LEGISLATIVE COMMITTEE
SUPPLEMENTAL MATERIALS TO COMMITTEE MEETING AGENDA

BRN Legislative Committee Meeting | October 15, 2020
10.0 Approval of Minutes

10.0.1 Review and Vote on Whether to Approve Previous Meeting Minutes: August 13, 2020

10.1 Discussion of Bills of Interest to the Board of Registered Nursing (Board) and Possible Vote to Recommend that the Board Adopt or Modify Positions on Bills Introduced during the 2019-2020 Legislative Session, Including But Not Limited To The Following Bills:
Agenda Item 10.0

Approval of Minutes

BRN Legislative Committee Meeting | October 15, 2020
DATE: August 13, 2020
START TIME: 1:56 p.m.

MEMBERS PRESENT: Michael Jackson
Imelda Ceja-Butkiewicz

10.0 Call to Order/Roll Call/Establishment of a Quorum/Approval of Minutes
Michael Jackson called the meeting to order at 1:56 p.m.
Quorum Not Established. Meeting presented as Information Only.

RECESS: Michael Jackson ordered the meeting to recess.
Time: 2:00 p.m.

RECONVENE: Michael Jackson reconvened the meeting to order.
Time: 2:10 p.m.

10.0.1 Review and Vote on Whether to Approve Previous Meeting’s Minutes:
➢ May 28, 2020

ACTION: Action Deferred to Next Committee Meeting: August 13, 2020
Meeting Presented as Information Only and Considered tabled until the next BRN Committee meeting.

10.1 Discussion of Bills of Interest to the Board of Registered Nursing (Board) and Possible Vote to Recommend that the Board Adopt or Modify Positions on Bills Introduced during the 2019-2020 Legislative Session, Including But Not Limited To the Following Bills:

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

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.

- **AB 329** (Rodriguez) Hospitals: assaults and batteries
- **AB 362** (Eggman) Controlled substances: overdose prevention program
- **AB 613** (Low) Professions and vocations: regulatory fees
- **AB 732** (Bonta) County jails: pregnant inmates
- **AB 890** (Wood) Nurse practitioners
- **AB 1145** (Cristina/Garcia) Child abuse: reportable conduct
- **AB 1616** (Low) Department of Consumer Affairs: boards: expunged convictions
- **AB 1759** (Salas) Health care workers: rural and underserved areas
- **AB 1909** (Gonzalez) Healing arts licensees: virginity examinations or tests
- **AB 1998** (Low) Dental Practice Act: unprofessional conduct: patient of record
- **AB 2028** (Aguilar-Curry) State agencies: meetings
- **AB 2113** (Low) Refugees, asylees, and immigrants: professional licensing
- **AB 2288** (Low) Nursing Programs: Clinical hours
- **AB 2549** (Salas) Department of Consumer Affairs: temporary licenses
- **AB 3016** (Dahle) Board of Registered Nursing: online license verification
- **AB 3045** (Gray) Boards: veterans: military spouses: licenses
- **SB 878** (Jones) Department of Consumer Affairs Licensing: applications: wait times
- **SB 1237** (Dodd) Nurse-Midwives: scope of practice

Thelma Harris, Legislative Committee Liaison, provided information of the Bills listed below:

**AB 890** (Wood) Nurse practitioners
- **POSITION:** Oppose Unless Amended
- **Update:** APRN Committee will provide suggestions to the Board.

**AB 2288** (Low) Nursing Programs: Clinical hours
- **POSITION:** Oppose
- **Update:** *Currently being In Senate Hearing; Update will be provided at a later date.*
AB 3016  (Dahle) Board of Registered Nursing: online license verification
Update: Information Only: Bill Is Currently Held In Committee.

SB 1237  (Dodd) Nurse-Midwives: scope of practice
Update: Concerns are expressed particularly in the language from the BRN Nurse-Midwives Advisory Committee and Board enforcer of Data. The board would not license them if they don’t receive that data.

POSITION: Support if Amended

PUBLIC COMMENT: No Public Comment

10.2 Public Comment For Items Not On The Agenda

PUBLIC COMMENT: Mitchel Erickson-Chair of APRN Advisory Committee

10.3 ADJOURNMENT
Time: 2:20 pm

Submitted By: N/A
Accepted By: N/A
Agenda Item 10.1

Discussion of Bills of Interest to the Board of Registered Nursing (Board) and Possible Vote to Recommend that the Board Adopt or Modify Positions on Bills Introduced during the 2019-2020 Legislative Session, Including But Not Limited To The Following Bills

BRN Legislative Committee Meeting | October 15, 2020
# 2020 TENTATIVE LEGISLATIVE CALENDAR

**Compiled by the Office of the Secretary of the Senate**

Revised August 14, 2020

## JANUARY

<table>
<thead>
<tr>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>TH</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
</tr>
</tbody>
</table>

### DEADLINES

- Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).
- Jan. 6 Legislature Reconvenes (J.R. 51(a)(4)).
- Jan. 10 Budget must be submitted by Governor (Art. IV, Sec. 12(a)).
- Jan. 17 Last day for policy committees to hear and report to fiscal committees fiscal bills introduced in their house in the odd-numbered year (J.R. 61(b)(1)).
- Jan. 20 Martin Luther King, Jr. Day.
- Jan. 24 Last day for any committee to hear and report to the floor bills introduced in that house in the odd-numbered year (J.R. 61(b)(2)).
- Jan. 24 Last day to submit bill requests to the Office of Legislative Counsel.
- Jan. 31 Last day for each house to pass bills introduced in that house in the odd-numbered year (Art. IV, Sec. 10(c)), (J.R. 61(b)(3)).

