If the California Board of Podiatric Medicine or a licensing agency of another state revokes or suspends, without a stay, the license of a doctor of podiatric medicine, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

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

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

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

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

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

(l) Except as otherwise provided in subdivision (k), any failure
by the administrator of any peer review body, the chief executive
officer or administrator of any health care facility, or any person
who is designated or otherwise required by law to file an 805
report, shall be punishable by a fine that under no circumstances
shall exceed fifty thousand dollars ($50,000) per violation. The
fine may be imposed in any civil or administrative action or
proceeding brought by or on behalf of any agency having
regulatory jurisdiction over the person regarding whom the report
was or should have been filed. If the person who is designated or
otherwise required to file an 805 report is a licensed physician and
surgeon, the action or proceeding shall be brought by the Medical
Board of California. If the person who is designated or otherwise
required to file an 805 report is a licensed doctor of podiatric
medicine, the action or proceeding shall be brought by the
California Board of Podiatric Medicine. The fine shall be paid to
that agency but not expended until appropriated by the Legislature.
The amount of the fine imposed, not exceeding fifty thousand
dollars ($50,000) per violation, shall be proportional to the severity
of the failure to report and shall differ based upon written findings,
including whether the failure to file caused harm to a patient or
created a risk to patient safety; whether the administrator of any
peer review body, the chief executive officer or administrator of
any health care facility, or any person who is designated or
otherwise required by law to file an 805 report exercised due
diligence despite the failure to file or whether they knew or should
have known that an 805 report would not be filed; and whether
there has been a prior failure to file an 805 report. The amount of
the fine imposed may also differ based on whether a health care
facility is a small or rural hospital as defined in Section 124840

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

SEC. 3. Section 2837.1 is added to the Business and Professions Code, to read:

2837.1. (a) Notwithstanding any other law, a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body recognized by the board may perform the functions specified in subdivision (c) without supervision by a physician and surgeon if the nurse practitioner meets all of the requirements of this article and practices in one of the following settings in which one or more physicians and surgeons are concurrently practicing with the nurse practitioner:

(1) A clinic, as defined in Section 1200 of the Health and Safety Code.

(2) A health facility, as defined in Section 1250 of the Health and Safety Code.

(3) A facility described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(4) A medical group practice, including a professional medical corporation, as defined in Section 2406, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians and surgeons that provides healthcare services.

(b) An entity described in subdivisions (1) to (4), inclusive, of subdivision (a) shall not interfere with, control, or otherwise direct the professional judgment of a nurse practitioner functioning pursuant to this section in a manner prohibited by Section 2400 or any other law.

(c) In addition to any other practices authorized by law, a nurse practitioner who meets the requirements of this section may perform the following functions without the supervision of a physician and surgeon in accordance with their education and training:

(1) Conduct an advanced assessment.

(2) Order and interpret diagnostic procedures.

(3) Establish primary and differential diagnoses.

(4) Prescribe, order, administer, dispense, and furnish therapeutic measures, including, but not limited to, the following:
(A) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources.

(B) Prescribe, administer, dispense, and furnish pharmacological agents, including over-the-counter, legend, and controlled substances.

(C) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including, but not limited to, durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services, including, but not limited to, home health care, hospice, and physical and occupational therapy.

(5) After performing a physical examination, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(6) Delegate tasks to a medical assistant pursuant to Sections 1206.5, 2060, 2070, and 2071, and Article 2 (commencing with Section 1366) of Chapter 3 of Division 13 of Title 16 of the California Code of Regulations.

(d) A nurse practitioner shall refer a patient to a physician and surgeon or other licensed health care provider if a situation or condition of a patient is beyond the scope of the education and training of the nurse practitioner.

(e) A nurse practitioner practicing under this section shall maintain professional liability insurance appropriate for the practice setting.

SEC. 4. Section 2837.2 is added to the Business and Professions Code, to read:

2837.2. (a) Notwithstanding any other law, a nurse practitioner who holds an active certification by a national certifying body recognized by the board may practice without supervision by a physician and surgeon if, in addition to satisfying the requirements of this article, the nurse practitioner satisfies both of the following requirements:

(1) The nurse practitioner has successfully completed a transition to practice program.

(2) A supervising physician and surgeon at the clinic, facility, or medical group attests under penalty of perjury to the board that the nurse practitioner has successfully completed the transition to practice program and is proficient in the competencies identified by the board to practice pursuant to this section.
(b) A nurse practitioner authorized to practice pursuant to this section shall comply with all of the following:

(1) The nurse practitioner, consistent with applicable standards of care, shall practice within the scope of their clinical and professional training and within the limits of their knowledge and experience.

(2) The nurse practitioner shall consult and collaborate with other healing arts providers based on the clinical condition of the patient to whom health care is provided.

(3) The nurse practitioner shall establish a plan for referral of complex medical cases and emergencies to a physician and surgeon or other appropriate healing arts providers.

(c) For purposes of this section, “transition to practice program” means a program in which additional clinical experience and mentorship are provided to prepare a nurse practitioner to practice without the routine presence of a physician and surgeon. A transition to practice program shall meet all of the following requirements:

(1) The transition to practice program shall consist of a minimum of three years or 4,600 hours.

(2) The transition to practice program shall require proficiency in competencies identified by the board by regulation.

(3) The transition to practice program is conducted in one of the settings specified in paragraphs (1) to (4), inclusive, of subdivision (a) of Section 2837.1 in which one or more physicians and surgeons practice concurrently with the nurse practitioner.

(d) A nurse practitioner practicing under this section shall maintain professional liability insurance appropriate for the practice setting.

SEC. 3. Article 8.5 (commencing with Section 2837.100) is added to Chapter 6 of Division 2 of the Business and Professions Code, to read:

Article 8.5. Advanced Practice Registered Nurses

2837.100. It is the intent of the Legislature that the requirements under this article shall not be undue or unnecessary burden to licensure or practice. The requirements are intended to ensure the new category of licensed nurse practitioners have the
least restrictive amount of education, training, and testing
necessary to ensure competent practice.

2837.101. (a) There is in the Department of Consumer Affairs
the Advanced Practice Registered Nursing Board consisting of
nine members.
(b) For purposes of this article, “board” means the Advanced
Practice Registered Nursing Board.
(c) This section shall remain in effect only until January 1, 2026,
and as of that date is repealed.

2837.102. Notwithstanding any other law, the repeal of Section
2837.101 renders the board or its successor subject to review by
the appropriate policy committees of the Legislature.

2837.103. (a) (1) Until January 1, 2026, four members of the
board shall be licensed registered nurses who shall be active as
a nurse practitioner and shall be active in the practice of their
profession engaged primarily in direct patient care with at least
five continuous years of experience.
(2) Commencing January 1, 2026, four members of the board
shall be nurse practitioners licensed under this chapter.
(b) Three members of the board shall be physicians and
surgeons licensed by the Medical Board of California or the
Osteopathic Medical Board of California. At least one of the
physician and surgeon members shall work closely with a nurse
practitioner. The remaining physician and surgeon members shall
focus on primary care in their practice.
(c) Two members of the board shall represent the public at large
and shall not be licensed under any board under this division or
any board referred to in Section 1000 or 3600.

2837.104. (a) (1) Notwithstanding any other law, a nurse
practitioner who holds a certification as a nurse practitioner from
a national certifying body recognized by the board may perform
the functions specified in subdivision (c) without supervision by a
physician and surgeon if the nurse practitioner meets all of the
requirements of this article and practices in one of the following
settings or organizations in which one or more physicians and
surgeons practice with the nurse practitioner:
(A) A clinic, as defined in Section 1200 of the Health and Safety
Code.
(B) A health facility, as defined in Section 1250 of the Health
and Safety Code.
(C) A facility described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A medical group practice, including a professional medical corporation, as defined in Section 2406, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians and surgeons that provides health care services.

(2) In health care agencies that have governing bodies, as defined in Division 5 of Title 22 of the California Code of Regulations, including, but not limited to, Sections 70701 and 70703 of Title 22 of the California Code of Regulations, the following apply:

(A) A nurse practitioner shall adhere to all bylaws.

(B) A nurse practitioner shall be eligible to serve on medical staff and hospital committees. A nurse practitioner who is not the holder of an active certificate pursuant to Section 2837.105 shall not serve as chair of medical staff committees.

(C) A nurse practitioner shall be eligible to attend meetings of the department to which the nurse practitioner is assigned. A nurse practitioner who is not the holder of an active certificate pursuant to Section 2837.105 shall not vote at department, division, or other meetings.

(b) An entity described in subparagraphs (A) to (D), inclusive, of paragraph (1) of subdivision (a) shall not interfere with, control, or otherwise direct the professional judgment of a nurse practitioner functioning pursuant to this section in a manner prohibited by Section 2400 or any other law.

(c) In addition to any other practices authorized by law, a nurse practitioner who meets the requirements of this section may perform the following functions without the supervision of a physician and surgeon in accordance with their education and training:

(1) Conduct an advanced assessment.

(2) Order and interpret diagnostic procedures.

(3) Establish primary and differential diagnoses.

(4) Prescribe, order, administer, dispense, and furnish therapeutic measures, including, but not limited to, the following:
(A) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources.

(B) Prescribe, administer, dispense, and furnish pharmacological agents, including over-the-counter, legend, and controlled substances.

(C) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including, but not limited to, durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services, including, but not limited to, home health care, hospice, and physical and occupational therapy.

(5) After performing a physical examination, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(6) Delegate tasks to a medical assistant pursuant to Sections 1206.5, 2069, 2070, and 2071, and Article 2 (commencing with Section 1366) of Chapter 3 of Division 13 of Title 16 of the California Code of Regulations.

(d) A nurse practitioner shall refer a patient to a physician and surgeon or other licensed health care provider if a situation or condition of a patient is beyond the scope of the education and training of the nurse practitioner.

(e) A nurse practitioner practicing under this section shall maintain professional liability insurance appropriate for the practice setting.

2837.105. (a) Notwithstanding any other law, the following apply to a nurse practitioner who is actively licensed under this article and who holds an active certification issued by the board under this section:

(1) The nurse practitioner may practice without supervision by a physician and surgeon outside of the settings or organizations specified under subparagraphs (A) to (D), inclusive, of paragraph (1) of subdivision (a) of Section 2387.104.

(2) Subject to subdivision (g) and any applicable conflict of interest policies of the bylaws, the nurse practitioner shall be eligible for membership of an organized medical staff.

(3) Subject to subdivision (g) and any applicable conflict of interest policies of the bylaws, a nurse practitioner member may vote at meetings of the department to which nurse practitioners are assigned.
(b) The board shall issue a certificate to practice outside of the settings and organizations specified under subparagraphs (A) to (D), inclusive, of paragraph (1) of subdivision (a) if, in addition to satisfying the requirements of this article, the nurse practitioner satisfies all of the following requirements:

(1) The nurse practitioner meets one of the following:
   (A) Holds a Doctorate of Nursing Practice degree (DNP) and holds active national certification in a nurse practitioner role and population foci by a national certifying body recognized by the board.
   (B) Holds a Master of Science degree in Nursing (MSN) and holds active national certification in a nurse practitioner role and population foci by a national certifying body recognized by the board and has two years of licensed practice as a nurse practitioner.

(2) The nurse practitioner has successfully completed a transition to practice.

(c) (1) Upon application of an applicant who meets the requirements for a certificate under this section, the board shall issue an inactive certificate.
(2) Upon application of a holder of a certificate issued pursuant to this section, the board shall change the status of an active certificate to inactive.
(3) The holder of an inactive certificate shall not engage in any activity for which an active certificate under this section is required and is not otherwise subject to the provisions of this section.
(4) Upon application of the holder of a certificate issued pursuant to this section, the board shall change the status of an inactive certificate to active if the holder’s license is in good standing and the holder pays the renewal fee.

(d) A nurse practitioner authorized to practice pursuant to this section shall comply with all of the following:
   (1) The nurse practitioner, consistent with applicable standards of care, shall practice within the scope of their clinical and professional education and training and within the limits of their knowledge and experience.
   (2) The nurse practitioner shall consult and collaborate with other healing arts providers based on the clinical condition of the patient to whom health care is provided.
(3) The nurse practitioner shall establish a plan for referral of complex medical cases and emergencies to a physician and surgeon or other appropriate healing arts providers.

(e) For purposes of this section, “transition to practice” means additional clinical experience and mentorship are provided to prepare a nurse practitioner to practice without the routine presence of a physician and surgeon. A transition to practice shall meet all of the following requirements:

(1) The transition to practice shall consist of a minimum of three years or 4,600 hours.

(2) The transition to practice shall require proficiency in competencies identified by the board by regulation.

(3) The transition to practice is conducted in one of the settings or organizations specified in subparagraphs (A) to (D), inclusive, of paragraph (1) of subdivision (a) of Section 2837.104 in which one or more physicians and surgeons practice with the nurse practitioner.

(4) After the nurse practitioner satisfies paragraph (1) of this subdivision, the nurse practitioner shall pass an objective examination developed and administered by the board. The examination shall test the competencies identified under paragraph (2) of this subdivision.

(f) A nurse practitioner practicing under this section shall maintain professional liability insurance appropriate for the practice setting.

(g) For purposes of this section, corporations and other artificial legal entities shall have no professional rights, privileges, or powers.

(h) Subdivision (g) shall not apply to a nurse practitioner if any of the following apply:

(1) The certificate issued pursuant to this section is inactive, surrendered, revoked, or otherwise restricted by the board.

(2) The nurse practitioner is employed pursuant to the exemptions under Section 2401.

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.
SUMMARY:

Existing law, 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. A willful violation of the act is a crime.

- provides for the regulation of health insurers by the Department of Insurance.

- requires the Department of Managed Health Care to adopt regulations to ensure that enrollees have access to needed health care services in a timely manner.

- requires the Department of Managed Health Care to develop indicators of timeliness of access to care, including waiting times for appointments with physicians, including primary care and specialty physicians.

- requires health care service plans to report annually to the Department of Managed Health Care on compliance with the standards developed pursuant to these provisions.

ANALYSIS:

Among other things, this bill would require a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2019, to permit an HIV specialist, as defined, to be an eligible primary care provider, as defined, if the provider requests primary care provider status and meets the plan’s or the health insurer’s eligibility criteria for all specialists seeking primary care provider status.
The bill’s language for the Health and Safety Code provides:
(b) For purposes of this section, “primary care provider” means a physician or a nonphysician medical practitioner, as each term is defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.
(c) For purposes of this section, “HIV specialist” means a physician, physician assistant, or a nurse practitioner who meets the criteria for an HIV specialist as published by the American Academy of HIV Medicine or the HIV Medicine Association, or who is contracted to provide outpatient medical care under the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (Public Law 101-381).

Amended analysis as of 4/11:
Changes the effective date from January 1, 2019, to January 1, 2020.

BOARD POSITION: Watch (4/11/19)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Not previously considered

SUPPORT:
AIDS Healthcare Foundation

OPPOSE: None on file
An act to add Section 1367.693 to the Health and Safety Code, and to add Section 10123.833 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST

AB 993, as amended, Nazarian. Health care coverage: HIV specialists. Existing law, 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. A willful violation of the act is a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires the Department of Managed Health Care to adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. Existing law requires the Department of Managed Health Care to develop indicators of timeliness of access to care, including waiting times for appointments with physicians, including primary care and specialty physicians. Existing law requires health care service plans to report annually to the Department of Managed Health Care on compliance with the standards developed pursuant to these provisions. Existing law also requires the Insurance Commissioner to promulgate regulations applicable to health insurers that contract with providers for alternative rates to ensure that insureds have the opportunity to access needed health care services in a timely manner.
This bill would require a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2019, to permit an HIV specialist, as defined, to be an eligible primary care provider, as defined, if the provider requests primary care provider status and meets the plan’s or the health insurer’s eligibility criteria for all specialists seeking primary care provider status. The bill would provide that these provisions do not apply to a health insurance policy that does not require an insured to obtain a referral from his or her primary care physician prior to seeking covered health care services from a specialist. The bill would provide that these provisions do not include an HIV specialist as a primary care physician for the purposes of network adequacy requirements. Because a willful violation of these requirements 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.

State-mandated local program: yes.

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

SECTION 1. Section 1367.693 is added to the Health and Safety Code, immediately following Section 1367.69, to read:

1367.693. (a) Every health care service plan contract that is issued, amended, or renewed on or after January 1, 2019, that provides hospital, medical, or surgical coverage, excluding specialized health care service plan contracts, shall permit an HIV specialist to be an eligible primary care provider, if the provider requests primary care provider status and meets the health care service plan’s eligibility criteria for all specialists seeking primary care provider status.

(b) For purposes of this section, “primary care provider” means a physician or a nonphysician medical practitioner, as each term is defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care...
for the majority of health care problems, including, but not limited
to, preventive services, acute and chronic conditions, and
psychosocial issues.
(c) For purposes of this section, “HIV specialist” means a
physician, physician assistant, or a nurse practitioner who meets
the criteria for an HIV specialist as published by the American
Academy of HIV Medicine or the HIV Medicine Association, or
who is contracted to provide outpatient medical care under the
federal Ryan White Comprehensive AIDS Resources Emergency
(CARE) Act of 1990 (Public Law 101-381).
(d) This section does not include an HIV specialist as a primary
care physician for the purposes of network adequacy requirements
under this chapter.
SEC. 2. Section 10123.833 is added to the Insurance Code, to
read:
10123.833. (a) Every health insurance policy that is issued,
amended, or renewed on or after January 1, 2019, that
provides hospital, medical, or surgical coverage, excluding
specialized health insurance policies, shall permit an HIV specialist
to be an eligible primary care provider, if the provider requests
primary care provider status and meets the health insurer’s
eligibility criteria for all specialists seeking primary care provider
status.
(b) For purposes of this section, “primary care provider” means
a physician or a nonphysician medical practitioner, as each term
is defined in Section 14254 of the Welfare and Institutions Code,
who has the responsibility for providing initial and primary care
to patients, for maintaining the continuity of patient care, and for
initiating referral for specialist care. This means providing care
for the majority of health care problems, including, but not limited
to, preventive services, acute and chronic conditions, and
psychosocial issues.
(c) For purposes of this section, “HIV specialist” means a
physician, physician assistant, or a nurse practitioner who meets
the criteria for an HIV specialist as published by the American
Academy of HIV Medicine or the HIV Medicine Association, or
who is contracted to provide outpatient medical care under the
federal Ryan White Comprehensive AIDS Resources Emergency
(CARE) Act of 1990 (Public Law 101-381).
(d) This section does not include an HIV specialist as a primary care physician for the purposes of the department's network adequacy requirements.

(e) This section does not apply to a health insurance policy that does not require an insured to obtain a referral from his or her primary care physician prior to seeking covered health care services from a specialist.

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.
BOARD OF REGISTERED NURSING
LEGISLATIVE COMMITTEE
May 9, 2019

BILL ANALYSIS

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<td>Healing arts licensees: self-administered hormonal contraceptives</td>
<td>April 22, 2019</td>
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SUMMARY:

Existing law authorizes certain healing arts licensees to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after appropriate prior examination, to prescribe, furnish, or dispense self-administered hormonal contraceptives to a patient.

ANALYSIS:

This bill would specify that “appropriate prior examination” for purposes of those provisions does not require a real-time synchronous interaction between the patient and the healing arts license.

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

BOARD POSITION: Not previously considered

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Not previously considered

SUPPORT:
Planned Parenthood Affiliates of California

OPPOSE: None on file
AMENDED IN ASSEMBLY APRIL 22, 2019
AMENDED IN ASSEMBLY MARCH 26, 2019
CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL    No. 1264

Introduced by Assembly Member Petrie-Norris

February 21, 2019

An act to amend Section 2242.2 of the Business and Professions Code, relating to healing arts, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL’S DIGEST


Existing law authorizes certain healing arts licensees to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after appropriate prior examination, to prescribe, furnish, or dispense self-administered hormonal contraceptives to a patient.

This bill would specify that “appropriate prior examination”—for purposes of those provisions—does not require a real-time synchronous interaction between the patient and the healing arts license.

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

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

SECTION 1. Section 2242.2 of the Business and Professions Code is amended to read:

2242.2. (a) Notwithstanding any other law, a physician and surgeon, a registered nurse acting in accordance with Section 2725.2, a certified nurse-midwife acting within the scope of Section 2746.51, a nurse practitioner acting within the scope of Section 2836.1, a physician assistant acting within the scope of Section 3502.1, and a pharmacist acting within the scope of Section 4052.3 may use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after an appropriate prior examination, prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient. Blood pressure, weight, height, and patient health history may be self-reported using the self-screening tool that identifies patient risk factors.

(b) For purposes of this section, an “appropriate prior examination” does not require a real-time synchronous interaction between the patient and the healing arts licensee.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure patients have access to necessary health care services at the earliest possible time, it is imperative that this bill take effect immediately.
SUMMARY:

The Nursing Practice Act:
- provides for the licensure and regulation of registered nurses by the Board of Registered Nursing within the Department of Consumer Affairs.
- requires the board to perform an analysis of the practice of the registered nurse no less than every five years.

ANALYSIS:

This bill would require the board to perform the analysis of the practice of the registered nurse no less than every six years.

Amended analysis as of 3/25:

The bill deletes language related to the mandated analysis.

The Nursing Practice Act requires an approved school of nursing or program of nursing to provide a course of instruction approved by the board, covering not less than 2 academic years, be affiliated or conducted in connection with one or more hospitals, and be an institution of higher education.

Existing law grants the board the authority to determine by regulation the required subjects of instruction to be completed in an approved school of nursing for licensure as a registered nurse.

This bill would now:
- exempt an approved school of nursing or approved nursing program that is accredited and maintains accreditation through a national nursing accrediting agency recognized by the United States Department of Education and maintains a minimum pass rate of 80% on the applicable licensing examination from board regulations or rules that oversee education programming and that require ongoing program approval.
exempt an approved school of nursing or approved nursing program from the requirement of obtaining board approval or authorization to regulate, impose fees, or otherwise control the enrollment of students, or to regulate or otherwise control partnerships between approved schools, programs, and clinical facilities.

specify that an approved school of nursing or approved nursing program is not required to obtain board approval or authorization to hire faculty or to provide up to 50% of clinical instruction as computer-based simulation.

provide that an approved school of nursing or approved nursing program is not required to obtain board approval or to pay a fee to provide for certain clinical experiences or placements.

The language to amend BPC Section 2786 related to the last point is:

(g) In addition to the prohibitions in subdivision (f), an approved school of nursing or an approved nursing program shall not be required to obtain board approval or authorization, and shall not be required to pay a fee to provide clinical experiences or clinical placements to students at a location already approved by the board for that school or program, or for a different school of nursing or approved nursing program, if the program staff of the location confirm that the new clinical experiences or clinical placements will not displace existing student clinical experiences or clinical placements.

Amended analysis as of 4/25:

The subject of the bill has been changed from “Nursing: schools and programs: analysis” to “Nursing: schools and programs: exemptions.”

This bill would now:

exempt an approved school of nursing or approved nursing program that is accredited and maintains accreditation through a national nursing accrediting agency recognized by the United States Department of Education or is a public institution, is accredited through a regional accrediting agency, maintains a minimum pass rate of 80% on the licensing examination for a minimum of 2 consecutive academic years, and meets other specified criteria;

require an approved school of nursing or an approved nursing program that is seeking exempt status to submit an application to the board and would require the board to approve the application if specific requirements are met;

require an exempt school of nursing or an exempt approved nursing program to continue to notify the board of other changes and to continue to submit annual reports to the board;

specify that an exempt approved school of nursing or an exempt approved nursing program is not required to pay fees or seek board approval for certain program changes that are approved by the applicable accreditors or within the scope of the program’s accreditation.
These changes would include, among others, clinical experience placements at a clinical agency or facility that is already approved by the board to provide clinical practice hours and if the program staff and school or program attest under penalty of perjury that the new clinical placements will not displace existing placements;

- specify that an institute of higher education or a private postsecondary school of nursing, subject to the above exemption provision, is prohibited from making a payment to any clinical agency or facility in exchange for clinical experience placements for students enrolled in a nursing program offered by or affiliated with the institution or private postsecondary school of nursing.

**BOARD POSITION:** Oppose (4/11/19)

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Watch (3/14/19)

**SUPPORT:**
California Association of Private Postsecondary Schools (Sponsor)
California Association of Colleges of Nursing
Chamberlain University College of Nursing
West Coast University College of Nursing
Western Governors University

**OPPOSE:**
California Board of Registered Nursing
California Nurses Association
California Organization of Associate Degree Nursing Programs
California School Employees Association
Community College League of California
Pasadena City College
Saddleback College
South Orange County Community College District
United Nurses Associations of California/Union of Health Care Professionals

The Nursing Practice Act provides for the licensure and regulation of registered nurses by the Board of Registered Nursing within the Department of Consumer Affairs. The act requires an approved school of nursing or program of nursing to provide a course of instruction approved by the board, covering not less than 2 academic years, be affiliated or conducted in connection with one or more hospitals, and be an institution of higher education. Existing law grants the board the authority to determine by regulation the required subjects of instruction to be completed in an approved school of nursing for licensure as a registered nurse.

This bill would exempt an approved school of nursing or approved nursing program that is accredited and maintains accreditation through a national nursing accrediting agency recognized by the United States Department of Education and or is a public institution, is accredited through a regional accrediting agency, maintains a minimum pass rate of 80% on the applicable licensing examination from board regulations.
or rules that oversee education programming and that require ongoing program approval for a minimum of 2 consecutive academic years, and meets other specified criteria. This bill would exempt an approved school of nursing or approved nursing program from the requirement of obtaining board approval or authorization to regulate, impose fees, or otherwise control the enrollment of students, or to regulate or otherwise control partnerships between approved schools, programs, and clinical facilities. The bill would require an approved school of nursing or an approved nursing program that is seeking exempt status to submit an application to the board and would require the board to approve the application if specific requirements are met. The bill would require an exempt school of nursing or an exempt approved nursing program to continue to notify the board of other changes and to continue to submit annual reports to the board. The bill would specify that an exempt approved school of nursing or an exempt approved nursing program is not required to pay fees or seek board approval for certain program changes that are approved by the applicable accreditors or within the scope of the program’s accreditation. These changes would include, among others, clinical experience placements at a clinical agency or facility that is already approved by the board to provide clinical practice hours and if the program staff and school or program attest under penalty of perjury that the new clinical placements will not displace existing placements. By expanding the scope of the crime of perjury, the bill would impose a state-mandated local program. This bill would also specify that an approved school of nursing or approved nursing program is not required to obtain board approval or authorization to hire faculty or to provide up to 50% of clinical instruction as computer-based simulation. The bill would further provide that an approved school of nursing or approved nursing program is not required to obtain board approval or to pay a fee to provide for certain clinical experiences or placements, as specified. Institute of higher education or a private postsecondary school of nursing, subject to the above exemption provision, is prohibited from making a payment to any clinical agency or facility in exchange for clinical experience placements for students enrolled in a nursing program offered by or affiliated with the institution or private postsecondary school of nursing. 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.


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

SECTION 1. Section 2786 of the Business and Professions Code is amended to read:

2786. (a) An approved school of nursing, or an approved nursing program, is one that has been approved by the board, gives the course of instruction approved by the board, covering not less than two academic years, is affiliated or conducted in connection with one or more hospitals, and is an institution of higher education. For purposes of this section, “institution of higher education” includes, but is not limited to, community colleges offering an associate of arts or associate of science degree and private postsecondary institutions offering an associate of arts, associate of science, or baccalaureate degree or an entry-level master’s degree, and is an institution that is not subject to the California Private Postsecondary Education Act of 2009 (Chapter 8 (commencing with Section 94800) of Part 59 of Division 10 of Title 3 of the Education Code).

(b) A school of nursing that is affiliated with an institution that is subject to the California Private Postsecondary Education Act of 2009 (Chapter 8 (commencing with Section 94800) of Part 59 of Division 10 of Title 3 of the Education Code), may be approved by the board to grant an associate of arts or associate of science degree to individuals who graduate from the school of nursing or to grant a baccalaureate degree in nursing with successful completion of an additional course of study as approved by the board and the institution involved.

(c) (1) The board shall determine by regulation the required subjects of instruction to be completed in an approved school of nursing for licensure as a registered nurse and shall include the minimum units of theory and clinical experience necessary to achieve essential clinical competency at the entry level of the registered nurse. The board’s regulations shall be designed to
require all schools to provide clinical instruction in all phases of the educational process, except as necessary to accommodate military education and experience as specified in Section 2786.1.

(d) An
(2) For purposes of this chapter, an “exempt approved school of nursing,” or an “exempt approved nursing program that meets both of the following criteria is exempt from board regulations or rules that oversee education programming, as described in subdivision (c), and that require ongoing program approval. “Program,” means a school or program that meets the following requirements:

(1) (A) Is accredited and maintains accreditation through a national nursing accrediting agency recognized by the United States Department of Education or is a public institution.
(B) Is accredited through a regional accrediting agency.
(2) (C) Maintains a minimum pass rate of 80 percent on the applicable licensing examination under this chapter for a minimum of two consecutive academic years.
(D) Maintains an official cohort default rate, as calculated by the United States Department of Education annually, that is less than 7.5 percent.
(E) Maintains debt-to-earnings rates, as calculated by the United States Department of Education, that qualify as passing under Sections 668.403 to 668.406, inclusive, of Title 34 of the Code of Federal Regulations as of January 1, 2017.
(3) (A) An approved school of nursing, or an approved nursing program, seeking exempt status shall submit an application to the board, and the board shall approve the application if the requirements under paragraph (2) are met.
(B) An exempt approved school of nursing, or an exempt approved nursing program, shall continue to notify the board of substantive changes and other changes as defined by board regulations and the national and regional accreditors.
(C) An exempt approved school of nursing, or an exempt approved nursing program, shall continue to submit annual reports to the board.
(D) An exempt approved school of nursing, or an exempt approved nursing program, shall apply for continuing approval five years after initial approval or its last continuing approval.

(4) An exempt approved school of nursing, or an exempt approved nursing program, shall not be required to pay fees or seek board approval for the changes to the following if the changes are approved by the applicable accreditors or within the scope of the program’s accreditation:

(A) Faculty.

(B) Enrollments.

(C) Clinical simulation hours in a skills lab, up to 50 percent of the total number of clinical hours.

(D) Clinical experience placements at a clinical agency or facility that is already approved by the board to provide clinical practice hours for the exempt school or program and if the program staff of the facility and the exempt school or program attest under penalty of perjury that the new clinical placements will not displace existing placements and all parties are in compliance with Section 2786.3.

(E) Clinical experience placements at a clinical agency or facility if the facility is approved by the board to provide clinical practice hours and if the program staff of the facility and the exempt school or program attest under penalty of perjury that the new clinical placements will not displace existing placements and all parties are in compliance with Section 2786.3.

(d) The board shall perform or cause to be performed an analysis of the practice of the registered nurse no less than every five years. Results of the analysis shall be utilized to assist in the determination of the required subjects of instruction, validation of the licensing examination, and assessment of the current practice of nursing.

(f) An approved school of nursing or approved nursing program shall not be required to obtain board approval or authorization to do any of the following:

(1) Regulate, impose fees, or otherwise control the enrollment of students.

(2) Regulate or otherwise control partnerships between approved schools of nursing or approved nursing programs and approved clinical facilities.
(3) Hire faculty.

(4) Provide up to 50 percent of clinical instruction as computer-based simulation.

(g) In addition to the prohibitions in subdivision (f), an approved school of nursing or an approved nursing program shall not be required to obtain board approval or authorization, and shall not be required to pay a fee to provide clinical experiences or clinical placements to students at a location already approved by the board for that school or program, or for a different school of nursing or approved nursing program, if the program staff of the location confirm that the new clinical experiences or clinical placements will not displace existing student clinical experiences or clinical placements.

SEC. 2. Section 2786.3 is added to the Business and Professions Code, to read:

2786.3. (a) An institution of higher education or a private postsecondary school of nursing subject to Section 2786 shall not make a payment to any clinical agency or facility in exchange for clinical experience placements for students enrolled in a nursing program offered by or affiliated with the institution or private postsecondary school of nursing.

(b) A payment shall be deemed a violation of subdivision (a) if made within two years of a clinical experience placement at a facility.

(c) The payment of pass-through fees for purposes of credentialing, databank registration, or similar fees shall not constitute a violation of subdivision (a).

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.
As originally introduced, this bill’s subject was Drug- or alcohol-related programs: “no unlawful use” requirement. The bill was amended March 25 to the subject noted above.

Existing law:
- establishes within the Health Professions Education Foundation the California Physician Corps Program, which includes the Steven M. Thompson Medical School Scholarship Program.
- provides student loan repayments for a physician and surgeon who agrees, in writing, prior to completing an accredited medical or osteopathic school based in the United States, to serve in an eligible practice setting in a medically underserved area for at least 3 years.

ANALYSIS:

This bill would:
- establish within the Office of Statewide Health Planning and Development the Primary Care Student Loan Repayment Program to provide loan repayment awards of up to $50,000 to physicians and surgeons and registered nurses who provide 32 hours a week or more of direct care service for a period of 2 years in either a federally designated health professional shortage area (HPSA) or primary care shortage area (PCSA) in California.
- establish in the State Treasury the Primary Care Student Loan Repayment Program Fund, to be used, upon appropriation by the Legislature, by the office to administer the program.

BOARD POSITION: Not previously considered

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Not previously considered

SUPPORT:

OPPOSE:
Introduced by Assembly Member Flora
(Coauthor: Assembly Member Diep)

February 22, 2019

An act to amend Section 11999.2 of the Health and Safety Code, relating to drugs and alcohol.
An act to add Article 7 (commencing with Section 128590) to Chapter 5 of Part 3 of Division 107 of the Health and Safety Code, relating to health care providers.

LEGISLATIVE COUNSEL’S DIGEST


Existing law establishes within the Health Professions Education Foundation the California Physician Corps Program, which includes the Steven M. Thompson Medical School Scholarship Program. Existing law provides student loan repayments for a physician and surgeon who agrees, in writing, prior to completing an accredited medical or osteopathic school based in the United States, to serve in an eligible practice setting in a medically underserved area for at least 3 years.

This bill would establish within the Office of Statewide Health Planning and Development the Primary Care Student Loan Repayment Program to provide loan repayment awards of up to $50,000 to physicians and surgeons and registered nurses who provide 32 hours a week or more of direct care service for a period of 2 years in either a federally designated health professional shortage area (HPSA) or primary care shortage area (PCSA) in California. The bill would
establish in the State Treasury the Primary Care Student Loan Repayment Program Fund, to be used, upon appropriation by the Legislature, by the office to administer the program.

Existing law prohibits state funds from being encumbered by a state agency for allocation to an entity, whether public or private, for a drug- or alcohol-related program, unless the drug- or alcohol-related program contains a component that clearly explains, in written materials, that unlawful use of drugs or alcohol is prohibited. Existing law prohibits these programs from including a message on the responsible use, if the use is unlawful, of drugs or alcohol.

This bill would make technical, nonsubstantive changes to those provisions.


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

SECTION 1. Article 7 (commencing with Section 128590) is added to Chapter 5 of Part 3 of Division 107 of the Health and Safety Code, to read:

Article 7. Primary Care Student Loan Repayment Program

128590. (a) There is hereby established within the Office of Statewide Health Planning and Development the Primary Care Student Loan Repayment Program to provide loan repayment awards of up to fifty thousand dollars ($50,000) per participant.

(b) There is hereby established in the State Treasury the Primary Care Student Loan Repayment Program Fund, which shall be used, upon appropriation by the Legislature, by the office to administer the program established pursuant to this article.

128591. (a) Applications for loan repayment awards shall be completed on forms established by the office.

(b) To be eligible for a loan repayment award, the applicant shall meet all of the following requirements:

1. Be either of the following:

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 Act.
(B) A registered nurse, licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

(2) Be in good standing with the applicable licensing board.

(3) Provide 32 hours or more a week of direct patient care for two years.

(4) Provide service in a federally designated health professional shortage area (HPSA) or primary care shortage area (PCSA) in California.

(5) Have outstanding educational debt from either a government or commercial institution.

SECTION 1. Section 11999.2 of the Health and Safety Code is amended to read:

11999.2. (a) Notwithstanding any other law, commencing July 1, 1990, state funds shall not be encumbered by a state agency for allocation to an entity, whether public or private, for a drug- or alcohol-related program, unless the drug- or alcohol related program contains a component that clearly explains, in written materials, that unlawful use of drugs or alcohol is prohibited. No aspect of a drug- or alcohol-related program shall include a message on the responsible use, if the use is unlawful, of drugs or alcohol.

(b)(1) All aspects of a drug- or alcohol-related program shall be consistent with the “no unlawful use” message, including, but not limited to, program standards, curricula, materials, and teachings.

(2) These materials and programs may include information regarding the health hazards of using illegal drugs and alcohol, concepts promoting the well-being of the whole person, risk reduction, the addictive personality, development of positive self-esteem, productive decision-making skills, and other preventive concepts consistent with the “no unlawful use” of drugs and alcohol message.

(e) The “no unlawful use” of drugs and alcohol message contained in drug- or alcohol-related programs shall apply to the use of drugs and alcohol prohibited by law.

(d) This section does not apply to a program funded by the state that provides education and prevention outreach to intravenous
1 drug users with AIDS or AIDS-related conditions, or persons at
2 risk of HIV infection through intravenous drug use.
SUMMARY:

Under existing law, the Public Utilities Commission has regulatory authority over public utilities, including telephone corporations.

Existing law:
- requires the commission to design and implement a program to provide a telecommunications device capable of serving the needs of individuals who are deaf or hearing impaired, together with a single party line, at no charge additional to the basic exchange rate, to any subscriber who is certified as an individual who is deaf or hearing impaired by a licensed physician and surgeon, audiologist, or a qualified state or federal agency, as determined by the commission.
- authorizes a physician assistant to certify the needs of an individual who has been diagnosed by a physician and surgeon as being deaf or hard of hearing to participate in the program after reviewing the medical records or copies of the medical records containing that diagnosis.

ANALYSIS:

This bill would additionally authorize a nurse practitioner to certify the needs of an individual who has been diagnosed by a physician and surgeon as being deaf or hard of hearing to participate in the program after reviewing the medical records or copies of the medical records containing that diagnosis.

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

Amended analysis as of 4/11:
This bill now additionally provides that a nurse practitioner is authorized to certify a subscriber to be disabled for purposes of the program that provides specialized or supplemental telephone communications equipment and to certify a subscriber as having a speech disability for purposes of the program that provides access to a speech-generating device.

**BOARD POSITION:** Watch (4/11/19)

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Not previously considered

**SUPPORT:**
California Association for Nurse Practitioners
Disability Rights California

**OPPOSE:** None on file
An act to amend Section 2881 of the Public Utilities Code, relating to telecommunications, and declaring the urgency thereof, to take effect immediately.
in the program after reviewing the medical records or copies of the medical records containing that diagnosis.

Existing law requires the commission to also design and implement a program whereby specialized or supplemental telephone communications equipment may be provided to subscribers who are certified to be disabled at no charge additional to the basic exchange rate. Existing law requires that the certification, including a statement of visual or medical need for specialized telecommunications equipment, be provided by a licensed optometrist, physician and surgeon, or physician assistant, acting within the scope of practice of the applicable license, or by a qualified state or federal agency as determined by the commission.

This bill would additionally authorize a nurse practitioner to certify a subscriber to be disabled for this purpose.

Existing law additionally requires the commission to design and implement a program to provide access to a speech-generating device to any subscriber who is certified as having a speech disability at no charge additional to the basic exchange rate. Existing law requires that the certification be provided by a licensed physician, licensed speech-language pathologist, or qualified state or federal agency.

This bill would additionally authorize a nurse practitioner to certify a subscriber as having a speech disability for this purpose.

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

State-mandated local program: no.

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

SECTION 1. Section 2881 of the Public Utilities Code is amended to read:

2881. (a) The commission shall design and implement a program to provide a telecommunications device capable of serving the needs of individuals who are deaf or hard of hearing, together with a single party line, at no charge additional to the basic exchange rate, to a subscriber who is certified as an individual who is deaf or hard of hearing by a licensed physician and surgeon, audiologist, or a qualified state or federal agency, as determined by the commission, and to a subscriber that is an organization representing individuals who are deaf or hard of hearing, as
determined and specified by the commission pursuant to subdivision (h). A licensed hearing aid dispenser may certify the need of an individual to participate in the program if that individual has been previously fitted with an amplified device by the dispenser and the dispenser has the individual’s hearing records on file before certification. In addition, a physician assistant or nurse practitioner may certify the needs of an individual who has been diagnosed by a physician and surgeon as being deaf or hard of hearing to participate in the program after reviewing the medical records or copies of the medical records containing that diagnosis.

(b) The commission shall also design and implement a program to provide a dual-party relay system, using third-party intervention to connect individuals who are deaf or hard of hearing and offices of organizations representing individuals who are deaf or hard of hearing, as determined and specified by the commission pursuant to subdivision (h), with persons of normal hearing by way of intercommunications devices for individuals who are deaf or hard of hearing and the telephone system, making available reasonable access of all phases of public telephone service to telephone subscribers who are deaf or hard of hearing. In order to make a dual-party relay system that will meet the requirements of individuals who are deaf or hard of hearing available at a reasonable cost, the commission shall initiate an investigation, conduct public hearings to determine the most cost-effective method of providing dual-party relay service to the deaf or hard of hearing when using a telecommunications device, and solicit the advice, counsel, and physical assistance of statewide nonprofit consumer organizations of the deaf, during the development and implementation of the system. The commission shall apply for certification of this program under rules adopted by the Federal Communications Commission pursuant to Section 401 of the federal Americans with Disabilities Act of 1990 (Public Law 101-336).

(c) The commission shall also design and implement a program whereby specialized or supplemental telephone communications equipment may be provided to subscribers who are certified to be disabled at no charge additional to the basic exchange rate. The certification, including a statement of visual or medical need for specialized telecommunications equipment, shall be provided by a licensed optometrist, physician and surgeon, or physician
assistant, or nurse practitioner, acting within the scope of practice of the applicable license, or by a qualified state or federal agency as determined by the commission. The commission shall, in this connection, study the feasibility of, and implement, if determined to be feasible, personal income criteria, in addition to the certification of disability, for determining a subscriber’s eligibility under this subdivision.

(d) (1) The commission shall also design and implement a program to provide access to a speech-generating device to any subscriber who is certified as having a speech disability at no charge additional to the basic exchange rate. The certification shall be provided by a licensed physician, licensed speech-language pathologist, nurse practitioner, or qualified state or federal agency. The commission shall provide to a certified subscriber access to a speech-generating device that is all of the following:

(A) A telecommunications device or a device that includes a telecommunications component.

(B) Appropriate to meet the subscriber’s needs for access to, and use of, the telephone network, based on the recommendation of a licensed speech-language pathologist.

(C) Consistent with the quality of speech-generating devices available for purchase in the state.

(2) The commission shall adopt rules to implement this subdivision and subdivision (e) by January 1, 2014.

(e) All of the following apply to any device or equipment described in this section that is classified as durable medical equipment under guidelines established by the United States Department of Health and Human Services:

(1) It is the intent of the Legislature that the commission be the provider of last resort and that eligible subscribers first obtain coverage from any available public or private insurance.

(2) The commission may require the subscriber to provide information about coverage for any or all of the cost of the device or equipment that is available from a public or private insurance, the cost to the subscriber of a deductible, copayment, or other relevant expense, and any related benefit cap information.

(3) The total cost of a device or equipment provided to a subscriber under this section shall not exceed the rate of reimbursement provided by Medi-Cal for that device or equipment.
(f) This section does not require the commission to provide training to a subscriber on the use of a speech-generating device.

(g) The commission shall establish a rate recovery mechanism through a surcharge not to exceed one-half of 1 percent uniformly applied to a subscriber’s intrastate telephone service, other than one-way radio paging service and universal telephone service, both within a service area and between service areas, to allow providers of the equipment and service specified in subdivisions (a) to (d), inclusive, to recover costs as they are incurred under this section. The surcharge shall be in effect until January 1, 2020. The commission shall require that the programs implemented under this section be identified on subscribers’ bills, and shall establish a fund and require separate accounting for each of the programs implemented under this section.

(h) The commission shall determine and specify those statewide organizations representing the deaf or hard of hearing that shall receive a telecommunications device pursuant to subdivision (a), or a dual-party relay system pursuant to subdivision (b), or both, and in which offices the equipment shall be installed in the case of an organization having more than one office.

(i) The commission may direct a telephone corporation subject to its jurisdiction to comply with its determinations and specifications pursuant to this section.

(j) The commission shall annually review the surcharge level and the balances in the funds established pursuant to subdivision (g). Until January 1, 2020, the commission may make, within the limits set by subdivision (g), necessary adjustments to the surcharge to ensure that the programs supported by the surcharge are adequately funded and that the fund balances are not excessive. A fund balance that is projected to exceed six months’ worth of projected expenses at the end of the fiscal year is excessive.

(k) In order to continue to meet the access needs of individuals with functional limitations of hearing, vision, movement, manipulation, speech, and interpretation of information, the commission shall perform an ongoing assessment of, and if appropriate, expand the scope of, the program to allow for additional access capability consistent with evolving telecommunications technology.

(l) The commission shall structure the programs required by this section so that a charge imposed to promote the goals of
universal service reasonably equals the value of the benefits of
universal service to contributing entities and their subscribers.
SEC. 2. This act is an urgency statute necessary for the
immediate preservation of the public peace, health, or safety within
the meaning of Article IV of the California Constitution and shall
go into immediate effect. The facts constituting the necessity are:
In order to ensure that persons who are deaf or hard of hearing
have ready access to necessary means of communication, including
the ability to contact first-responders in emergency situations, it
is necessary for this act to take effect immediately.
SUMMARY:

1. Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems.

   • The existing act establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of EMS systems.
   • requires the authority to develop planning and implementation guidelines for EMS systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of EMS systems, and receive plans for the implementation of EMS and trauma care systems from local EMS agencies.

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.

   • requires the county board of supervisors to prescribe the membership, and appoint the members, of the committee.

3. Existing law establishes the Commission on Emergency Medical Services with 18 members. The commission, among other things, reviews and approves regulations, standards, and guidelines developed by the authority.

ANALYSIS:

Re 1., above: This bill would:

   • establish within the act until January 1, 2030, the Community Paramedicine or Triage to Alternate Destination Act of 2019.
• authorize a local EMS agency to develop a community paramedicine or triage to alternate destination program, as defined, to provide specified community paramedicine services.

• require the authority to develop regulations to establish minimum standards for a program, and would further require the Commission on Emergency Medical Services to review and approve those regulations.

• require the authority to review a local EMS agency’s proposed program and approve, approve with conditions, or deny the proposed program no later than 6 months after it is submitted by the local EMS agency.

• require a local EMS agency that opts to develop a program to perform specified duties that include, among others, integrating the proposed program into the local EMS agency’s EMS plan.

• require the Emergency Medical Services Authority to submit an annual report on the community paramedicine or triage to alternate destination programs operating in California to the Legislature, as specified.

• require the authority to contract with an independent third party to prepare a final report on the results of the community paramedicine or triage to alternate destination programs on or before June 1, 2028, as specified.

• prohibit a person or organization from providing community paramedicine or triage to alternate destination services or representing, advertising, or otherwise implying that it is authorized to provide those services unless it is expressly authorized by a local EMS agency to provide those services as part of a program approved by the authority.

• prohibit a community paramedic or a triage paramedic from providing their respective services unless the community paramedic or triage paramedic has been certified and accredited to perform those services and is working as an employee of an authorized provider.

Re 2., above: This bill would, notwithstanding these provisions:
• 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 or triage to alternate destination program if the local EMS agency develops that program.

• specifically require the mayor of a city and county to appoint the membership.

• repeal these provisions on January 1, 2030.

Re 3., above: This bill would increase the membership of the commission to 20 members and modify the entities that submit names for appointment to the commission by the Governor, the Senate Committee on Rules, and the Speaker of the Assembly.
Amended analysis as of 4/22:

The bill is amended to provide the following addition to the Health and Safety Code:

Section 1831.
Regulations adopted by the Emergency Medical Services Authority pursuant to Section 1830 relating to a triage to alternate destination program shall include all of the following: …

(e) A process for local EMS agencies to certify and provide periodic updates to the authority to demonstrate that the alternate destination facility authorized to receive patients maintains adequate licensed medical and professional staff, facilities, and equipment pursuant to the authority’s regulations and the provisions of this chapter, which shall include all of the following:
(1) Identification of qualified staff to care for the degree of a patient’s injuries and needs.
(2) Certification of standardized medical and nursing procedures for nursing staff.
(3) Certification that the necessary equipment and services are available at the alternate destination facility to care for patients, including, but not limited to, an automatic external defibrillator and at least one bed or mat per individual patient.

BOARD POSITION: Oppose (4/11/19)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (3/14/19)

SUPPORT:
California Chapter of the American College Of Emergency Physicians (cosponsor)
California Professional Firefighters (cosponsor)

OPPOSE:
California Ambulance Association California Association for Health Services at Home California Nurses Association
An act to amend Section 1799.2 of, to add Section 1797.259 to, to add and repeal Section 1797.273 of, and to add and repeal Chapter 13 (commencing with Section 1800) of Division 2.5 of, the Health and Safety Code, relating to community paramedicine.

LEGISLATIVE COUNSEL’S DIGEST

AB 1544, as amended, Gipson. Community Paramedicine or Triage to Alternate Destination Act.

(1) Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The existing act establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of EMS systems. Among other duties, existing law requires the authority to develop planning and implementation guidelines for EMS systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of EMS systems, and receive plans for the implementation of EMS and trauma care systems from local EMS agencies. Existing law makes violation of the act or regulations adopted pursuant to the act punishable as a misdemeanor.

This bill would establish within the act until January 1, 2030, the Community Paramedicine or Triage to Alternate Destination Act of 2019. The bill would authorize a local EMS agency to develop a
community paramedicine or triage to alternate destination program, as defined, to provide specified community paramedicine services. The bill would require the authority to develop regulations to establish minimum standards for a program, and would further require the Commission on Emergency Medical Services to review and approve those regulations. The bill would require the authority to review a local EMS agency’s proposed program and approve, approve with conditions, or deny the proposed program no later than 6 months after it is submitted by the local EMS agency. The bill would require a local EMS agency that opts to develop a program to perform specified duties that include, among others, integrating the proposed program into the local EMS agency’s EMS plan. The bill would require the Emergency Medical Services Authority to submit an annual report on the community paramedicine or triage to alternate destination programs operating in California to the Legislature, as specified. The bill would also require the authority to contract with an independent 3rd party to prepare a final report on the results of the community paramedicine or triage to alternate destination programs on or before June 1, 2028, as specified.

The bill would prohibit a person or organization from providing community paramedicine or triage to alternate destination services or representing, advertising, or otherwise implying that it is authorized to provide those services unless it is expressly authorized by a local EMS agency to provide those services as part of a program approved by the authority. The bill would also prohibit a community paramedic or a triage paramedic from providing their respective services unless the community paramedic or triage paramedic has been certified and accredited to perform those services and is working as an employee of an authorized provider. Because a violation of the act described above is punishable as a misdemeanor, and because this bill would create new requirements within the act, the bill would expand an existing crime, thereby imposing 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, notwithstanding these provisions, if the county elects to develop a community paramedicine or triage to alternate destination.
program, require the committee to be established, if one is not already established, to include additional members, as specified, and to advise a local EMS agency within the county on the development of its community paramedicine or triage to alternate destination program if the local EMS agency develops that program. The bill would specifically require the mayor of a city and county to appoint the membership.

The bill would repeal these provisions on January 1, 2030.

(3) Existing law establishes the Commission on Emergency Medical Services with 18 members. The commission, among other things, reviews and approves regulations, standards, and guidelines developed by the authority.

This bill would increase the membership of the commission to 20 members and modify the entities that submit names for appointment to the commission by the Governor, the Senate Committee on Rules, and the Speaker of the Assembly.

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

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


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

SECTION 1. Section 1797.259 is added to the Health and Safety Code, to read:

> 1797.259. A local EMS agency that elects to implement a community paramedicine or triage to alternate destination program pursuant to Section 1840 shall develop and, prior to implementation, submit a plan for that program to the authority according to the requirements of Chapter 13 (commencing with Section 1800).

SEC. 2. Section 1797.273 is added to the Health and Safety Code, to read:

> 1797.273. (a) Notwithstanding Sections 1797.270 and 1797.272, if a local EMS agency within the county elects to develop a community paramedicine or triage to alternate destination program pursuant to Section 1840, the county board of supervisors,
or in the case of a city and county, the mayor, shall establish an
emergency medical care committee.

(b) The board of supervisors or the mayor shall ensure that the
membership of the committee includes all of the following
members to advise the local EMS agency on the development of
the community paramedicine or triage to alternate destination
program:

(1) One emergency medicine physician and surgeon who is
board certified or board eligible practicing at an emergency
department within the jurisdiction of the local EMS agency.
(2) One registered nurse practicing within the jurisdiction of
the local EMS agency.
(3) One licensed paramedic practicing within the jurisdiction
of the local EMS agency. Whenever possible, the paramedic shall
be employed by a public agency.
(4) One acute care hospital representative with an emergency
department operating that operates within the jurisdiction of the
local EMS agency.
(5) If a local EMS agency elects to implement a triage to
alternate destination program to a sobering center, one individual
with expertise in substance use disorder detoxification and
recovery.
(6) Additional advisory members in the fields of public health,
social work, hospice, or mental health practicing within the
jurisdiction of the local EMS agency with expertise commensurate
with the program specialty or specialties described in Section 1815
that the local EMS agency proposes to adopt.

(c) The requirements of this section shall apply to any
emergency medical care committees, or other committees, created
for the purposes described in Section 1797.274. Committee
established pursuant to this section or Section 1797.270.

(d) This section shall remain in effect only until January 1, 2030,
and as of that date is repealed.

SEC. 3. Section 1799.2 of the Health and Safety Code is
amended to read:

1799.2. The commission shall consist of 20 members appointed
as follows:

(a) One full-time physician and surgeon, whose primary practice
is emergency medicine, appointed by the Senate Committee on
Rules from a list of three names submitted by the California Chapter of the American College of Emergency Physicians.

(b) One physician and surgeon, who is a trauma surgeon, appointed by the Speaker of the Assembly from a list of three names submitted by the California Chapter of the American College of Surgeons.

(c) One physician and surgeon appointed by the Senate Committee on Rules from a list of three names submitted by the California Medical Association.

(d) One county health officer appointed by the Governor from a list of three names submitted by the California Conference of Local Health Officers.

(e) One registered nurse, who is currently, or has been previously, authorized as a mobile intensive care nurse and who is knowledgeable in state emergency medical services programs and issues, appointed by the Governor from a list of three names submitted by the California Labor Federation.

(f) One full-time paramedic or EMT-II, who is not employed as a full-time peace officer, appointed by the Senate Committee on Rules from a list of three names submitted by the California Labor Federation.

(g) One prehospital emergency medical service provider from the private sector, appointed by the Speaker of the Assembly from a list of three names submitted by the California Ambulance Association.

(h) One management member of an entity providing fire protection and prevention services appointed by the Governor from a list of three names submitted by the California Fire Chiefs Association.

(i) One physician and surgeon who is board prepared or board certified in the specialty of emergency medicine by the American Board of Emergency Medicine and who is knowledgeable in state emergency medical services programs and issues appointed by the Speaker of the Assembly from a list of three names submitted by the California Chapter of the American College of Emergency Physicians.

(j) One hospital administrator of a base hospital who is appointed by the Governor from a list of three names submitted by the California Hospital Association.
(k) One full-time peace officer, who is either an EMT-II or a paramedic, who is appointed by the Governor from a list of three names submitted by the California Peace Officers Association.

(l) Two public members who have experience in local EMS policy issues, at least one of whom resides in a rural area as defined by the authority, and who are appointed by the Governor.

(m) One administrator from a local EMS agency appointed by the Governor from a list of four names submitted by the Emergency Medical Services Administrator’s Association of California.

(n) One medical director of a local EMS agency who is an active member of the Emergency Medical Directors Association of California and who is appointed by the Governor.

(o) One person appointed by the Governor, who is an active member of the California State Firemen’s Association.

(p) One person who is employed by the Department of Forestry and Fire Protection (CAL-FIRE) appointed by the Governor from a list of three names submitted by the California Professional Firefighters.

(q) One person who is employed by a city, county, or special district that provides fire protection appointed by the Governor from a list of three names submitted by the California Professional Firefighters.

(r) One physician and surgeon specializing in the comprehensive care of individuals with co-occurring mental health or psychosocial and substance use disorders appointed by the Governor in consultation with the California Psychiatric Association and the California Society of Addiction Medicine.

(s) One licensed clinical social worker appointed by the Governor in consultation with the California State Council of the Service Employees International Union and the California Chapter of the National Association of Social Workers.

SEC. 4. Chapter 13 (commencing with Section 1800) is added to Division 2.5 of the Health and Safety Code, to read:
Chapter 13. Community Paramedicine Or Triage to Alternate Destination


This chapter shall be known, and may be cited, as the Community Paramedicine or Triage to Alternate Destination Act of 2019.

(a) It is the intent of the Legislature to establish state standards that govern the implementation of community paramedicine or triage to alternate destination programs by local EMS agencies in California.

(b) It is the intent of the Legislature that community paramedicine or triage to alternate destination programs be community-focused extensions of the traditional emergency response and transportation paramedic model that has developed over the last 50 years and be recognized as an emerging model of care created to meet an unmet need in California’s communities.

(c) It is the intent of the Legislature to improve the health of individuals in their communities by authorizing licensed paramedics, working under expert medical oversight, to deliver community paramedicine or triage to alternate destination services 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 or triage to alternate destination program achieve all of the following:

(1) Improve coordination among providers of medical services, behavioral health services, and social services.

(2) Preserve and protect the underlying 911 emergency medical services delivery system.

(3) Preserve, protect, and deliver the highest level of patient care to every Californian.

(4) Preserve and protect the current health care workforce and empower local health care systems to provide care more effectively and efficiently.

(e) It is the intent of the Legislature that an alternate destination facility participating as part of an approved program always be
staffed by a health care professional with a higher scope of practice, such as, at minimum, a registered nurse.

(f) It is the intent of the Legislature that the delivery of community paramedicine or triage to alternate destination services is a public good to be delivered in a manner that promotes the continuity of both care and providers. It is the intent of the Legislature that the delivery of these services be coordinate and consistent with, and complementary to, the existing first response and emergency medical response system in place within the jurisdiction of the local EMS agency.

g) It is the intent of the Legislature that a community paramedicine or triage to alternate destination program be designed to improve community health and be implemented in a fashion that respects the current emergency medical system and its providers, and the health care delivery system. In furtherance of the public interest and good, agencies that provide first response services are well positioned to deliver care under a community paramedicine or triage to alternate destination program.

(h) It is the intent of the Legislature that the development of any community paramedicine or triage to alternate destination program reflect 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 or triage to alternate destination program to improve patient care and community health. A community paramedicine or triage to alternate destination program should not be used to replace or eliminate health care workers, reduce personnel costs, harm the working conditions of emergency medical and health care workers, or otherwise compromise the emergency medical response or health care system. The highest priority of any community paramedicine or triage to alternate destination program shall be improving patient care.
Article 2. Definitions

1810. Unless otherwise indicated in this chapter, the definitions contained in this article govern the provisions of this chapter.

1811. “Alternate destination facility” means a treatment location that is an authorized mental health facility, as defined in Section 1812 or an authorized sobering center as defined in Section 1813.

1812. “Authorized mental health facility” means a designated facility, as defined in subdivision (n) of Section 5008 of the Welfare and Institutions Code, that has at least one registered nurse staffed onsite at the facility at all times.

1813. “Authorized sobering center” means a noncorrectional facility that provides a safe, supportive environment for intoxicated individuals to become sober that meets both of the following requirements:
(a) The facility is staffed at all times with at least one registered nurse.
(b) The facility is a federally qualified health center, including a clinic described in subdivision (b) of Section 1211.

1814. “Community paramedic” means a paramedic in good standing licensed under this division who has completed the curriculum for community paramedic training adopted pursuant to paragraph (1) of subdivision (d) of Section 1830, has received certification in one or more of the community paramedicine program specialties described in Section 1815, and is certified and 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 paramedicine services consisting of one or more of the program specialties described in this section 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 paramedicine 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, including collaboration with, and by providing referral
to, home health services when eligible.
(b) Providing directly observed therapy (DOT) to persons with
tuberculosis in collaboration with a public health agency to ensure
effective treatment of the tuberculosis and to prevent spread of the
disease.
(c) Providing case management services to frequent emergency
medical services users in collaboration with, and by providing
referral to, existing appropriate community resources.

1816. “Community paramedicine provider” means an advanced
life support provider authorized by a local EMS agency to provide
advanced life support who has entered into a contract to deliver
community paramedicine services as described in Section 1815
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.

1818. “Triage paramedic” means a paramedic licensed under
this division who has completed the curriculum for triage
paramedic services adopted pursuant to paragraph (2) of
subdivision (d) of Section 1830 and has been accredited by a local
EMS agency in one or more of the triage paramedic specialties
described in Section 1819 as part of an approved triage to alternate
destination program.

1819. (a) “Triage to alternate destination program” means a
program developed by a local EMS agency and approved by the
Emergency Medical Services Authority to provide triage paramedic
assessments consisting of one or more specialties described in this
section operating under triage and assessment protocols developed
by the local EMS agency that are consistent with the minimum
triage and assessment protocols established by the authority. Triage
paramedic assessments may consist of the following program
specialties:
(1) Providing care and comfort services to hospice patients in
their homes in response to 911 calls by providing for the patient’s
and the family’s immediate care needs, including grief support in
collaboration with the patient’s hospice agency until the hospice
nurse arrives to treat the patient.
(2) Providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination facility.

(b) This section does not prevent or eliminate any authority to provide continuous transport of a patient to a participating hospital for priority evaluation by a physician, nurse practitioner, or physician assistant before transport to an alternate destination facility.

1820. “Triage to alternate destination provider” means an advanced life support provider authorized by a local EMS agency to provide advanced life support triage paramedic assessments as part of an approved triage to alternate destination program specialty, as described in Section 1819.

Article 3. State Administration

1830. (a) The Emergency Medical Services Authority shall develop regulations that establish minimum standards for the development of a community paramedicine or triage to alternate destination program.

(b) The Commission on Emergency Medical Services shall review and approve the regulations described in this section in accordance with Section 1799.50.

(c) The regulations described in this section shall be based upon, and informed by, the Community Paramedicine Pilot Program under the Office of Statewide Health Planning and Development Health Workforce Pilot Project No. 173 and the protocols and operation of the pilot projects approved under the project.

(d) The regulations that establish minimum standards for the development of a community paramedicine or triage to alternate destination program shall include all of the following:

(1) Minimum standards and curriculum for each program specialty described in Section 1815. The authority, in developing the minimum standards and curriculum, shall provide for community paramedics to be trained in one or more of the program specialties described in Section 1815 and approved by the local EMS agency pursuant to Section 1840.

(2) Minimum standards and curriculum for each program specialty described in Section 1819. The authority, in developing the minimum standards and curriculum, shall provide for triage
paramedics to be trained in one or more of the program specialties
described in Section 1819 and approved by the local EMS agency
pursuant to Section 1840.

(3) A process for verifying on a paramedic’s license the
successful completion of the training described in paragraph (1)
or (2).

(4) Staff qualifications to care for a patient’s injuries and needs
based on degree and severity.

(5) Standardized medical and nursing procedures for nursing
staff.

(6) The medical equipment and services required to be available
at an alternate destination facility to care for patients, including,
but not limited to, an automatic external defibrillator and at least
one bed or mat per patient.

(7) Limitations that may apply to the ability of an alternate
destination facility to treat patients requiring medical services,
including, but limited to, time of day.

(8) Minimum standards for approval, review, withdrawal, and
revocation of a community paramedicine or triage to alternate
destination program in accordance with Section 1797.105. Those
standards shall include, but not be limited to, both of the following:

(A) A requirement that facilities participating in the program
accommodate privately or commercially insured, Medi-Cal,
Medicare, and uninsured patients.

(B) Immediate termination of participation in the program by
the alternate destination facility or the community paramedicine
or triage to alternate destination provider if it fails to operate in
accordance with subdivision (b) of Section 1317.

(9) Minimum standards for collecting and submitting data to
the authority to ensure patient safety that include consideration of
both quality assurance and quality improvement. These standards
shall include, but not be limited to, all of the following:

(A) Intervals for community paramedicine or triage to alternate
destination providers, participating health facilities, and local EMS
agencies to submit community paramedicine services data.

(B) Relevant program use data and the online posting of program
analyses.

(C) Exchange of electronic patient health information between
community paramedicine or triage to alternate destination providers
and health providers and facilities. The authority may grant a
one-time temporary waiver, not to exceed five years, of this requirement for alternate destination facilities that are unable to immediately comply with the electronic patient health information requirement.

(D) Emergency medical response system feedback, including feedback from the emergency medical care committee described in subdivision (b) of Section 1797.273.

(E) If the community paramedicine or triage to alternate destination program utilizes an alternate destination facility, consideration of ambulance patient offload times for the alternate destination facility, 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 or triage to alternate destination program’s medical protocols or other processes.

(G) An assessment of the impact that implementation of a community paramedicine or triage to alternate destination program has on the delivery of emergency medical services, including the impact on response times in the local EMS agency’s jurisdiction.

1831. Regulations adopted by the Emergency Medical Services Authority pursuant to Section 1830 relating to a triage to alternate destination program shall include all of the following:

(a) Local EMS agencies participating in providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination facility shall ensure that any patient who meets the triage criteria for transport to an alternate destination facility, but who requests to be transported to an emergency department of a general acute care hospital, shall be transported to the emergency department of a general acute care hospital.

(b) Local EMS agencies participating in providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination facility shall require that a patient who is transported to an alternate destination facility and, upon assessment, is found to no longer meet the criteria for admission to an alternate destination facility, be immediately transported to the emergency department of a general acute care hospital.
(c) For authorizing transport to an alternate destination facility, training and accreditation for the triage paramedic and the incumbent transport provider shall include topics relevant to the needs of the patient population, including, but not limited to:

(1) A requirement that a participating triage paramedic complete instruction on all of the following:

(A) Mental health crisis intervention, to be provided by a licensed physician and surgeon with experience in the emergency department of a general acute care hospital.
(B) Assessment and treatment of intoxicated patients.
(C) Local EMS agency policies for the triage, treatment, transport, and transfer of care, of patients to an alternate destination facility.

(2) A requirement that the local EMS agency verify that the participating triage paramedic 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:
(A) Psychiatric disorders.
(B) Neuropharmacology.
(C) Alcohol and substance abuse.
(D) Patient consent.
(E) Patient documentation.
(F) Medical quality improvement.

(d) For authorizing transport to a sobering center, a training component that requires a participating triage paramedic and the medics staffing the ambulance of the incumbent transport provider to complete instruction on all of the following:

(1) The impact of alcohol intoxication on the local public health and emergency medical services system.
(2) Alcohol and substance use disorders.
(3) Triage and transport parameters.
(4) Health risks and interventions in stabilizing acutely intoxicated patients.
(5) Common conditions with presentations similar to intoxication.
(6) Disease process, behavioral emergencies, and injury patterns common to those with chronic alcohol use disorders.
(e) A process for local EMS agencies to certify and provide periodic updates to the authority to demonstrate that the alternate destination facility authorized to receive patients maintains adequate licensed medical and professional staff, facilities, and equipment pursuant to the authority’s regulations and the provisions of this chapter, which shall include all of the following:

1. Identification of qualified staff to care for the degree of a patient’s injuries and needs.
2. Certification of standardized medical and nursing procedures for nursing staff.
3. Certification that the necessary equipment and services are available at the alternate destination facility to care for patients, including, but not limited to, an automatic external defibrillator and at least one bed or mat per individual patient.

1832. (a) The Emergency Medical Services Authority shall develop and periodically review and update the minimum medical protocols applicable to each community paramedicine program specialty described in Section 1815 and the minimum triage and assessment protocols for triage to alternate destination program specialties described in Section 1819.

(b) In complying with the requirements of this section, the authority shall establish and consult with an advisory committee comprised of the following members:

1. Individuals in the fields of public health, social work, hospice, substance-use or mental health with expertise commensurate with the program specialty or specialties described in Section 1815.
2. Physicians and surgeons whose primary practice is emergency medicine.
3. Two local EMS medical directors selected by the EMS Medical Directors Association of California.
4. Two local EMS directors selected by the California Chapter of the American College of Emergency Physicians.

(c) The protocols developed and revised pursuant to this section shall be based upon, and informed by, the Community Paramedicine Pilot Program under the Office of Statewide Health Planning and Development’s Health Workforce Pilot Project No. 173, and further refinements provided by local EMS agencies during the course and operation of the pilot projects.
1833. (a) Notwithstanding Section 10231.5 of the Government Code, the Emergency Medical Services Authority shall submit an annual report on the community paramedicine or triage to alternate destination programs operating in California to the relevant policy committees of the Legislature in accordance with Section 9795 of the Government Code and shall post the annual report on its internet website. The authority shall submit and post its first report six months after the authority adopts the regulations described in Section 1830. Thereafter, the authority shall submit and post its report annually on or before January 1, for a period of five years.

(b) The report required by this section shall include all of the following:

(1) An assessment of each program specialty, including an assessment of patient outcomes in the aggregate and an assessment of any adverse patient events resulting from services provided under plans approved pursuant to this chapter.

(2) An assessment of the impact that the program specialties have had on the emergency medical system.

(3) An update on the implementation of program specialties operating in local EMS agency jurisdictions.

(4) Policy recommendations for improving the administration of local plans and patient outcomes.

(c) All data collected by the authority shall be posted on its internet website in a downloadable format and in a manner that protects the confidentiality of individually identifiable patient information.

1834. (a) Notwithstanding Section 10231.5 of the Government Code, on or before June 1, 2028, the Emergency Medical Services Authority shall submit a final report on the results of the community paramedicine or triage to alternate destination programs operating in California to the relevant policy committees of the Legislature, in accordance with Section 9795 of the Government Code, and shall post the report on its internet website.

(b) The authority shall identify and contract with an independent third-party evaluator to develop the report required by this section.

(c) The report shall include all of the following:

(1) A detailed assessment of each community paramedicine or triage to alternate destination program operating in local EMS agency jurisdictions.
(2) An assessment of patient outcomes in the aggregate resulting from services provided under approved plans under the program.

(3) An assessment of workforce impact due to implementation of the program.

(4) An assessment of the impact of the program on the emergency medical services system.

(5) An assessment of how the currently operating program specialties achieve the legislative intent stated in Section 1801.

(6) An assessment of community paramedic and triage training.

(d) The report may include recommendations for changes to, or the elimination of, community paramedicine or triage to alternate destination program specialties that do not achieve the community health and patient goals described in Section 1801.

1835. (a) The Emergency Medical Services Authority shall review a local EMS agency’s proposed community paramedicine or triage to alternate destination program using procedures consistent with Section 1797.105 and review the local EMS agency’s program protocols in order to ensure compliance with the statewide minimum protocols developed under Section 1832.

(b) The authority may impose conditions as part of the approval of a community paramedicine or triage to alternate destination 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 or triage to alternate destination program no later than six months after it is submitted by the local EMS agency.

1836. A community paramedicine pilot program approved under the Office of Statewide Health Planning and Development’s Health Workforce Pilot Project No. 173 before January 1, 2020, is authorized to operate until one year after the regulations described in Section 1830 become effective.

Article 4. Local Administration

1840. A local EMS agency may develop a community paramedicine or triage to alternate destination program that is consistent with the Emergency Medical Services Authority’s regulations and the provisions of this chapter and submit evidence
of compliance with the requirements of Section 1841 to the
authority for approval pursuant to Section 1835.

1841. A local EMS agency that elects to develop a community
paramedicine or triage to alternate destination program shall do
all of the following:

(a) Integrate the proposed community paramedicine or triage
to alternate destination 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 or triage to alternate destination
providers, to provide services as described in Section 1815 or 1819,
at a periodic interval established by the local EMS agency.

(c) Facilitate any necessary agreements with one or more
community paramedicine or triage to alternate destination providers
for the delivery of community paramedicine or triage to alternate
destination services within the local EMS agency’s jurisdiction
that are consistent with the proposed community paramedicine or
triage to alternate destination program. The local EMS agency
shall provide medical control and oversight of the program.

(d) The local EMS agency shall not include the provision of
community paramedic program specialties or triage to alternate
destination program specialties as part of an existing or proposed
contract for the delivery of emergency medical transport services
awarded pursuant to Section 1797.224.

(e) Coordinate, review, and approve any agreements necessary
for the provision of community paramedicine specialties or triage
to alternate destination services consistent with all of the following:

(1) Provide a first right of refusal to the public agency or
agencies within the jurisdiction of the proposed program area to
provide the proposed program specialties. If the public agency or
agencies agree to provide the proposed program specialties, the
local EMS agency shall review and approve any written agreements
necessary to implement the program with those public agencies.

(2) Review and approve agreements with community
paramedicine triage to alternate destination providers that partner
with a private provider to deliver those program specialties.

(3) If a public agency declines to provide the proposed program
specialties pursuant to paragraph (1) or (2), the local EMS agency
shall develop a process to select community paramedicine or triage
to alternate destination providers to deliver the program specialties.

(f) Facilitate necessary agreements between the triage to
alternate destination program provider and the existing emergency
medical transport provider to ensure transport to the appropriate
facility.

(g) At the discretion of the local medical director, develop
additional triage and assessment protocols commensurate with the
need of the local programs authorized under this act.

(h) Prohibit triage and assessment protocols or a triage
paramedic’s decision to authorize transport to an alternate
destination facility from being based on, or affected by, a patient’s
ethnicity, citizenship, age, preexisting medical condition, insurance
status, economic status, ability to pay for medical services, or any
other characteristic listed or defined in subdivision (b) or (e) of
Section 51 of the Civil Code, except to the extent that a
circumstance such as age, sex, preexisting medical condition, or
physical or mental disability is medically significant to the
provision of appropriate medical care to the patient.

(i) Certify and provide documentation and periodic updates to
the Emergency Medical Service Authority showing that the
alternate destination facility authorized to receive patients
maintains adequate licensed medical and professional staff,
facilities, and equipment that comply with the requirements of the
Emergency Medical Services Authority’s regulations and the
provisions of this chapter.

(j) Secure an agreement with the alternate destination facility
that requires the facility to notify the local EMS agency within 24
hours if there are changes in the status of the facility with respect
to protocols and the facility’s ability to care for patients.

(k) Secure an agreement with the alternate destination that
requires the facility to operate in accordance with Section 1317.
The agreement shall provide that failure to operate in accordance
with Section 1317 will result in the immediate termination of use
of the facility as part of the triage to alternate destination facility.

(l) In implementing a triage to alternate destination program
specialties described in Section 1819, the local EMS agency shall
continue to use, and coordinate with, any emergency medical
transport providers operating within the jurisdiction of the local
EMS agency pursuant to Section 1797.201 or 1797.224. The local
EMS agency shall not in any manner eliminate or reduce the services of the emergency medical transport providers.

(m) Establish a process to verify training and accreditation of community paramedics in each of the proposed community paramedicine program specialties described in subdivisions (a) to (c), inclusive, of Section 1815.

(n) Establish a process for training and accreditation of triage paramedics in each of the proposed triage to alternate destination program’s specialties described in Section 1819.

(o) Facilitate funding discussions between a community paramedicine, triage to alternate destination provider, or incumbent emergency medical transport provider and public or private health system participants to support the implementation of the local EMS agency’s community paramedicine or triage to alternate destination program.

Article 5. Miscellaneous

1850. A community paramedicine pilot program approved under the Office of Statewide Health Planning and Development’s Health Workforce Pilot Project No. 173 before January 1, 2020, to deliver community paramedicine services, as described in Section 1815, or triage to alternate destination services, as described in Section 1819, is authorized to continue the use of existing providers and is exempt from subdivisions (d) and (e) of Section 1841 until the provider elects to reduce or eliminate one or more of those community paramedicine services approved under the pilot program or fails to comply with the program standards as required by this chapter.

1851. A person or organization shall not provide community paramedicine or triage to alternate destination services or represent, advertise, or otherwise imply that it is authorized to provide community paramedicine or triage to alternate destination services unless it is expressly authorized by a local EMS agency to provide those services as part of a community paramedicine or triage to alternate destination program approved by the Emergency Medical Services Authority in accordance with Section 1835.

1852. A community paramedic shall provide community paramedicine services only if the community paramedic has been certified and accredited to perform those services by a local EMS
agency and is working as an employee of an authorized community
paramedicine provider.
1853. A triage paramedic shall provide triage to alternate
destination services only if the triage paramedic has been accredited
to perform those services by a local EMS agency and is working
as an employee of an authorized triage to alternate destination
provider.
1854. The disciplinary procedures for a community paramedic
shall be consistent with subdivision (d) of Section 1797.194.
1855. Entering into an agreement to be a community
paramedicine or triage to alternate destination provider pursuant
to this chapter shall not alter or otherwise invalidate an agency’s
authority to provide or administer emergency medical services
pursuant to Section 1797.201 or 1797.224.
1856. The liability provisions described in Chapter 9
(commencing with Section 1799.100) apply to this chapter.
1857. This chapter shall remain in effect only until January 1,
2030, and as of that date is repealed.
SEC. 5. No reimbursement is required by this act pursuant to
Section 6 of Article XIII B of the California Constitution because
the only costs that may be incurred by a local agency or school
district will be incurred because this act creates a new crime or
infraction, eliminates a crime or infraction, or changes the penalty
for a crime or infraction, within the meaning of Section 17556 of
the Government Code, or changes the definition of a crime within
the meaning of Section 6 of Article XIII B of the California
Constitution.
BILL ANALYSIS

AUTHOR: Bonta
BILL NUMBER: AB 1592

SPONSOR: California Athletic Trainers’ Association
BILL STATUS:

SUBJECT: Athletic trainers
DATE LAST AMENDED: March 28, 2019

SUMMARY:
Existing law provides for the licensure and regulation of various professions and vocations by regulatory boards and entities within the Department of Consumer Affairs, including athlete agents.

ANALYSIS:
This bill would

• enact the Athletic Training Practice Act, which, until January 1, 2028, would establish the California Board of Athletic Training within the Department of Consumer Affairs to exercise licensing, regulatory, and disciplinary functions under the act.

• prohibit a person from practicing as an athletic trainer or using certain titles or terms without being licensed by the board.

• define the practice of athletic training, specify requirements for licensure as an athletic trainer, and would require a licensed athletic trainer to practice only under the supervision of a physician and surgeon.

• provide that an athletic trainer license would be valid for 2 years and subject to renewal, and would authorize the board to deny, suspend, or revoke a license and to discipline a licensee for specified reasons.

• specify acts that constitute unprofessional conduct and would make it a misdemeanor for any person to violate the act.

• establish the Athletic Trainers Fund for the deposit of application and renewal fees, as specified, and would make those fees available to the board for the purpose of implementing the act’s provisions upon appropriation by the Legislature.
• authorize the Director of Consumer Affairs to seek and receive donations from the California Athletic Trainers’ Association or any other private individual or entity for the initial costs of implementing the act, and would specify that, if private funds are unavailable, would specify that a general fund or special fund loan may be used and repaid with fee revenue.

• repeal its provisions on January 1, 2028.

BOARD POSITION: Not previously considered

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Not previously considered

SUPPORT:
American Medical Society for Sports Medicine
Biola University
Board of Certification, Inc.
California Athletic Trainers Association
California Coaches Association
California Community College Athletic Trainers Association
California Interscholastic Federation
Commission on Accreditation of Athletic Training Education
Concussion Legacy Foundation
Eric Paredes Save A Live Foundation
Far West Athletic Trainers’ Association
Los Angeles Rams
Meticulous Medical, Inc
Modesto City Schools District
National Athletic Trainers’ Association
National Collegiate Athletic Association
National Federation of State High School Associations
Pacific Union College
Pivot Physical Therapy/Onsite Innovations
Preventixc
Southern California Intercollegiate Athletic Conference
Travis R. Roy Sudden Cardiac Arrest Fund
Via Heart Project
547 Individuals
126 High schools

OPPOSE:
California Nurses Association
California Physical Therapy Association
Occupational Therapy Association of California
The American Occupational Therapy Association, Inc.
United Nurses Associations of California/Union of Health Care Professionals
28 individuals
AMENDED IN ASSEMBLY MARCH 28, 2019
CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL  No. 1592

Introduced by Assembly Member Bonta

February 22, 2019

An act to amend, repeal, and add Sections 101 and 144 of, and to add and repeal Chapter 5.8 (commencing with Section 2697) of Division 2 of, the Business and Professions Code, relating to athletic trainers.

LEGISLATIVE COUNSEL’S DIGEST

AB 1592, as amended, Bonta. Athletic trainers.

Existing law provides for the licensure and regulation of various professions and vocations by regulatory boards and entities within the Department of Consumer Affairs, including athlete agents.

This bill would state the intent of the Legislature to enact legislation relating to the licensure and regulation of athletic trainers. It would enact the Athletic Training Practice Act, which, until January 1, 2028, would establish the California Board of Athletic Training within the Department of Consumer Affairs to exercise licensing, regulatory, and disciplinary functions under the act. The bill would prohibit a person from practicing as an athletic trainer or using certain titles or terms without being licensed by the board. The bill would define the practice of athletic training, specify requirements for licensure as an athletic trainer, and would require a licensed athletic trainer to practice only under the supervision of a physician and surgeon. The bill would provide that an athletic trainer license would be valid for 2 years and subject to renewal, and would authorize the board to deny, suspend, or revoke a license and to discipline a licensee for specified reasons. The bill
would specify acts that constitute unprofessional conduct and would make it a misdemeanor for any person to violate the act.

The bill would establish the Athletic Trainers Fund for the deposit of application and renewal fees, as specified, and would make those fees available to the board for the purpose of implementing the act’s provisions upon appropriation by the Legislature. The bill would authorize the Director of Consumer Affairs to seek and receive donations from the California Athletic Trainers’ Association or any other private individual or entity for the initial costs of implementing the act, and would specify that, if private funds are unavailable, would specify that a general fund or special fund loan may be used and repaid with fee revenue.

The bill would repeal its provisions on January 1, 2028.

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.


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

SECTION 1. Section 101 of the Business and Professions Code is amended to read:

101. The department is comprised of the following:
(a) The Dental Board of California.
(b) The Medical Board of California.
(c) The State Board of Optometry.
(d) The California State Board of Pharmacy.
(e) The Veterinary Medical Board.
(f) The California Board of Accountancy.
(g) The California Architects Board.
(h) The State Board of Barbering and Cosmetology.
(i) The Board for Professional Engineers, Land Surveyors, and Geologists.
(j) The Contractors’ State License Board.
(k) The Bureau for Private Postsecondary Education.
(m) The Board of Registered Nursing.
(n) The Board of Behavioral Sciences.
(o) The State Athletic Commission.
(p) The Cemetery and Funeral Bureau.
(q) The Bureau of Security and Investigative Services.
(r) The Court Reporters Board of California.
(s) The Board of Vocational Nursing and Psychiatric Technicians.
(t) The Landscape Architects Technical Committee.
(u) The Division of Investigation.
(v) The Bureau of Automotive Repair.
(w) The Respiratory Care Board of California.
(x) The Acupuncture Board.
(y) The Board of Psychology.
(z) The California Board of Podiatric Medicine.
(aa) The Physical Therapy Board of California.
(ab) The Arbitration Review Program.
(ac) The Physician Assistant Board.
(ad) The Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.
(ae) The California Board of Occupational Therapy.
(af) The Osteopathic Medical Board of California.
(ag) The Naturopathic Medicine Committee.
(ah) The Dental Hygiene Board of California.
(ai) The Professional Fiduciaries Bureau.
(aj) The State Board of Chiropractic Examiners.
(ak) The Bureau of Real Estate Appraisers.
(al) The Structural Pest Control Board.
(am) The Bureau of Cannabis Control.
(an) Any other boards, offices, or officers subject to its jurisdiction by law.
(ao) This section shall become operative on July 1, 2018.
(ao) The California Board of Athletic Training.
This section shall remain in effect only until January 1, 2028, and as of that date is repealed.
SEC. 2. Section 101 is added to the Business and Professions Code, to read:
101. The department is comprised of the following:
(a) The Dental Board of California.
(b) The Medical Board of California.
(c) The State Board of Optometry.
(d) The California State Board of Pharmacy.
(e) The Veterinary Medical Board.
(f) The California Board of Accountancy.
(g) The California Architects Board.
(h) The State Board of Barbering and Cosmetology.
(i) The Board for Professional Engineers, Land Surveyors, and Geologists.
(j) The Contractors’ State License Board.
(k) The Bureau for Private Postsecondary Education.
(m) The Board of Registered Nursing.
(n) The Board of Behavioral Sciences.
(o) The State Athletic Commission.
(p) The Cemetery and Funeral Bureau.
(q) The Bureau of Security and Investigative Services.
(r) The Court Reporters Board of California.
(s) The Board of Vocational Nursing and Psychiatric Technicians.
(t) The Landscape Architects Technical Committee.
(u) The Division of Investigation.
(v) The Bureau of Automotive Repair.
(w) The Respiratory Care Board of California.
(x) The Acupuncture Board.
(y) The Board of Psychology.
(z) The California Board of Podiatric Medicine.
(aa) The Physical Therapy Board of California.
(ab) The Arbitration Review Program.
(ac) The Physician Assistant Board.
(ad) The Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.
(ae) The California Board of Occupational Therapy.
(af) The Osteopathic Medical Board of California.
(ag) The Naturopathic Medicine Committee.
(ah) The Dental Hygiene Board of California.
(ai) The Professional Fiduciaries Bureau.
(aj) The State Board of Chiropractic Examiners.
(ak) The Bureau of Real Estate Appraisers.
(al) The Structural Pest Control Board.
(am) The Bureau of Cannabis Control.
Any other boards, offices, or officers subject to its jurisdiction by law.

This section shall become operative on January 1, 2028.

SEC. 3. Section 144 of the Business and Professions Code is amended to read:

144. (a) Notwithstanding any other law, an agency designated in subdivision (b) shall require an applicant to furnish to the agency a full set of fingerprints for purposes of conducting criminal history record checks. Any agency designated in subdivision (b) may obtain and receive, at its discretion, criminal history information from the Department of Justice and the United States Federal Bureau of Investigation.

(b) Subdivision (a) applies to the following:

1. California Board of Accountancy.
2. State Athletic Commission.
3. Board of Behavioral Sciences.
4. Court Reporters Board of California.
6. California State Board of Pharmacy.
7. Board of Registered Nursing.
8. Veterinary Medical Board.
9. Board of Vocational Nursing and Psychiatric Technicians.
10. Respiratory Care Board of California.
11. Physical Therapy Board of California.
12. Physician Assistant Committee of the Medical Board of California.
13. Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.
14. Medical Board of California.
15. State Board of Optometry.
16. Acupuncture Board.
17. Cemetery and Funeral Bureau.
19. Division of Investigation.
20. Board of Psychology.
21. California Board of Occupational Therapy.
22. Structural Pest Control Board.
23. Contractors’ State License Board.
(26) Board for Professional Engineers, Land Surveyors, and Geologists.
(27) Bureau of Cannabis Control.
(28) California Board of Podiatric Medicine.
(29) Osteopathic Medical Board of California.
(30) The California Board of Athletic Training.

(c) For purposes of paragraph (26) of subdivision (b), the term “applicant” shall be limited to an initial applicant who has never been registered or licensed by the board or to an applicant for a new licensure or registration category.

(d) This section shall remain in effect only until January 1, 2028, and as of that date is repealed.

SEC. 4. Section 144 is added to the Business and Professions Code, to read:

144. (a) Notwithstanding any other law, an agency designated in subdivision (b) shall require an applicant to furnish to the agency a full set of fingerprints for purposes of conducting criminal history record checks. Any agency designated in subdivision (b) may obtain and receive, at its discretion, criminal history information from the Department of Justice and the United States Federal Bureau of Investigation.

(b) Subdivision (a) applies to the following:

(1) California Board of Accountancy.
(2) State Athletic Commission.
(3) Board of Behavioral Sciences.
(4) Court Reporters Board of California.
(5) State Board of Guide Dogs for the Blind.
(6) California State Board of Pharmacy.
(7) Board of Registered Nursing.
(8) Veterinary Medical Board.
(9) Board of Vocational Nursing and Psychiatric Technicians.
(10) Respiratory Care Board of California.
(11) Physical Therapy Board of California.
(12) Physician Assistant Committee of the Medical Board of California.
(13) Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.
(14) Medical Board of California.
(15) State Board of Optometry.
(16) Acupuncture Board.
(17) Cemetery and Funeral Bureau.
(18) Bureau of Security and Investigative Services.
(19) Division of Investigation.
(20) Board of Psychology.
(21) California Board of Occupational Therapy.
(22) Structural Pest Control Board.
(23) Contractors’ State License Board.
(24) Naturopathic Medicine Committee.
(25) Professional Fiduciaries Bureau.
(26) Board for Professional Engineers, Land Surveyors, and Geologists.
(27) Bureau of Cannabis Control.
(28) California Board of Podiatric Medicine.
(29) Osteopathic Medical Board of California.
(c) For purposes of paragraph (26) of subdivision (b), the term “applicant” shall be limited to an initial applicant who has never been registered or licensed by the board or to an applicant for a new licensure or registration category.
(d) This section shall become operative on January 1, 2028.

SEC. 5. Chapter 5.8 (commencing with Section 2697) is added to Division 2 of the Business and Professions Code, to read:

Chapter 5.8. Athletic Trainers

Article 1. Administration

2697. This chapter shall be known, and may be cited, as the Athletic Training Practice Act.

2697.1. For the purposes of this chapter, the following definitions apply:
(a) “Athlete” means a person who participates in an athletic activity.
(b) “Athletic activity” means participation in exercise, sport, game, recreation, wellness, fitness, performing arts, or employment activities that requires physical strength, range of motion, flexibility, body awareness and control, speed, stamina, or agility.
(c) “Athletic trainer” means a person who meets the requirements of this chapter, is licensed by the board, and practices under the supervision of a licensed physician or surgeon. An athletic trainer is a healing arts licensee.
(d) “Board” means the California Board of Athletic Training.
(e) “Director” means the Director of Consumer Affairs.
2697.2. (a) There is established the California Board of Athletic Training within the Department of Consumer Affairs.
(b) The board shall consist of seven members, all of whom shall be California residents, as follows:
(1) Three licensed athletic trainers, except that initially, the board shall include three athletic trainers certified by the Board of Certification, Inc. or another nationally accredited athletic trainer certification agency, who shall satisfy the remainder of the licensure requirements described in Section 2697.4 as soon as it is practically possible.
(2) Three public members.
(3) One physician and surgeon licensed by the Medical Board of California or one osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California.
(c) Subject to confirmation by the Senate, the Governor shall appoint the licensed athletic trainers, one of the public members, and the physician and surgeon or osteopathic physician and surgeon. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.
(1) The athletic trainers shall be appointed from the following:
(A) Two members shall be actively practicing athletic training and engaged primarily in direct patient care as an athletic trainer with at least five continuous years of experience.
(B) One member shall be active primarily as an educator or administrator in a program to educate athletic trainers.
(2) The physician and surgeon or osteopathic physician and surgeon shall be appointed from persons who have supervised or are currently supervising athletic trainers.
(3) Each public member shall satisfy all of the following:
(A) Chapter 6 (commencing with Section 450) of Division 1.
(B) Shall not be or have ever been an athletic trainer or in training to become an athletic trainer.
(C) Shall not be a current or former licensee of any board under this division or of any board referred to in Section 1000 or 3600.
(D) Shall not be an officer or faculty member of any college, school, or institution involved in athletic training, physical therapy, or occupational therapy education.
(E) Shall have no pecuniary interests in the provision of health care services.

(d) (1) All appointments shall be for a term of four years and shall expire on June 30 of the year in which the term expires. Appointees may be reappointed once. Vacancies shall be filled for any unexpired term.

(2) Notwithstanding paragraph (1), for initial appointments to the board, one public member appointed by the Governor, the physician and surgeon or osteopathic physician and surgeon, and one of the licensed athletic trainers shall serve terms of two years, and the remaining members shall serve terms of four years.

(e) Each of the board members shall receive per diem and expenses, except as otherwise specified in Section 103.

(f) The appointing power shall have the power to remove any member of the board from office for neglect of any duty required by law or for incompetency or unprofessional or dishonorable conduct.

(g) No person may serve as a member of the board for more than two consecutive terms. Vacancies shall be filled by appointment for the unexpired term.

(h) Annually, the board shall elect one of its members as president and one of its members as vice president.

(i) Subject to Sections 107 and 154, the board may employ an executive officer and other officers and employees.

2697.3. (a) (1) The board shall adopt, repeal, and amend regulations as may be necessary to administer and enforce this chapter.

(2) Before adopting regulations, the board may consult the professional standards issued by the National Athletic Trainers’ Association, the Board of Certification, Inc., the Commission on Accreditation of Athletic Training Education, or any other nationally recognized professional athletic training organization.

(b) The board shall confirm, to the extent practicable, the information provided in an application before issuing a license to an applicant pursuant to this chapter.

(c) The board shall give protection of the public the highest priority in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.
Article 2. Licensure

2697.4. Except as otherwise provided in this chapter, the board shall issue an athletic training license to an applicant who meets all of the following requirements:
   (a) At the time of application, the applicant is over 18 years of age, is not addicted to alcohol or any controlled substance, and has not committed acts or crimes constituting grounds for denial of a license under Section 480.
   (b) The applicant has submitted an application developed by the board.
   (c) The applicant passed an athletic training certification examination offered by the Board of Certification, Inc., its predecessors or successors, or another nationally accredited athletic trainer certification agency approved and recognized by the board.
   (d) The applicant has passed a criminal background check.
   (e) The applicant has paid the application fee established by the board.

2697.5. A license issued by the board pursuant to Section 2697.4 is valid for two years and thereafter is subject to the renewal requirements described in Sections 2697.7.

2697.7. The board shall renew a license if an applicant meets both of the following requirements:
   (a) Pays the renewal fee as established by the board as described in Section 2697.20.
   (b) Submits proof of both of the following:
      (1) Subject to subdivision (c) of Section 2697.3, satisfactory completion of necessary continuing education, as determined by the board.
      (2) Has a current athletic training certification from a certification body approved by the board, including, but not limited to, the Board of Certification, Inc., or its predecessors or successors.

2697.8. (a) The board may deny a license or discipline a licensee who is described by any of the following:
      (1) Does not meet the requirements of this chapter.
      (2) Has had an athletic training license, certification, or registration revoked or suspended by an accredited organization or another state or country.
(3) Has been convicted of a crime that is substantially related to the functions or duties of an athletic trainer.

(4) Has committed unprofessional conduct, as described in Section 2697.10.

(b) The board may order any of the following actions regarding an athletic training license after notice and a hearing to determine unprofessional conduct:

(1) Placing the license on probation with terms and conditions.

(2) Suspending the license and the ability to practice athletic training for a period not to exceed one year.

(3) Revoking the license.

(4) Suspending or staying the disciplinary order, or portions of it, with or without conditions.

(5) Issuing an initial license on probation, with specific terms and conditions, to an applicant who has violated this chapter or the regulations adopted pursuant to it, but who has met all other requirements for licensure.

(6) Taking any other action as the board, in its discretion, deems proper to protect the public health and safety pursuant to subdivision (c) of Section 2697.3.

(c) If a license is suspended, the holder may not practice as an athletic trainer during the term of suspension. Upon the expiration of the term of suspension, the license shall be reinstated and the holder entitled to resume practice under any remaining terms of the discipline, unless it is established to the satisfaction of the board that the holder of the license practiced in this state during the term of suspension. In this event, the board, after notice and a hearing on this issue alone, may revoke the license.

(d) The board shall retain jurisdiction to proceed with any investigation, action, or disciplinary proceeding against a license, or to render a decision suspending or revoking a license, regardless of the expiration, lapse, or suspension of the license by operation of law, by order or decision of the board or a court of law, or by the voluntary surrender of a license by the licensee.

2697.9. (a) A holder of a license that has been revoked, suspended, or placed on probation, may petition the board for reinstatement or modification of a penalty, including reduction or termination of probation, after a period not less than the applicable following minimum period has elapsed from either the effective date of the decision ordering that disciplinary action, or, if the
order of the board or any portion of it was stayed, from the date
the disciplinary action was actually implemented in its entirety.
The minimum periods that shall elapse prior to a petition are as
follows:
(1) For a license that was revoked for any reason other than
mental or physical illness substantially related to the functions or
duties of an athletic trainer, at least three years.
(2) For early termination of probation scheduled for three or
more years, at least two years.
(3) For modification of a penalty, reinstatement of a license
revoked for mental or physical illness substantially related to the
functions or duties of an athletic trainer, or termination of
probation scheduled for less than three years, at least one year.
(b) The board may, in its discretion, specify in its disciplinary
order a lesser period of time, provided that the period shall not
be less than one year.
(c) The petition submitted shall contain any information required
by the board, which may include a current set of fingerprints
accompanied by the fingerprinting fee.
(d) The board shall give notice to the Attorney General of the
filing of the petition. The petitioner and the Attorney General shall
be given timely notice by letter of the time and place of the hearing
on the petition, and an opportunity to present both oral and
documentary evidence and argument to the board. The petitioner
shall at all times have the burden of proof to establish by clear
and convincing evidence that they are entitled to the relief sought
in the petition.
(e) The board, or the administrative law judge if one is
designated by the board, shall hear the petition and shall prepare
a written decision setting forth the reasons supporting the decision.
(f) The board may grant or deny the petition or may impose any
terms and conditions that it reasonably deems appropriate as a
condition of reinstatement or reduction of penalty.
(g) The board shall refuse to consider a petition while the
petitioner is under sentence for any criminal offense, including
any period during which the petitioner is on court-imposed
probation or parole or subject to an order of registration pursuant
to Section 290 of the Penal Code.
(h) No petition shall be considered while there is an accusation
or petition to revoke probation pending against the petitioner.
2697.10. For purposes of this chapter, unprofessional conduct includes, but is not limited to, the following:

(a) Incompetence, negligence, or gross negligence in carrying out usual athletic trainer functions.

(b) Repeated similar negligent acts in carrying out usual athletic trainer functions.

(c) A conviction for practicing medicine without a license in violation of Chapter 5 (commencing with Section 2000), in which event a certified copy of the record of conviction shall be conclusive evidence thereof.

(d) The use of advertising relating to athletic training which violates Section 17500.

(e) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a licensee by another healing arts board under the department, another state or territory of the United States, or by any other government agency. A certified copy of the decision, order, or judgment shall be conclusive evidence thereof.

(f) Procuring a license by fraud, misrepresentation, or mistake.

(g) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspire to violate, any provision or term of this chapter or any regulation adopted pursuant to this chapter.

(h) Making or giving any false statement or information in connection with the application for issuance or renewal of a license.

(i) Conviction of a crime or of any offense substantially related to the qualifications, functions, or duties of a licensee, in which event the record of the conviction shall be conclusive evidence thereof.

(j) Impersonating an applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a license.

(k) Impersonating a licensee, or permitting or allowing another unlicensed person to use a license.

(l) Committing any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of a licensee.

(m) Committing any act punishable as a sexually related crime, if that act is substantially related to the qualifications, functions,
or duties of a licensee, in which event a certified copy of the record
of conviction shall be conclusive evidence thereof.

(n) Using excessive force upon or mistreating or abusing any
patient. For purposes of this subdivision, “excessive force” means
force clearly in excess of that which would normally be applied
in similar clinical circumstances.

(o) Falsifying or making grossly incorrect, grossly inconsistent,
or unintelligible entries in a patient or hospital record or any other
record.

(p) Changing the prescription of a physician and surgeon or
falsifying verbal or written orders for treatment or a diagnostic
regime received, whether or not that action resulted in actual
patient harm.

(q) Failing to maintain confidentiality of patient medical
information, except as disclosure is otherwise permitted or required
by law.

(r) Delegating to an unlicensed employee or person a service
that requires the knowledge, skills, abilities, or judgment of a
licensee.

(s) Committing any act that would be grounds for denial of a
license under Section 480.

(t) Except for good cause, the knowing failure to protect patients
by failing to follow infection control guidelines of the committee,
thereby risking transmission of infectious diseases from licensee
to patient, from patient to patient, or from patient to licensee.

(u) As a licensee, obtaining, possessing, or prescribing a
controlled substance in violation of Division 10 (commencing with
Section 11000) of the Health and Safety Code or any dangerous
drug or dangerous device in violation of Chapter 9 (commencing
with Section 4000).

(v) As a licensee, using to an extent or in a manner dangerous
or injurious to themselves, to any other person, or to the public,
or that impairs their ability to conduct with safety to the public
the practice authorized by their license, of any of the following:

1. A controlled substance as defined in Division 10
(commencing with Section 11000) of the Health and Safety Code.
2. A dangerous drug or dangerous device as defined in Section
4022.
3. Alcoholic beverages.
(w) As a licensee, being convicted of a criminal offense involving
the prescription, consumption, or self-administration of any of the
substances described in paragraphs (1) and (2) of subdivision (v),
or the possession of, or falsification of a record pertaining to, the
substances described in paragraph (1) of subdivision (v), in which
event the record of the conviction is conclusive evidence thereof.

(x) As a licensee, being committed or confined by a court of
competent jurisdiction for intemperate use of any of the substances
described in paragraphs (1) and (2) of subdivision (v), in which
event the court order of commitment or confinement is prima facie
evidence of the commitment or confinement.

(y) As a licensee, falsifying, or making grossly incorrect, grossly
inconsistent, or unintelligible entries in any patient record, or any
other record.

Article 3. Athletic Training

2697.11. (a) A person shall not practice athletic training or
hold themselves out as an athletic trainer or as being able to
practice athletic training, or to render athletic training services
in this state unless the person is licensed as an athletic trainer
pursuant to this chapter.

(b) A person shall not use the title “athletic trainer,” “licensed
athletic trainer,” “certified athletic trainer,” “athletic trainer
certified,” “a.t.,” “a.t.l.,” “l.a.t.,” “c.a.t.,” “a.t.c.,” or any other
variation of these terms, or any other similar terms indicating that
the person is an athletic trainer unless that person is licensed
pursuant to this chapter.

(c) A person who is currently using one of the titles listed under
subdivision (b) and is covered under a collective bargaining
agreement is not subject to the requirements of subdivision (b)
until the parties to that bargaining agreement renew that
agreement. At that time, a person shall not use the titles listed in
subdivision (b) if the individual does not meet the requirements of
this section. Those individuals may choose a different title to
describe their positions under the new collective bargaining
agreement.

(d) No employee whose title is changed in order to comply with
this section shall suffer any loss of employment status as a result
of the title change, including, but not limited to, layoff, demotion,
termination, reclassification, or loss of pay, seniority, benefits, or any other status or compensation related to the position.

2697.12. (a) The practice of athletic training includes all of the following:

(1) Risk management and injury or illness prevention through preparticipation screening and evaluation, educational programs, physical conditioning and reconditioning programs, application of commercial products, use of protective equipment, promotion of healthy behaviors, and reduction of environmental risks.

(2) The clinical evaluation and assessment of an injury sustained or exacerbated while participating in athletic activity or a condition exacerbated while participating in athletic activity, for which the athletic trainer has had formal training during a professional education program or advanced postprofessional study and falls within the scope of practice of athletic training, by obtaining a history of the injury or condition, inspection and palpation of the injured part and associated structures, and performance of specific testing techniques related to stability and function to determine the extent of an injury.

(3) The immediate care of an injury sustained or exacerbated while participating in athletic activity or a condition exacerbated while participating in athletic activity, for which the athletic trainer has had formal training during a professional education program or advanced postprofessional study and falls within the scope of practice of athletic training, by the application of first aid and emergency procedures, techniques, and equipment for nonlife-threatening or life-threatening injuries or conditions.

(4) The rehabilitation and reconditioning from an injury sustained or exacerbated while participating in athletic activity and reconditioning from a condition, for which the athletic trainer has had formal training during a professional education program or advanced postprofessional study and falls within the scope of practice of athletic training, including, but not limited to, the application of physical agents and modalities, therapeutic exercise, manual therapy and massage, standard reassessment techniques and procedures, commercial products and durable medical equipment, and educational programs, in accordance with guidelines established with a healing arts licensee.
(b) The practice of athletic training does not include grade 5 spinal manipulations, the diagnosis of disease, or the practice of medicine.

(c) An athletic trainer shall refer a patient to an appropriate healing arts licensee when the management of the injury or condition does not fall within the practice of athletic training as defined in this section.

(d) An athletic trainer shall not provide, offer to provide, or represent that they are qualified to provide any treatment that they are not qualified to perform by their professional education or advanced postprofessional study or does not fall within the scope of practice of athletic training.

2697.13. (a) An athletic trainer shall only render athletic training services under the supervision of a physician and surgeon licensed by the Medical Board of California or an osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California.

(b) For purposes of this section, “supervision” means services are provided either under a verbal order by a physician and surgeon who is present when the services are provided or, if the physician is not present, under a written order, telecommunication, or an athletic training treatment plan or protocol that meets all of the following:

(1) The plan or protocol specifies the athletic training services, and referral requirements specific to the athletic trainer’s individual training and competence.

(2) The plan or protocol is established with and approved by the supervising physician and surgeon or osteopathic physician and surgeon.

(3) The plan or protocol accounts for the supervising physician and surgeon’s availability to the athletic trainer as determined by the supervising physician and surgeon.

2697.14. The practice of athletic training does not include any of the following:

(a) The practice of occupational therapy, as defined in Chapter 5.6 (commencing with Section 2570).

(b) The practice of physical therapy, as defined in Chapter 5.7 (commencing with Section 2600).

(c) The practice of physician assistants, as defined in Chapter 7.7 (commencing with Section 3500).
(d) The practice of medicine, as defined in Chapter 5 (commencing with Section 2000).
(e) The practice of nursing, as defined in Chapter 6 (commencing with Section 2700).
(f) The practice of chiropractic, as defined in Chapter 2 (commencing with Section 1000).

2697.15. The requirements of this chapter do not apply to the following:
(a) An athletic trainer licensed, certified, or registered in another state or country who is in California temporarily, while traveling with a team or organization, to engage in the practice of athletic training for, among other things, an athletic or sporting event and only when the athletic trainer limits their scope of practice to the members of the team or organization or during an emergency.
(b) An athletic trainer licensed, certified, or registered in another state or country who is invited by a sponsoring organization, such as the United States Olympic Committee, to temporarily provide athletic training services under the other state or country’s scope of practice for athletic training.
(c) A student enrolled in an athletic training education program, while participating in educational activities during the course of educational rotations under the supervision and guidance of an athletic trainer licensed under this chapter, a physician and surgeon licensed by the Medical Board of California, an osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California, or any other healing arts licensee, when the student’s title clearly indicates student status.
(d) A member or employee of the United States Armed Forces, licensed, certified, or registered in another state as an athletic trainer, as part of temporary federal deployment or employment in California for a limited time.

2697.16. An individual who provides instruction to an individual or group to improve physical conditioning, for the use of exercise equipment, or on the mechanics of activities of cycling, running, free weights, calisthenics, or other technical aspects of exercise is not engaging in athletic training.

2697.17. This chapter does not limit, impair, or otherwise apply to the practice of any person licensed and regulated under any other chapter of this division.
2697.18. This chapter does not require new or additional reimbursement by a health care service plan, health insurer, workers’ compensation insurance plan, employer, or state program for services rendered by an individual licensed under this chapter.

2697.19. Any person who violates this chapter shall be guilty of a misdemeanor punishable by imprisonment in the county jail not exceeding six months, or by a fine not exceeding one thousand dollars ($1,000), or by both.

Article 4. Revenue

2697.20. (a) The Athletic Trainers Fund is hereby established in the State Treasury. All fees collected pursuant to this chapter shall be paid into the fund. Moneys in the fund shall be available to the board, upon appropriation by the Legislature, for expenditure by the board to defray its expenses for administering this chapter.

(b) The board shall charge the following fees:

(1) An application fee of not more than one hundred dollars ($100).

(2) An initial license fee, which shall be prorated and based on the biennial renewal fee.

(3) A renewal fee to be established by the board, not to exceed the costs of providing the regulatory administration of this chapter.

(4) A delinquency fee for late payment of the license renewal fee in the following amounts:

(A) If the license is renewed not more than two years from the date of its expiration, the delinquency fee shall be 50 percent of the renewal fee in effect at the time or renewal.

(B) If the license is renewed more than two years after date of expiration of the license, the delinquency fee shall be 100 percent of the renewal fee in effect at the time of renewal.

(5) A duplicate license fee, to replace one that is lost or destroyed, or in the event of a name change, of thirty-five dollars ($35).

(6) An endorsement fee of not more fifty dollars ($50).

(7) A fee to collect fingerprints for criminal history record checks charged by the Department of Justice and the Federal Bureau of Investigation.
2697.21. Notwithstanding any other law, including Section 11005 of the Government Code, the director may seek and receive funds from the California Athletic Trainers Association or any other private individual or entity for the initial costs of implementing this chapter. If private funds are unavailable to cover the startup costs of implementing this act, a general fund or special fund loan may be used and shall be repaid with fee revenue.

2697.22. This chapter shall remain in effect only until January 1, 2028, and as of that date is repealed.

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

SECTION 1. It is the intent of the Legislature to enact legislation that would provide for the licensure and regulation of athletic trainers.
AUTHOR: Maienschein

BILL NUMBER: AB 1676

SPONSOR: 2020 Mom
Maternal Mental Health Now

BILL STATUS: Committee on Health

SUBJECT: Health care: mental health

DATE LAST AMENDED: April 22, 2019

SUMMARY:

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.

- requires health care service plans and health insurers, by July 1, 2019, to develop maternal mental health programs, as specified.

ANALYSIS:

This bill would:

- require health care service plans and health insurers, by January 1, 2021, to establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist, as specified, in order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness.

- require health care service plans and insurers to communicate information relating to the telehealth program at least twice a year in writing.

- require health care service plans and health insurers to maintain records and data pertaining to the utilization of the program and the availability of psychiatrists in order to facilitate ongoing changes and improvements.

- exempt certain specialized health care service plans and health insurers from these provisions.
Amended analysis as of 4/22:

The bill would require the consultation to be done by telephone or telehealth video, and would authorize the consultation to include guidance on providing triage services and referrals to evidence based treatment options, including psychotherapy.

**BOARD POSITION:** Watch (4/11/19)

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Watch (3/14/19)

**SUPPORT:**

**OPPOSE:**
An act to add Section 1367.626 to the Health and Safety Code, and to add Section 10123.868 to the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL’S DIGEST

AB 1676, as amended, Maienschein. Health care: mental health.

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. Existing law also requires health care service plans and health insurers, by July 1, 2019, to develop maternal mental health programs, as specified.

This bill would require health care service plans and health insurers, by January 1, 2021, to establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist, as specified, in order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness. The bill would require the consultation to be done by telephone or telehealth video, and would authorize the consultation to include guidance on providing triage services and
referrals to evidence based treatment options, including psychotherapy. The bill would require health care service plans and insurers to communicate information relating to the telehealth program at least twice a year in writing. The bill would require health care service plans and health insurers to maintain records and data pertaining to the utilization of the program and the availability of psychiatrists in order to facilitate ongoing changes and improvements, as necessary. The bill would exempt certain specialized health care service plans and health insurers from these provisions. 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.


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

SECTION 1. Section 1367.626 is added to the Health and Safety Code, to read:

1367.626. (a) In order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness, by January 1, 2021, a health care service plan shall establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist during standard provider hours, which may include evenings and weekends. The telehealth consultation program shall provide consultation by telephone or telehealth video, and may include guidance on providing triage services and referrals to evidence-based treatment options, including psychotherapy.

(b) A health care service plan shall communicate information relating to the telehealth program and its availability to contracting medical providers who treat children and pregnant and postpartum persons, including pediatricians, obstetricians, and primary care providers, at least twice a year in writing.
(c) A health care service plan shall maintain records and data pertaining to the utilization of its telehealth consultation program and the availability of psychiatrists in order to facilitate ongoing changes and improvements to the program, as necessary.

(d) This section shall not apply to specialized health care service plans, except specialized behavioral health-only plans offering professional mental health services.

SEC. 2. Section 10123.868 is added to the Insurance Code, to read:

10123.868. (a) In order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness, by January 1, 2021, a health insurer shall establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist during standard provider hours, which may include evenings and weekends. The telehealth consultation program shall provide consultation by telephone or telehealth video, and may include guidance on providing triage services and referrals to evidence-based treatment options, including psychotherapy.

(b) A health insurer shall communicate information relating to the telehealth program and its availability to contracting medical providers who treat children and pregnant and postpartum persons, including pediatricians, obstetricians, and primary care providers, at least twice a year in writing.

(c) A health insurer shall maintain records and data pertaining to the utilization of its telehealth consultation program and the availability of psychiatrists in order to facilitate ongoing changes and improvements to the program, as necessary.

(d) This section shall not apply to specialized health insurers, except specialized behavioral health-only insurers offering professional mental health services.

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

Existing law generally requires the licensure and regulation of various healthcare facilities, including, among others, a residential care facility for persons with chronic life-threatening illness.

The Compassionate Use Act of 1996, an initiative measure enacted by the approval of Proposition 215 at the November 5, 1996, statewide general election, prohibits specified criminal penalties from being imposed on a patient or a patient’s primary caregiver who possesses or cultivates cannabis for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.

Existing law, known as the Medical Marijuana Program, requires counties to administer an identification card program for qualified patients and provides immunity from arrest to qualified patients with a valid identification card or designated primary caregivers, within prescribed limits.

ANALYSIS:

This bill would:

- require a healthcare facility to allow a patient who is receiving palliative care to use medical cannabis within the healthcare facility, subject to certain restrictions.

- require a patient to provide the facility with a copy of the patient’s medical marijuana card or written documentation that the use of medical cannabis is recommended by a physician.

- authorize a healthcare facility to reasonably restrict the manner in which a patient stores and uses medical cannabis to ensure the safety of other patients, guests, and employees of the healthcare facility, compliance with other state laws, and the safe operations of the healthcare facility.

- prohibit the department that licenses the healthcare facility from enforcing these provisions, and compliance with the bill would not be a condition for obtaining, retaining, or renewing a license as a healthcare facility.

Amended analyses as of 4/1 and 4/11:
The bill was amended to change the SUBJECT from “Access to Cannabis in Healthcare Facilities Act” to the one listed, above.

The bill changes the language from “a patient who is receiving palliative care” to “a terminally ill patient” (defined as having a prognosis of one year or less to live) as one who can access medical cannabis in specified types of health facilities subject to certain restrictions.

**BOARD POSITION:** Watch (4/11/19)

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Watch (3/14/19)

**SUPPORT:**
Americans for Safe Access
California Health Coalition Advocacy
California NORML
Cannabis Nurses Network
CannaKids
Eaze
Southern California Coalition
Five Individuals

**OPPOSE:**
California Association of Health Facilities
California Chapter of the American College of Emergency Physicians
California Hospital Association
LeadingAge California
An act to add Chapter 4.9 (commencing with Section 1649) to Division 2 of the Health and Safety Code, relating to health care facilities.

LEGISLATIVE COUNSEL’S DIGEST

SB 305, as amended, Hueso. Compassionate Access to Medical Cannabis Act or Ryan’s Law.

Existing law generally requires the licensure and regulation of various health care facilities, including, among others, a residential care facility for persons with chronic life-threatening illness, hospice facility. The Compassionate Use Act of 1996, an initiative measure enacted by the approval of Proposition 215 at the November 5, 1996, statewide general election, prohibits specified criminal penalties from being imposed on a patient or a patient’s primary caregiver who possesses or cultivates cannabis for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician. Existing law, known as the Medical Marijuana Program, requires counties to administer an identification card program for qualified patients and provides immunity from arrest to qualified patients with a valid identification card or designated primary caregivers, within prescribed limits.

This bill, the Compassionate Access to Medical Cannabis Act or Ryan’s Law, would require specified types of health care facilities to
allow a terminally ill patient to use medical cannabis within the health care facility, subject to certain restrictions. The bill would require a patient to provide the health care facility with a copy of their medical marijuana card or written documentation that the use of medical cannabis is recommended by a physician. The bill would authorize a health care facility to reasonably restrict the manner in which a patient stores and uses medical cannabis to ensure the safety of other patients, guests, and employees of the health care facility, compliance with other state laws, and the safe operations of the health care facility. The bill would prohibit the department that licenses the health care facility from enforcing these provisions, and compliance with the bill would not be a condition for obtaining, retaining, or renewing a license as a health care facility.


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

SECTION 1. Chapter 4.9 (commencing with Section 1649) is added to Division 2 of the Health and Safety Code, to read:

Chapter 4.9. Compassionate Access to Medical Cannabis Act or Ryan’s Law

1649. (a) This chapter shall be known, and may be cited, as the “Compassionate Access to Medical Cannabis Act” or “Ryan’s Law.”

(b) It is the intent of the Legislature in enacting this chapter to support the ability of a terminally ill patient to safely use medical cannabis within specified health care facilities in compliance with the Compassionate Use Act of 1996 and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10.

1649.5. Unless the context requires otherwise, the following definitions shall apply to this chapter:

(a) “Compassionate Use Act of 1996” means the initiative measure enacted by the approval of Proposition 215 at the November 5, 1996, statewide general election and found at Section 11362.5, and any amendments to that act.

(b) Except as provided in paragraph (2), “health care facility” means a clinic licensed pursuant to Chapter 1 (commencing with Section 1200), a health facility licensed pursuant to Chapter 2
(commencing with Section 1250), a residential care facility for persons with chronic life-threatening illness licensed pursuant to Chapter 3.01 (commencing with Section 1568.01), a residential care facility for the elderly licensed pursuant to Chapter 3.2 (commencing with Section 1569), a home health agency licensed pursuant to Chapter 8 (commencing with Section 1725), or a hospice licensed pursuant to Chapter 8.5 (commencing with Section 1745).

(b) (1) Except as provided in paragraph (2), “health care facility” means a health facility specified in subdivision (a), (c), (f), (i), or (n) of Section 1250.

(2) The meaning of “health care facility” shall not include a chemical dependency recovery hospital or a state hospital.

(c) “Medical cannabis” means cannabis or a cannabis product used in compliance with the Compassionate Use Act of 1996 and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10.

d) “Patient” means an individual who is terminally ill.

e) “Terminally ill” means a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

1649.10. A health care facility shall do all of the following: (a) Allow a patient to use medical cannabis within the health care facility.

(b) Prohibit smoking or vaping as methods to use medical cannabis.

(c) Include the use of medical cannabis within the patient’s medical records.

d) Require a patient to provide a copy of the patient’s valid identification card as described in Section 11362.715 or a copy of that patient’s written documentation as defined in Section 11362.7.

e) Develop and disseminate written guidelines for the use of medical cannabis within the health care facility pursuant to this chapter.

1649.15. A health care facility may reasonably restrict the manner in which a patient stores and uses medical cannabis to ensure the safety of other patients, guests, and employees of the health care facility, compliance with other state laws, and the safe operations of the health care facility. A health care facility shall
include all restrictions within the written guidelines required by Section 1649.10.

1649.20. This chapter shall not be deemed to require a health care facility to provide a patient with a recommendation to use medical cannabis in compliance with the Compassionate Use Act of 1996 and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 or include medical cannabis in a patient’s discharge plan.

1649.25. (a) This chapter shall not be enforced by the department that licenses the health care facility.

(b) Compliance with this chapter shall not be a condition for obtaining, retaining, or renewing a license as a health care facility.

(c) This chapter shall not be deemed to reduce, expand, or otherwise modify the laws restricting the cultivation, possession, distribution, or use of cannabis that may be otherwise applicable, including, but not limited to, the Control, Regulate and Tax Adult Use of Marijuana Act, an initiative measure enacted by the approval of Proposition 64 at the November 8, 2016, statewide general election, and any amendments to that act.
### BILL ANALYSIS

<table>
<thead>
<tr>
<th>AUTHOR:</th>
<th>Mitchell</th>
<th>BILL NUMBER:</th>
<th>SB 464</th>
</tr>
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<tbody>
<tr>
<td>SPONSOR:</td>
<td>ACT for Women and Girls and 4 others</td>
<td>BILL STATUS:</td>
<td>Senate Committee on Appropriations</td>
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<tr>
<td>SUBJECT:</td>
<td>California Dignity in Pregnancy and Childbirth Act</td>
<td>DATE LAST AMENDED:</td>
<td>April 11, 2019</td>
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### SUMMARY:

Existing law:
- requires the State Department of Public Health to maintain a program of maternal and child health, which may include, among other things, facilitating services directed toward reducing infant mortality and improving the health of mothers and children.
- requires the Office of Health Equity within the department to serve as a resource for ensuring that programs collect and keep data and information regarding ethnic and racial health statistics, and strategies and programs that address multicultural health issues, including, but not limited to, infant and maternal mortality.

### ANALYSIS:

This bill would:
- make legislative findings relating to implicit bias and racial disparities in maternal mortality rates.
- require a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities.
- require the health care provider to complete initial basic training through the program and a refresher course every two years thereafter, or on a more frequent basis if deemed necessary by the facility.
- require the department to track and publish data on maternal death and severe morbidity, disaggregated by county, facility, and racial and ethnic identity.
The bill also addresses death certificates. It amends HSC Section 102875 to add the provision that the certificate of death shall indicate whether the decedent was pregnant within 42 days of death or within 43 to 365 days of death.

**Amended analyses of 4/1 and 4/11:**
The bill removes the previous requirement that data tracked and published related to maternal death and severe morbidity need not be disaggregated by county, facility, and racial and ethnic identity. New: Existing law requires hospitals to provide specified information regarding patient’s rights to each patient upon admission or as soon thereafter as reasonably practical, including, among other things, information about the right to be informed of continuing health care requirements following discharge from the hospital.

This bill would require:
- the hospital to additionally provide patients with information on the patient’s right to be free of discrimination on the basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language, or immigration status.
- The bill would additionally require the hospital to provide patients with information on how to file a complaint with specified state entities.

**BOARD POSITION:** Watch (4/11/19)

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Watch (3/14/19)

**SUPPORT:**
- ACT for Women and Girls
- Black Women for Wellness
- NARAL Pro-Choice California
- Western Center on Law & Poverty
- California Nurse-Midwives Association
- Alliance for Californians for Community Empowerment Action
- Asian Pacific Policy and Planning Council
- BreastfeedLA
- California Association of Licensed Midwives
- California Black Women’s Health Project
- California Latinas for Reproductive Justice
- California Pan-Ethnic Health Network
- California Rural Legal Assistance Foundation
- Center on Reproductive Rights & Justice
- Child Care Law Center
- Children’s Defense Fund
- Citizens for Choice
- Coalition of California Welfare Rights Organizations, Inc.
- Community Health Councils
- Consumer Watchdog
- County Health Executives Association of California
- Courage Campaign
- Fields Family Counseling Services
- Health Access California
If/When/How: Lawyering for Reproductive Justice
In Our Own Voice: National Black Women’s Reproductive Justice Agenda
Indivisible CA: StateStorng
Legal Services for Prisoners with Children
Legislative Women’s Caucus
Los Angeles Black Worker Center
Maternal Mental Health NOW
Moms Rising
National Council of Jewish Women California
National Health Law Program
Option House, Inc.
The Coalition of OC Community Health Centers
The Praxis Project
The Women’s Foundation of California
Therapeutic Play Foundation

**SUPPORT with amendments:**
California Association of Licensed Midwives

**OPPOSE:** None received
An act to amend Sections 1262.6 and 102875 of, and to add Article 4.6 (commencing with Section 123630) to Chapter 2 of Part 2 of Division 106 of, the Health and Safety Code, relating to maternal health.

LEGISLATIVE COUNSEL'S DIGEST


Existing law requires the State Department of Public Health to maintain a program of maternal and child health, which may include, among other things, facilitating services directed toward reducing infant mortality and improving the health of mothers and children. Existing law requires the Office of Health Equity within the department to serve as a resource for ensuring that programs collect and keep data and information regarding ethnic and racial health statistics, and strategies and programs that address multicultural health issues, including, but not limited to, infant and maternal mortality.

This bill would make legislative findings relating to implicit bias and racial disparities in maternal mortality rates. The bill would require a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an evidence-based implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities. The bill would require the health care provider to
complete initial basic training through the program and a refresher
course every 2 years thereafter, or on a more frequent basis if deemed
necessary by the facility.

The bill would require the department to track and publish data on
maternal death and severe morbidity, disaggregated by county, facility,
and racial and ethnic identity, except as specified.

Existing law requires that each death be registered with the local
registrar of births and deaths in the district in which the death was
officially pronounced or the body was found. Existing law sets forth
the persons responsible for completing the certificate of death and
requires certain medical and health content on the certificate, including
information indicating whether the decedent was pregnant at the time
of death or within the year prior to the death, if known. Certain
violations of these requirements are a crime.

This bill would require the certificate to indicate whether the decedent
was pregnant within 42 days of death or within 43 to 365 days of death.
By changing the definition of existing crimes, the bill would impose a
state-mandated local program.

Existing law requires hospitals to provide specified information
regarding patient’s rights to each patient upon admission or as soon
thereafter as reasonably practical, including, among other things,
information about the right to be informed of continuing health care
requirements following discharge from the hospital. Existing law makes
violations of these requirements a crime.

This bill would require the hospital to additionally provide patients
with information on how to file a discrimination complaint, as specified,
if the patient feels they were discriminated against on the basis of race,
gender, age, class, sexual orientation, gender identity, disability,
language proficiency, nationality, immigration status, gender expression,
or religion. The bill would additionally require the hospital to provide patients with information on how to file a complaint with specified state entities. By expanding the scope 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.


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

SECTION 1. Section 1262.6 of the Health and Safety Code is amended to read:

1262.6. (a) Each hospital shall provide each patient, upon admission or as soon thereafter as reasonably practical, written information regarding the patient’s right to the following:

1. To be informed of continuing health care requirements following discharge from the hospital.
2. To be informed that, if the patient so authorizes, that a friend or family member may be provided information about the patient’s continuing health care requirements following discharge from the hospital.
3. Participate actively in decisions regarding medical care. To the extent permitted by law, participation shall include the right to refuse treatment.
4. Appropriate pain assessment and treatment consistent with Sections 124960 and 124961.
5. Information on how to file a discrimination complaint with the State Department of Public Health’s Center for Health Care Quality and the Department of Fair Employment and Housing as well as the procedure for filing a complaint against a specific provider covered by the Medical Board of California with the Medical Board of California’s Central Complaint Unit if the patient feels they were discriminated against on the basis of race, gender, age, class, sexual orientation, gender identity, disability, language proficiency, nationality, immigration status, gender expression, or religion.
6. To be free of discrimination on the basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language, or immigration status as set forth in Section 51 of the Civil Code.
7. Information on how to file a complaint with the following:
(A) The State Department of Public Health, in accordance with Section 1288.4.

(B) The Department of Fair Employment and Housing.

(C) The Medical Board of California.

(b) A hospital may include the information required by this section with other notices to the patient regarding patient rights. If a hospital chooses to include this information along with existing notices to the patient regarding patient rights, this any newly required information shall be provided when the hospital exhausts its existing inventory of written materials and prints new written materials.

SEC. 2. Section 102875 of the Health and Safety Code is amended to read:

102875. The certificate of death shall be divided into two sections.

(a) The first section shall contain those items necessary to establish the fact of the death, including all of the following and those other items as the State Registrar may designate:

1. (A) Personal data concerning decedent including full name, sex, color or race, marital status, name of spouse, date of birth and age at death, birthplace, usual residence, occupation and industry or business, and whether the decedent was ever in the Armed Forces of the United States.

(B) A person completing the certificate shall record the decedent’s sex to reflect the decedent’s gender identity. The decedent’s gender identity shall be reported by the informant, unless the person completing the certificate is presented with a birth certificate, a driver’s license, a social security record, a court order approving a name or gender change, a passport, an advanced health care directive, or proof of clinical treatment for gender transition, in which case the person completing the certificate shall record the decedent’s sex as that which corresponds to the decedent’s gender identity as indicated in that document. If none of these documents are presented and the person with the right, or a majority of persons who have equal rights, to control the disposition of the remains pursuant to Section 7100 is in disagreement with the gender identity reported by the informant, the gender identity of the decedent recorded on the death certificate shall be as reported by that person or majority of persons.
(C) If a document specified in subparagraph (B) is not presented and a majority of persons who have equal rights to control the disposition of the remains pursuant to Section 7100 do not agree with the gender identity of the decedent as reported by the informant, any one of those persons may file a petition, in the superior court in the county in which the decedent resided at the time of the decedent’s death, or in which the remains are located, naming as a party to the action those persons who otherwise have equal rights to control the disposition and seeking an order of the court determining, as appropriate, who among those parties shall determine the gender identity of the decedent.

(D) A person completing the death certificate in compliance with subparagraph (B) is not liable for any damages or costs arising from claims related to the sex of the decedent as entered on the certificate of death.

(E) A person completing the death certificate shall comply with the data and certification requirements described in Section 102800 by using the information available to the person prior to the deadlines for completion specified in that section.

(2) Date of death, including month, day, and year.

(3) Place of death.

(4) Full name of father and birthplace of father, and full maiden name of mother and birthplace of mother.

(5) Informant.

(6) Disposition of body information, including signature and license number of embalmer, if the body is embalmed, or name of embalmer if affixed by attorney-in-fact; name of funeral director, or person acting as such; and date and place of interment or removal. Notwithstanding any other law, an electronic signature substitute, or some other indicator of authenticity, approved by the State Registrar may be used in lieu of the actual signature of the embalmer.

(7) Certification and signature of attending physician and surgeon or certification and signature of coroner when required to act by law. Notwithstanding any other law, the person completing the portion of the certificate setting forth the cause of death may attest to its accuracy by use of an electronic signature substitute, or some other indicator of authenticity, approved by the State Registrar in lieu of a signature.
(8) Date accepted for registration and signature of local registrar. Notwithstanding any other law, the local registrar may elect to use an electronic signature substitute, or some other indicator of authenticity, approved by the State Registrar in lieu of a signature.

(b) The second section shall contain those items relating to medical and health data, including all of the following and other items as the State Registrar may designate:

(1) Disease or conditions leading directly to death and antecedent causes.

(2) Operations and major findings thereof.

(3) Accident and injury information.

(4) Information indicating whether the decedent was pregnant at the time of death, or within the year prior to the death, if known, as determined by observation, autopsy, or review of the medical record. This paragraph shall not be interpreted to require the performance of a pregnancy test on a decedent, or to require a review of medical records in order to determine pregnancy. The certificate shall indicate whether the decedent was pregnant within 42 days of death or within 43 to 365 days of death.

SEC. 3. Article 4.6 (commencing with Section 123630) is added to Chapter 2 of Part 2 of Division 106 of the Health and Safety Code, to read:

Article 4.6. California Dignity in Pregnancy and Childbirth Act

123630. This article shall be known, and may be cited, as the California Dignity in Pregnancy and Childbirth Act.

123630.1. The Legislature hereby finds and declares all of the following:

(a) Every person should be entitled to dignity and respect during and after pregnancy and childbirth. Patients should receive the best care possible regardless of their race, gender, age, class, sexual orientation, gender identity, disability, language proficiency, nationality, immigration status, gender expression, or religion.

(b) The United States has the highest maternal mortality rate in the developed world. About 700 women die each year from childbirth, and another 50,000 suffer from severe complications. In California, since 2006, the rate of maternal death has decreased 55 percent, in contrast to the steady increase in the United States as a whole.
(c) However, for women of color, particularly Black women, the maternal mortality rate remains three to four times higher than White women. Black women make up 5 percent of the pregnancy cohort in California, but 21 percent of the pregnancy-related deaths.

(d) Forty-one percent of all pregnancy-related deaths had a good to strong chance of preventability. California has a responsibility to decrease the number of preventable maternal deaths.

(e) Maternal deaths among Black women are also more likely to be miscoded. Thirty-five percent of pregnancy-related deaths among Black women in California were miscoded, misidentifying pregnancy-related deaths as other deaths.

(f) Access to prenatal care, socioeconomic status, and general physical health do not fully explain the disparity seen in Black women’s maternal mortality and morbidity rates. There is a growing body of evidence that Black women are often treated unfairly and unequally in the health care system.

(g) Implicit bias is a key cause that drives health disparities in communities of color. At present, health care providers in California are not required to undergo any implicit bias testing or training. Nor does there exist any system to track the number of incidents where implicit prejudice and implicit stereotypes have led to negative birth and maternal health outcomes.

(h) It is the intent of the Legislature to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care so that all people are treated with dignity and respect by their health care providers.

123630.2. For the purposes of this article, the following terms have the following meanings:

(a) “Pregnancy-related death” is the death of a person while pregnant or within 365 days of the end of a pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to, or aggravated by, the pregnancy or its management, but not from accidental or incidental causes.

(b) “Implicit bias” is a bias in judgment or behavior that results from subtle cognitive processes, including implicit prejudice and implicit stereotypes that often operate at a level below conscious awareness and without intentional control.

(c) “Implicit prejudice” is prejudicial negative feelings or beliefs about a group that a person holds without being aware of them.
(d) “Implicit stereotypes” are the unconscious attributions of particular qualities to a member of a certain social group. Implicit stereotypes are influenced by experience and are based on learned associations between various qualities and social categories, including race or gender.

(e) “Perinatal care” is the provision of care during pregnancy, labor, delivery, and postpartum and neonatal periods.

123630.3. (a) A hospital as defined in subdivision (a) or (f) of Section 1250 that provides perinatal care, and an alternative birth center or primary care clinic subject to Section 1204.3, shall implement an evidence-based implicit bias program for all health care providers involved in the perinatal care of patients within those facilities.

(b) An implicit bias program implemented pursuant to subdivision (a) shall include all of the following:

(1) Identification of previous or current unconscious biases and misinformation.

(2) Identification of personal, interpersonal, institutional, structural, and cultural barriers to inclusion.

(3) Corrective measures to decrease implicit bias at the interpersonal and institutional levels, including ongoing policies and practices for that purpose.

(4) Information on the effects, including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of minority communities.

(5) Information about cultural identity across racial or ethnic groups.

(6) Information about communicating more effectively across identities, including racial, ethnic, religious, and gender identities.

(7) Discussion on power dynamics and organizational decisionmaking.

(8) Discussion on health inequities within the perinatal care field, including information on how implicit bias impacts maternal and infant health outcomes.

(9) Perspectives of diverse, local constituency groups and experts on particular racial, identity, cultural, and provider-community relations issues in the community.

(10) Information on reproductive justice.
(c) (1) A health care provider described in subdivision (a) shall complete initial basic training through the implicit bias program based on the components described in subdivision (b).

(2) Upon completion of the initial basic training, a health care provider shall complete a refresher course under the implicit bias program every two years thereafter, or on a more frequent basis if deemed necessary by the facility, in order to keep current with changing racial, identity, and cultural trends and best practices in decreasing interpersonal and institutional implicit bias.

123630.4. (a) The State Department of Public Health shall track and publish data on maternal death and severe morbidity, including, but not limited to, all of the following health conditions:

(1) Obstetric hemorrhage.

(2) Hypertension.

(3) Preeclampsia and eclampsia.

(4) Venous thromboembolism.

(5) Sepsis.

(6) Cerebrovascular accident.

(7) Amniotic fluid embolism.

(8) Other indirect obstetric complications.

(9) Other complications pertaining to the pregnancy and puerperium period.

(b) The data on maternal death and severe morbidity published pursuant to subdivision (a) shall be disaggregated by county, facility, and racial and ethnic identity, except where disaggregation would permit the identification of individuals. Data that cannot be completely disaggregated shall be aggregated into categories that facilitate comparisons and identify disparities.

(b) The data on maternal severe morbidity collected pursuant to subdivision (a) shall be published after all of the following have occurred:

(1) The data has been risk-adjusted pursuant to a valid methodology.

(2) The data has been aggregated by state regions with populations of 100,000 to 200,000, inclusive.

(3) The data has been disaggregated by racial and ethnic identity.

(c) The data on maternal deaths collected pursuant to subdivision (a) shall be published after all of the following have occurred:
(1) The data has been aggregated by state regions with populations of 100,000 to 200,000, inclusive.

(2) The data has been disaggregated by racial and ethnic identity.

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.
BILL ANALYSIS

AUTHOR: Caballero  BILL NUMBER: SB 567

SPONSOR: California Nurses Association; National Nurses United  BILL STATUS:

SUBJECT: Workers’ compensation: hospital employees  DATE LAST AMENDED: Introduced

SUMMARY:

Existing law:

• establishes a workers’ compensation system, administered by the Administrative Director of the Division of Workers’ Compensation, to compensate an employee for injuries sustained in the course of employment.

• creates a rebuttable presumption that specified injuries sustained in the course of employment of a specified member of law enforcement or a specified first responder arose out of and in the course of employment.

ANALYSIS:

This bill would:

• define “injury,” for a hospital employee who provides direct patient care in an acute care hospital, to include infectious diseases, cancer, musculoskeletal injuries, post-traumatic stress disorder, and respiratory diseases.

• create rebuttable presumptions that these injuries that develop or manifest in a hospital employee who provides direct patient care in an acute care hospital arose out of and in the course of the employment.

• extend these presumptions for specified time periods after the hospital employee’s termination of employment.

BOARD POSITION: Support (4/11/19)
LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Not previously considered

SUPPORT:
California Nurses Association (Sponsor)
National Nurses United (Sponsor)
California School Employees Association, AFL-CIO
California Teamsters Public Affairs Council
Engineers and Scientists of California, Local 20 IFPTE
Consumer Attorneys of California
United Nurses Associations of California
Union of Health Care Professionals
California Labor Federation, AFL-CIO

OPPOSE:
Acclamation Insurance Management Services
Allied Managed Care
American Property Casualty Insurance Association
Antelope Valley Hospital
Association of California Healthcare Districts
Bakersfield Memorial Hospital (Dignity Health)
Banner Lassen Medical Center
Bear Valley Community Healthcare District
California Association of Joint Powers Authorities
California Chamber of Commerce
California Children’s Hospital Association
California Coalition on Workers’ Compensation
California Hospital Association
California Special Districts Association
California State Association of Counties
Chambers of Commerce Alliance of Ventura and Santa Barbara Counties
Chinese Hospital
College Hospital Cerritos
Community Medical Centers
Cottage Health
County Of Los Angeles Board of Supervisors
CSAC Excess Insurance Authority
Dana Point Chamber of Commerce
Dignity Health
District Hospital Leadership Forum
Dominican Hospital (Dignity Health)
El Camino Hospital
Encompass Health
Enloe Medical Center
Fairchild Medical Center
Glendale Memorial Hospital and Health Center (Dignity Health)
Henry Mayo Newhall Hospital
Inland Empire (Dignity Health)
Jerold Phelps Community Hospital
John Muir Health
Kern Medical
Kern Valley Healthcare District
Lompoc Valley Medical Center
Marian Regional Medical Center (Dignity Health)
Marin General Hospital
Mark Twain Medical Center (Dignity Health)
MemorialCare
Mercy General Hospital (Dignity Health)
Mercy Hospital of Folsom (Dignity Health)
Mercy Hospitals Bakersfield (Dignity Health)
Mercy Medical Center - Merced (Dignity Health)
Mercy Medical Center Mt. Shasta (Dignity Health)
Mercy Medical Center Redding (Dignity Health)
Mercy San Juan Medical Center (Dignity Health)
Methodist Hospital of Sacramento (Dignity Health)
Methodist Hospital of Southern California
Modoc Medical Center
Monterey Park Hospital
Murrieta/Wildomar Chamber of Commerce
North Orange County Chamber
NorthBay Healthcare
Northridge Hospital Center
Orchard Hospital
Oxnard Chamber of Commerce
Palomar Health
Patient's Hospital of Redding
PHH Health
Plumas District Hospital
Providence St. Joseph Health
Ridgecrest Regional Hospital
Rural County Representatives of California
Saint Francis Memorial Hospital (Dignity Health)
San Gorgonio Memorial Hospital
Santa Maria Valley Chamber of Commerce
Sequoia Hospital (Dignity Health)
Sharp Healthcare
Sonoma Valley Hospital
Southern Humboldt Community Health Care District
Southwest Healthcare System
St. Elizabeth Community Hospital (Dignity Health)
St. Joseph's Behavioral Health Center (Dignity Health)
St. Joseph's Medical Center, Stockton (Dignity Health)
St. Mary's Medical Center, San Francisco (Dignity Health)
Stanford Health Care
Stanford Health Care-Valley Care
Tenet Healthcare
United Hospital Association
Valley Children's Healthcare
Valley Industry and Commerce Association
Vista del Mar Hospital
Woodland Memorial Hospital (Dignity Health)
SENATE BILL No. 567

Introduced by Senators Caballero and Skinner

February 22, 2019

An act to add Sections 3212.13, 3212.14, 3212.15, 3212.16, and 3212.17 to the Labor Code, relating to workers’ compensation.

LEGISLATIVE COUNSEL’S DIGEST

SB 567, as introduced, Caballero. Workers’ compensation: hospital employees.
Existing law establishes a workers’ compensation system, administered by the Administrative Director of the Division of Workers’ Compensation, to compensate an employee for injuries sustained in the course of employment. Existing law creates a rebuttable presumption that specified injuries sustained in the course of employment of a specified member of law enforcement or a specified first responder arose out of and in the course of employment.
This bill would define “injury,” for a hospital employee who provides direct patient care in an acute care hospital, to include infectious diseases, cancer, musculoskeletal injuries, post-traumatic stress disorder, and respiratory diseases. The bill would create rebuttable presumptions that these injuries that develop or manifest in a hospital employee who provides direct patient care in an acute care hospital arose out of and in the course of the employment. The bill would extend these presumptions for specified time periods after the hospital employee’s termination of employment. The bill would also make related findings and declarations.
The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares the following:

(a) According to the United States Department of Labor, health care is one of the fastest growing sectors, currently employing 20 million people, and is expected to add more jobs than any other occupational group. Women represent nearly 80 percent of the health care workforce.

(b) Registered nurses constitute the largest occupation within the health care sector and number over 2,500,000, of which 70 percent are employed in hospitals. Nearly 90 percent of registered nurses are women.

(c) Workers’ compensation was created to ensure that workers who are injured or become ill due to work are promptly and fully cared for and that employers are held responsible for maintaining a safe and healthy work environment. Certain occupations have significantly increased exposure or susceptibility to particular work-related injuries or illnesses that can be recognized, and at least partially remedied, through guaranteed access to the workers’ compensation system.

(d) In California and many other states, a number of injuries and illnesses are already presumed work-related, and therefore eligible for workers’ compensation benefits, for firefighters, police officers, first responders, and other categories of workers. These professions predominantly employ men. According to the United States Department of Labor, three out of four EMTs and paramedics are men, seven out of eight police officers are men, and 19 out of 20 firefighters are men.

(e) According to the United States Department of Labor, nine out of 10 registered nurses are women. Registered nurses working in a hospital treat the same patients that first responders, firefighters, and police officers treat.

(f) In California, women earn 89 cents for every dollar earned by a man, according to the United States Census Bureau. Given this persistent wage gap and the additional caregiving burden that women often bear, guaranteeing access to workers’ compensation for nurses, of whom nearly 90 percent are women, will aid in addressing economic and social gender inequality.

(g) By the nature of their profession, health care workers are in constant danger of being directly exposed to many hazards,
including infectious diseases, carcinogens, ergonomic hazards, and traumatic events, and indirectly exposed through contact with various pieces of equipment, chemicals, and clothing.

(h) Registered nurses have significantly more exposure to infectious diseases, including bloodborne pathogens, methicillin-resistant Staphylococcus aureus (MRSA), tuberculosis, and meningitis, than other workers. According to the Healthcare Cost and Utilization Project, one out of every 100 inpatient stays in California involved MRSA. In addition, the incidence of tuberculosis in California was significantly higher than the national average, according to the federal Centers for Disease Control and Prevention.

(i) Registered nurses experience more work-related injuries and illnesses than workers overall in the United States, including 43 percent more musculoskeletal disorders, over 10 percent more injuries and illnesses of all kinds, and 131 percent more injuries from workplace violence.

(j) Registered nurses encounter a variety of carcinogenic exposures in the course of doing their jobs. Antineoplastic and other hazardous drugs are administered by registered nurses. While these drugs are life-saving treatments for patients, they are hazardous and can cause cancer. Studies have documented the wide-ranging contamination of the workplace that occurs when antineoplastic drugs and other hazardous drugs are handled and administered. Registered nurses are exposed in the course of doing their jobs to these cancer-causing chemicals. Additionally, the National Institute for Occupational Safety and Health has determined that some anesthetic gases are carcinogenic hazards to registered nurses and other health care workers. Furthermore, the International Agency for Research on Cancer (IARC) recently determined that night shift work is “probably carcinogenic to humans,” the second highest level of evidence of carcinogenicity.

(k) Registered nurses provide hands-on, direct patient care, which often requires physically assisting, moving, and repositioning patients. Many studies have documented the high rates of musculoskeletal disorders that occur among nurses. In crafting a regulation, the Division of Occupational Safety and Health has deemed musculoskeletal disorders and related injuries a significant hazard specifically encountered by health care workers.
Registered nurses encounter many traumatic events in the course of providing care to patients, including workplace violence and threats, active shooter incidents, traumatic patient deaths, repeated exposure to patients’ trauma, and other events. A landmark study found that 22 percent of nurses had symptoms of post-traumatic stress disorder. This excess stress and trauma must be recognized and addressed as an occupational hazard in nursing.

The Nurses’ Health Study found that frequent use of disinfectants is associated with a significantly increased risk for chronic obstructive pulmonary disease and for poor asthma control.

Because health care workers have significantly increased exposure or susceptibility to particular work-related injuries or illnesses, it is appropriate to protect them by guaranteeing access to the workers’ compensation system.

SEC. 2. Section 3212.13 is added to the Labor Code, to read:

3212.13. (a) In the case of a hospital employee who provides direct patient care in an acute care hospital, the term “injury” as used in this division includes an infectious disease when any part of the disease or infection develops or manifests itself during a period of the person’s employment with the hospital.

(b) The compensation that is awarded for an infectious disease shall include, but not be limited to, full hospital, surgical, medical treatment, disability indemnity, and death benefits, as provided by the workers’ compensation laws of this state.

(c) (1) An infectious disease that develops or manifests in a hospital employee who provides direct patient care in an acute care hospital shall be presumed to arise out of and in the course of the employment. This presumption is rebuttable by other evidence, but, unless rebutted, the appeals board shall presume the infectious disease arose out of and in the course of the employment.

(2) The bloodborne infectious disease presumption, tuberculosis presumption, and meningitis presumption shall be extended to a hospital employee pursuant to paragraph (1) following termination of employment for a period of three calendar months for each full year of employment, but not to exceed 60 months, beginning with the last date actually worked in the specified capacity.

(3) Notwithstanding paragraph (2), the methicillin-resistant Staphylococcus aureus skin infection presumption shall be extended to a hospital employee pursuant to paragraph (1) following termination of employment for a period of 90 days,
beginning with the last day actually worked in the specified capacity.

(d) An infectious disease that develops or manifests in a hospital employee who provides direct patient care in an acute care hospital shall not be attributed to a disease or skin infection that existed before that development or manifestation.

(e) For purposes of this section:
(1) “Acute care hospital” means a health facility as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code.
(2) “Bloodborne infectious disease” means a disease caused by exposure to pathogenic microorganisms that are present in human blood that can cause disease in humans, including those pathogenic microorganisms defined as bloodborne pathogens by the Department of Industrial Relations.
(3) “Infectious disease” means any of the following:
(A) Methicillin-resistant Staphylococcus aureus skin infection.
(B) Bloodborne infectious diseases.
(C) Tuberculosis.
(D) Meningitis.

SEC. 3. Section 3212.14 is added to the Labor Code, to read:
3212.14. (a) In the case of a hospital employee who provides direct patient care in an acute care hospital, the term “injury” as used in this division includes cancer that develops or manifests itself during a period of the person’s employment with the hospital if the employee demonstrates exposure, while employed with the hospital, to a known or suspected carcinogen as defined by the International Agency for Research on Cancer or by the director.
(b) The compensation that is awarded for cancer shall include, but not be limited to, full hospital, surgical, medical treatment, disability indemnity, and death benefits, as provided by this division.
(c) Cancer that develops or manifests in a hospital employee who provides direct patient care in an acute care hospital shall be presumed to arise out of and in the course of the employment. This presumption is rebuttable by evidence that the primary site of the cancer has been established and that the carcinogen to which the member has demonstrated exposure is not reasonably linked to the disabling cancer. Unless rebutted, the appeals board shall presume the cancer arose out of and in the course of the
employment. This presumption shall be extended to a hospital employee following termination of employment for a period of three calendar months for each full year of employment, but not to exceed 120 months, beginning with the last date actually worked in the specified capacity.

(d) As used in this section, “acute care hospital” means a health facility as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code.

SEC. 4. Section 3212.15 is added to the Labor Code, to read:

3212.15. (a) In the case of a hospital employee who provides direct patient care in an acute care hospital, the term “injury” as used in this division includes a musculoskeletal injury that develops or manifests itself during a period of the person’s employment with the hospital.

(b) The compensation that is awarded for a musculoskeletal injury shall include, but not be limited to, full hospital, surgical, medical treatment, disability indemnity, and death benefits, as provided by this division.

(c) The musculoskeletal injury that develops or manifests in a hospital employee who provides direct patient care in an acute care hospital shall be presumed to arise out of and in the course of the employment. This presumption is rebuttable by other evidence, but, unless rebutted, the appeals board shall presume the musculoskeletal injury arose out of and in the course of the employment. This presumption shall be extended to a hospital employee following termination of employment for a period of three calendar months for each full year of employment, but not to exceed 60 months, beginning with the last date actually worked in the specified capacity. A musculoskeletal injury that develops or manifests in a hospital employee who provides direct patient care in an acute care hospital shall not be attributed to a disease that existed before that development or manifestation.

(d) As used in this section:

(1) “Acute care hospital” means a health facility as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code.

(2) “Musculoskeletal injury” means acute injury or cumulative trauma of the muscles, tendons, ligaments, bursas, peripheral nerves, joints, bones, or blood vessels.

SEC. 5. Section 3212.16 is added to the Labor Code, to read:
3212.16. (a) In the case of a hospital employee who provides direct patient care in an acute care hospital, the term “injury” as used in this division includes post-traumatic stress disorder that is diagnosed by a mental health professional and that develops or manifests itself during a period of the person’s employment with the hospital.

(b) The compensation that is awarded for post-traumatic stress disorder shall include, but not be limited to, full hospital, surgical, medical treatment, disability indemnity, and death benefits, as provided by this division.

(c) The post-traumatic stress disorder that develops or manifests in a hospital employee who provides direct patient care in an acute care hospital shall be presumed to arise out of and in the course of the employment. This presumption is rebuttable by other evidence, but, unless rebutted, the appeals board shall presume the post-traumatic stress disorder arose out of and in the course of the employment. This presumption shall be extended to a hospital employee following termination of employment for a period of three calendar months for each full year of employment, but not to exceed 36 months, beginning with the last date actually worked in the specified capacity.

(d) As used in this section:

1. “Acute care hospital” means a health facility as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code.

2. “Mental health professional” means a person with professional training, experience, and demonstrated competence in the treatment and diagnosis of mental conditions, who is certified or licensed to provide mental health care services and for whom diagnoses of mental conditions are within the professional’s scope of practice, including a physician and surgeon, nurse with recognized psychiatric specialties, psychologist, clinical social worker, mental health counselor, or alcohol or drug abuse counselor.

SEC. 6. Section 3212.17 is added to the Labor Code, to read:

3212.17. (a) In the case of a hospital employee who provides direct patient care in an acute care hospital, the term “injury” as used in this division includes respiratory disease that develops or manifests itself during a period of the person’s employment with the hospital.
(b) The compensation that is awarded for respiratory disease shall include, but not be limited to, full hospital, surgical, medical treatment, disability indemnity, and death benefits, as provided by this division.

c) The respiratory disease that develops or manifests in a hospital employee who provides direct patient care in an acute care hospital shall be presumed to arise out of and in the course of the employment. This presumption is rebuttable by other evidence, but, unless rebutted, the appeals board shall presume the respiratory disease arose out of and in the course of the employment. This presumption shall be extended to a hospital employee following termination of employment for a period of three calendar months for each full year of employment, but not to exceed 120 months, beginning with the last date actually worked in the specified capacity. The respiratory disease that develops or manifests in a hospital employee who provides direct patient care in an acute care hospital shall not be attributed to a disease that existed before that development or manifestation.

(d) As used in this section:

(1) “Acute care hospital” means a health facility as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code.

(2) “Respiratory disease” includes chronic obstructive pulmonary disease or asthma.
SUMMARY:

1. The Physician Assistant Practice Act provides for licensure and regulation of physician assistants by the Physician Assistant Board, which is within the jurisdiction of the Medical Board of California. That act requires the board to issue licenses under the name of the Medical Board of California.

2. The act:
   • authorizes a physician assistant to perform medical services as set forth by regulations and the act and when those services are rendered under the supervision of a licensed physician and surgeon.
   • requires the physician assistant and the supervising physician and surgeon to establish written guidelines and protocols for adequate supervision and a delegation of services agreement.

3. The act authorizes a physician assistant, under the supervision of a physician and surgeon, to 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.

4. The act defines various terms for its purposes.

ANALYSIS:

Re 1, above:
This bill would rename the board the Physician Assistant Board of California and instead provide that the board is within the Department of Consumer Affairs. The bill would require the board to issues licenses under its name.

Re 2., above:
This bill would:
• instead authorize a physician assistant to perform various medical services, including evaluating, diagnosing, managing, and providing medical treatment, pursuant to a practice agreement or in certain organized health care practice settings if the medical services are provided in collaboration with a physician and surgeon or other qualified health care provider in a manner consistent with the education, training, experience, and competencies of the physician assistant and the standard of care, as specified.

• authorize a physician assistant to bill and receive direct payment for medical services they provide.

Re 3., above:
This bill would:
• instead authorize a physician assistant to, unless otherwise prohibited, prescribe, dispense, order, administer, and procure drugs and medical devices to a patient or a person who may lawfully furnish the medication or medical device.

• authorize a physician assistant to initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including, but not limited to, durable medical equipment, nutrition, blood and blood products, and diagnostic support services, including, but not limited to, home health care, hospice, and physical and occupational therapy.

Re 4., above:
This bill would:
• revise and change the definitions as applicable to carry out the bill’s provisions.

• provide that any reference to “protocols” or “delegation of services agreement” in any other law referencing the act means “practice agreement,” as defined by the act, and that any reference to “supervision” in any other law referencing the act means “collaboration,” as defined by the act.

• also make various conforming changes.

Amended analyses of 4/10:

The subject of the bill changed from “Physician assistants: scope of practice” to “Physician assistants: practice agreement: supervision.”

The bill now deletes the provision renaming the Physician Assistant Board and placing it within the Department of Consumer Affairs rather than the Medical Board of California.

The Physician Assistant Practice Act currently:
• prohibits a physician and surgeon from supervising more than 4 physician assistants at any one time;
• requires the medical record to identify the physician and surgeon who is responsible for the supervision of the physician assistant;

• requires the supervising physician and surgeon to be physically available to the physician assistant for consultation when that assistance is rendered;

• requires the physician assistant and the supervising physician and surgeon to establish written guidelines for adequate supervision;

• authorizes the supervising physician and surgeon to satisfy this requirement by adopting protocols for some or all of the tasks performed by the physician assistant;

• authorizes a delegation of services agreement to authorize a physician assistant to order durable medical equipment, to approve, sign, modify, or add to a plan of treatment or plan of care for individuals receiving home health services or personal care services, or to certify disability.

This bill would:

• remove the limit on the number of physician assistants that a physician and surgeon may supervise;

• remove the requirements that the medical record identify the responsible supervising physician and surgeon and that those written guidelines for adequate supervision be established;

• authorize a physician assistant to perform various medical services if certain requirements are met including that the medical services are rendered pursuant to a signed delegation of services agreement or a practice agreement, as defined, and the physician assistant is competent to perform the medical services;

• require a practice agreement between a physician assistant and a physician and surgeon to meet specified requirements.

This bill would change the provisions of 3., above, in SUMMARY:

This bill would now:

• authorize a physician assistant to furnish or order a drug or device subject to specified supervision. Specifically, the bill would prohibit a physician and surgeon from supervising more than 6 physician assistants for purposes of the provisions relating to physician assistants furnishing or ordering drugs or devices.

This bill would further refine definitions of 4., above, in SUMMARY:

The bill would now:
• delete the word “protocol” and provide that any reference to “delegation of services agreement” in any other law means “practice agreement” and provides a definition for “practice agreement;”

• provide that “supervision” does not require the supervising physician and surgeon to be physically present.

Amended analysis as of 4/24:

Additionally, the Physician Assistant Practice Act requires the Physician Assistant Board to make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration and approval of applications by licensed physicians to supervise physician assistants.

This bill would:
• remove the requirement that the Physician Assistant Board make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration and approval of applications by licensed physicians and surgeons to supervise physician assistants;

• provides that the PA renders services pursuant to a practice agreement and deletes the language “a delegation of services agreement.”

BOARD POSITION: Watch (4/11/19)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (3/14/19)

SUPPORT:
California Academy of PAs (Sponsor)
America’s Physician Groups
Association of California Healthcare Districts
California Association for Health Services at Home
California Medical Association
California Psychiatric Association

OPPOSE: None on file
SB 697, as amended, Caballero. Physician assistants: practice agreement: supervision.

The Physician Assistant Practice Act provides for licensure and regulation of physician assistants by the Physician Assistant Board, which is within the jurisdiction of the Medical Board of California. The act authorizes a physician assistant to perform medical services as set forth by regulations and the act and when those services are rendered under the supervision of a licensed physician and surgeon. The act requires the Physician Assistant Board to, among other things, make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration and approval of applications by licensed physicians to supervise physician assistants.

The act prohibits a physician and surgeon from supervising more than 4 physician assistants at any one time. The act requires the medical record to identify the physician and surgeon who is responsible for the supervision of the physician assistant. The act requires the supervising physician and surgeon to be physically available to the physician assistant.
assistant for consultation when that assistance is rendered. The act requires the physician assistant and the supervising physician and surgeon to establish written guidelines for adequate supervision, and authorizes the supervising physician and surgeon to satisfy this requirement by adopting protocols for some or all of the tasks performed by the physician assistant, as provided. The act additionally authorizes a delegation of services agreement to authorize a physician assistant to order durable medical equipment, to approve, sign, modify, or add to a plan of treatment or plan of care for individuals receiving home health services or personal care services, or to certify disability, as provided.

This bill would remove the requirement that the Physician Assistant Board make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration and approval of applications by licensed physicians and surgeons to supervise physician assistants. The bill, except as described below, would remove the limit on the number of physician assistants that a physician and surgeon may supervise. The bill would remove the requirements that the medical record identify the responsible supervising physician and surgeon and that those written guidelines for adequate supervision be established. The bill would instead authorize a physician assistant to perform various medical services if certain requirements are met including that the medical services are rendered pursuant to a signed delegation of services agreement or a practice agreement, as defined, and the physician assistant is competent to perform the medical services. The bill would also require a practice agreement between a physician assistant and a physician and surgeon to meet specified requirements.

The act authorizes a physician assistant, under the supervision of a physician and surgeon, to 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.

This bill would instead authorize a physician assistant to furnish or order a drug or device subject to specified supervision. Specifically, the bill would prohibit a physician and surgeon from supervising more than 6 physician assistants for purposes of the provisions relating to physician assistants furnishing or ordering drugs or devices.

The act defines various terms for its purposes.

This bill would revise and change the definitions as applicable to carry out the bill’s provisions. The bill would provide that any reference
to “delegation of services agreement” in any other law means “practice agreement,” as defined by the bill, and that “supervision” does not require the supervising physician and surgeon to be physically present. The bill would also make various conforming changes.

The act makes a violation of specified provisions punishable as a misdemeanor.

By revising and recasting the provisions of the act, the bill would change the definition of that crime and would, therefore, result in 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.


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

SECTION 1. Section 3500 of the Business and Professions Code is amended to read:

3500. In its concern with the growing shortage and geographic maldistribution of health care services in California, the Legislature intends to establish in this chapter a framework for another category of health manpower—the physician assistant. The purpose of this chapter is to encourage the effective utilization of the skills of physicians and surgeons, and physicians and surgeons and podiatrists practicing in the same medical group practice, by enabling them to work with qualified physician assistants to provide quality care.

This chapter is established to encourage the coordinated care between physician assistants, physicians and surgeons, podiatrists, and other qualified health care providers practicing in the same medical group, and to provide health care services. It is also the purpose of this chapter to allow for innovative development of programs for the education, training, and utilization of physician assistants.

SEC. 2. Section 3501 of the Business and Professions Code is amended to read:

3501. As used in this chapter:
(a) “Board” means the Physician Assistant Board.
(b) “Approved program” means a program for the education of
physician assistants that has been formally approved by the board.
(c) “Trainee” means a person who is currently enrolled in an
approved program.
(d) “Physician assistant” or “PA” means a person who meets
the requirements of this chapter and is licensed by the board.
(e) “Supervising physician” or “supervising physician and
surgeon” means a physician and surgeon licensed by the Medical
Board of California or by the Osteopathic Medical Board of
California who supervises one or more physician assistants, who
possesses a current valid license to practice medicine, and who is
not currently on disciplinary probation prohibiting the employment
or supervision of a physician assistant.
(f) “Supervision” means that a licensed physician and surgeon
oversees the activities of, and accepts responsibility for, the medical
services rendered by a physician assistant. Supervision shall not
be construed to require the physical presence of the physician and
surgeon.
(g) “Regulations” means the rules and regulations as set forth
in Chapter 13.8 (commencing with Section 1399.500) of Title 16
of the California Code of Regulations.
(h) “Routine visual screening” means noninvasive
nonpharmacological simple testing for visual acuity, visual field
defects, color blindness, and depth perception.
(i) “Program manager” means the staff manager of the diversion
program, as designated by the executive officer of the board. The
program manager shall have background experience in dealing
with substance abuse issues.
(j) “Organized health care system” includes a licensed clinic as
described in Chapter 1 (commencing with Section 1200) of
Division 2 of the Health and Safety Code, an outpatient setting as
described in Chapter 1.3 (commencing with Section 1248) of
Division 2 of the Health and Safety Code, a health facility as
described in Chapter 2 (commencing with Section 1250) of
Division 2 of the Health and Safety Code, a county medical facility
as described in Chapter 2.5 (commencing with Section 1440) of
Division 2 of the Health and Safety Code, an accountable care
organization, a home health agency, a physician’s office, office,
a professional medical corporation, a medical partnership, a
medical foundation, and any other organized entity that lawfully
provides medical services.
(k) “Practice agreement” means the writing, developed through
collaboration among one or more physicians and surgeons, one or
more physician assistants, and, if applicable, administrators of an
organized health care system, that outlines the medical services
the physician assistant is authorized to perform and that grants
approval for physicians and surgeons on the staff of an organized
health care system to supervise one or more physician assistants
in the organized health care system. Any reference to a delegation
of services agreement relating to physician assistants in any other
law shall have the same meaning as a practice agreement.
(l) “Other specified medical services” means tests or
examinations performed or ordered by a PA practicing in
compliance with this chapter or regulations of the board or the
Medical Board of California promulgated under this chapter.
SEC. 3. Section 3502 of the Business and Professions Code is
amended to read:
3502. (a) Notwithstanding any other law, a PA may perform
those medical services as set forth by the regulations to be adopted
under this chapter if the following requirements are met:
(1) The PA renders the services under the supervision of a
licensed physician and surgeon who is not subject to a disciplinary
condition imposed by the Medical Board of California or by the
Osteopathic Medical Board prohibiting that supervision or
prohibiting the employment of a physician assistant.
(2) The PA renders the services pursuant to a delegation of
services agreement or a practice agreement that meets the
requirements of Section 3502.3.
(b) (1) Notwithstanding any other law, a physician assistant
performing medical services under the supervision of a physician
and surgeon may assist a doctor of podiatric medicine who is a
partner, shareholder, or employee in the same medical group as
the supervising physician and surgeon. A physician assistant who
assists a doctor of podiatric medicine pursuant to this subdivision
shall do so only according to patient-specific orders from a
supervising physician and surgeon.
(2) A supervising physician and surgeon shall be available to the physician assistant for consultation when assistance is rendered pursuant to this subdivision. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c) This section shall not be construed to require that a physician and surgeon review or countersign a medical record of a patient treated by a physician assistant, unless required by the practice agreement. The board may, as a condition of probation of a licensee, require the review or countersignature of records of patients treated by a physician assistant for a specified duration.

(d) This chapter does not authorize the performance of medical services in any of the following areas:

   (1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.
   (2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.
   (3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.
   (4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

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

SEC. 4. Section 3502.1 of the Business and Professions Code is amended to read:

3502.1. In addition to the medical services authorized in the regulations adopted pursuant to Section 3502, and except as prohibited by Section 3502, a PA may furnish or order a drug or device subject to all of the following:

   (a) The PA shall furnish or order a drug or device in accordance with the practice agreement and consistent with the PA’s educational preparation or for which clinical competency has been established and maintained.
   (b) (1) A practice agreement authorizing a PA to order or furnish a drug or device shall specify which PAs may furnish or
order a drug or device, 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 PA's competence, including peer review, and review of the practice agreement.

(2) In addition to the requirements in paragraph (1), if the practice agreement authorizes the PA to furnish a Schedule II controlled substance, the practice agreement shall address the diagnosis of the illness, injury, or condition for which the PA may furnish the Schedule II controlled substance.

(c) The PA shall furnish or order drugs or devices under physician and surgeon supervision. This subdivision shall not be construed to require the physical presence of the physician and surgeon, but does require the following:

(1) Adherence to adequate supervision agreed to in the practice agreement.

(2) The physician and surgeon be available by telephone or other electronic communication method at the time the PA examines the patient.

(d) For purposes of this section, a physician and surgeon shall not supervise more than six PAs at one time.

(e) (1) Except as provided in paragraph (2), the PA may furnish or order only those 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) that have been agreed upon and specified in the practice agreement.

(2) The PA may furnish or order Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, in accordance with a patient-specific protocol of the practice agreement or a patient-specific order approved by the treating or supervising physician. A copy of the section of the PA's practice agreement relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the PA furnishing the order.

(f) (1) The PA has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section or has completed a program for
instruction of PAs that meet the requirements of Section 1399.530 of Title 16 of the California Code of Regulations.

(2) Except as provided in subdivision (c), a physician and surgeon through a practice agreement may determine the extent of supervision necessary pursuant to this section in the furnishing or ordering of drugs and devices.

(3) PAs who hold an active license, who are authorized through a practice agreement 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. Evidence of completion of a course meeting the standards, including pharmacological content, established in Section 1399.610 and 1399.612 of Title 16 of the California Code of Regulations shall be deemed to meet the requirements of this Section.

(g) For purposes of this section:
(1) “Furnishing” or “ordering” shall include the following:
(A) Ordering a drug or device in accordance with the practice agreement.
(B) Transmitting an order of a supervising physician and surgeon.
(C) Dispensing a medication pursuant to Section 4170.
(2) “Drug order” or “order” means an order for medication that is dispensed to or for an ultimate user, issued by a PA as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations.

(h) Notwithstanding any other law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the a supervising physician; (2) all references to “prescription” in this code and the Health and Safety Code shall include drug orders issued by physician assistants; and (3) the signature of a PA on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.
SEC. 5. Section 3502.3 of the Business and Professions Code is amended to read:

3502.3. (a) (1) A practice agreement shall include, but is not limited to, provisions that address the following:

(A) The types of medical services a physician assistant is authorized to perform and how the services are performed.
(B) Policies and procedures to ensure adequate supervision of the physician assistant, including but not limited to, appropriate communication, availability, consultations, and referrals between a physician and surgeon and the physician assistant in the provision of medical services.
(C) The methods for the continuing evaluation of the competency and qualifications of the physician assistant.
(D) The furnishing or ordering of drugs or devices by a physician assistant pursuant to Section 3502.1.
(E) Any additional provisions agreed to by the physician assistant and physician and surgeon or organized health care system.

(2) A practice agreement shall be signed by both of the following:

(A) The physician assistant.
(B) One or more physicians and surgeons or a physician and surgeon who is authorized to approve the practice agreement on behalf of the staff of the physicians and surgeons on the staff of an organized health care system.

(3) For purposes of the act adding this subdivision, a delegation of services agreement in effect prior to January 1, 2020, shall be deemed to meet the requirements of this subdivision.

(4) Nothing in this section shall be construed to require approval of a practice agreement by the board.

(b) Notwithstanding any other law, in addition to any other practices that meet the general criteria set forth in this chapter or regulations adopted by the board or the Medical Board of California for inclusion in a practice agreement, California, a practice agreement may authorize a PA to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in Section 3502 or the practice agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.
(2) For individuals receiving home health services or personal care services, after consultation with a supervising physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

(3) After performance of a physical examination by the PA under the supervision of a physician and surgeon consistent with this chapter, certify disability pursuant to Section 2708 of the Unemployment Insurance Code. The Employment Development Department shall implement this paragraph on or before January 1, 2017.

(c) This section shall not be construed to affect the validity of any practice agreement in effect prior to the effective date of this section or those adopted subsequent to the effective date of this section.

SEC. 6. Section 3509 of the Business and Professions Code is amended to read:

3509. It shall be the duty of the board to:

(a) Establish standards and issue licenses of approval for programs for the education and training of physician assistants.

(b) Make recommendations to the Medical Board of California concerning the scope of practice for physician assistants.

(c) Make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration of applications by licensed physicians to supervise physician assistants and approval of such applications.

(d) Require the examination of applicants for licensure as a physician assistant who meet the requirements of this chapter.

SEC. 6.

SEC. 7. Section 3516 of the Business and Professions Code is amended to read:

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

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

**SEC. 7.**

**SEC. 8.** Section 3516.5 of the Business and Professions Code is repealed.

**SEC. 8.**

**SEC. 9.** Section 3518 of the Business and Professions Code is amended to read:

3518. The board shall keep a current register for licensed PAs, by specialty if applicable. The register shall show the name of each licensee, the licensee’s last known address of record, and the date of the licensee’s licensure. Any interested person is entitled to obtain a copy of the register in accordance with the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code) upon application to the board together with a sum as may be fixed by the board, which amount shall not exceed the cost of this list so furnished.

**SEC. 9.**

**SEC. 10.** Section 3521 of the Business and Professions Code is repealed.

**SEC. 10.**

**SEC. 11.** Section 3522 of the Business and Professions Code is repealed.

**SEC. 11.**

**SEC. 12.** Section 3527 of the Business and Professions Code is amended to read:

3527. (a) The board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a PA license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

(b) The board may order the denial of an application for, or the suspension or revocation of, or the imposition of probationary conditions upon, an approved program after a hearing as required in Section 3528 for a violation of this chapter or the regulations adopted pursuant thereto.
(c) The Medical Board of California may order the imposition of probationary conditions upon a physician and surgeon’s authority to supervise a PA, after a hearing as required in Section 3528, for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

(d) The board may order the denial of an application for, or the suspension or revocation of, or the imposition of probationary conditions upon, a PA license, after a hearing as required in Section 3528 for unprofessional conduct that includes, except for good cause, the knowing failure of a licensee to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of bloodborne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Public Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other bloodborne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the Osteopathic Medical Board, the Podiatric Medical Board of California, the Dental Board of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians of the State of California to encourage appropriate consistency in the implementation of this subdivision.

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

(e) The board may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license.

(f) The expiration, cancellation, forfeiture, or suspension of a PA license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or
the voluntary surrender of a license by a licensee shall not deprive
the board of jurisdiction to commence or proceed with any
investigation of, or action or disciplinary proceeding against, the
licensee or to render a decision suspending or revoking the license.

SEC. 13.

SEC. 13. Section 3528 of the Business and Professions Code
is amended to read:

3528. Any proceedings involving the denial, suspension, or
revocation of the application for licensure or the license of a PA
or the application for approval or the approval of an approved
program under this chapter shall be conducted in accordance with
Chapter 5 (commencing with Section 11500) of Part 1 of Division
3 of Title 2 of the Government Code.

SEC. 14.

SEC. 14. The provisions of this measure are severable. If any
provision of this measure or its application is held invalid, that
invalidity shall not affect other provisions or applications that can
be given effect without the invalid provision or application.

SEC. 15.

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