### FEBRUARY

<table>
<thead>
<tr>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>TH</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
</tr>
</tbody>
</table>

### MARCH

<table>
<thead>
<tr>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>TH</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### APRIL

<table>
<thead>
<tr>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>TH</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MAY

<table>
<thead>
<tr>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>TH</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Holiday schedule subject to Senate Rules committee approval.*
**2020 TENTATIVE LEGISLATIVE CALENDAR**
COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE
Revised August 14, 2020

**JUNE**

<table>
<thead>
<tr>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>TH</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>15</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>18</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>22</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>25</td>
<td>26</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>29</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**June 5** Last day for *policy committees* to hear and report to the floor non-fiscal bills introduced in their house (J.R. 61(b)(6)). Last day for *policy committees* to meet prior to June 8 (J.R. 61(b)(7)).

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

**June 19** Last day for *fiscal committees* to hear and report to the floor bills introduced in their house (J.R. 61(b)(8)). Last day for *fiscal committees* to meet prior to June 29 (J.R. 61(b)(9)).

**June 22-26** Floor Session Only. No committees, other than conference or Rules committees, may meet for any purpose (J.R. 61(b)(10)).

**June 25** Last day for a legislative measure to qualify for the November 3 General Election ballot (Election code Sec. 9040).

**June 26** Last day for each house to pass bills introduced in that house (J.R. 61(b)(11)).

**July**

<table>
<thead>
<tr>
<th>S</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>TH</th>
<th>F</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td>31</td>
<td></td>
</tr>
</tbody>
</table>

**July 2** *Summer Recess* begins upon adjournment provided Budget Bill has been passed (J.R. 51(b)(2)).

**July 3** Independence Day observed.

**July 27** Legislature reconvenes from *Summer Recess* (J.R. 51(b)(2)).

**Aug. 18** Last day for *policy committees* to meet and report bills (J.R. 61(b)(14)).

**Aug. 21** Last day for *fiscal committees* to meet and report bills (J.R. 61(b)(15)).

**Aug. 24 – 31** Floor Session only. No committees, other than conference and Rules committees, may meet for any purpose (J.R. 61(b)(16)).

**Aug. 25** Last day to amend bills on the Floor (J.R. 61(b)(17)).

**Aug. 27** Last day to amend bills on the floor for Chaptering purposes only. *Chaptering Amends Only*

**Aug. 31** Last day for each house to pass bills, except bills that take effect immediately or bills in Extraordinary Session (Art. IV, Sec. 10(c)), (J.R. 61(b)(18)). *Final recess* begins upon adjournment (J.R. 51(b)(3)).

**IMPORTANT DATES OCCURRING DURING FINAL RECESS**

**2020**

**Sept. 30** Last day for Governor to sign or veto bills passed by the Legislature before Sept. 1 and in the Governor’s possession on or after Sept. 1 (Art. IV, Sec. 10(b)(2)).

**Nov. 3** General Election

**Nov. 30** Adjournment *Sine Die* at midnight (Art. IV, Sec. 3(a)).

**Dec. 7** 12 m. convening of 2021-22 Regular Session (Art. IV, Sec. 3(a)).

**2021**

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

**Jan. 4** Legislature reconvenes (JR 51(a)(1)).

*Holiday schedule subject to Senate Rules committee approval.*
<table>
<thead>
<tr>
<th>BILL #</th>
<th>AUTHOR/BILL SPONSOR</th>
<th>SUBJECT</th>
<th>COM POSITION/ date</th>
<th>BOARD POSITION/ date</th>
<th>BILL STATUS as of Oct 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB 329</td>
<td>Rodriguez/CENA</td>
<td>Hospitals: assaults and batteries</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Dead</td>
</tr>
<tr>
<td>AB 362</td>
<td>Eggman/DPA; HRC</td>
<td>Controlled substances: overdose prevention program</td>
<td>Information 5/9/19</td>
<td>Watch 4/11/19</td>
<td>Dead</td>
</tr>
<tr>
<td>AB 613</td>
<td>Low</td>
<td>Professions and vocations: regulatory fees</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Dead</td>
</tr>
<tr>
<td>AB 732</td>
<td>Bonta</td>
<td>County jails: prisons: incarcerated pregnant persons</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Enrolled</td>
</tr>
<tr>
<td>AB 890</td>
<td>Wood</td>
<td>Nurse practitioners: scope of practice: unsupervised practice</td>
<td>Oppose unless amended 01/09/19</td>
<td>Oppose unless amended 6/24/20</td>
<td>Chaptered</td>
</tr>
<tr>
<td>AB 1145</td>
<td>Cristina Garcia</td>
<td>Child abuse: reportable conduct</td>
<td>Watch 3/14/19</td>
<td>Watch 4/11/19</td>
<td>Chaptered</td>
</tr>
<tr>
<td>AB 1616</td>
<td>Low</td>
<td>Department of Consumer Affairs: boards: expunged convictions</td>
<td></td>
<td></td>
<td>Dead</td>
</tr>
<tr>
<td>AB 1759</td>
<td>Salas</td>
<td>Health care workers: rural and underserved areas</td>
<td></td>
<td></td>
<td>Dead</td>
</tr>
<tr>
<td>AB 1909</td>
<td>Gonzalez</td>
<td>Healing arts licensees: virginity examinations or tests</td>
<td></td>
<td></td>
<td>Dead</td>
</tr>
<tr>
<td>AB 1998</td>
<td>Low</td>
<td>Dental Practice Act: unprofessional conduct: patient of record</td>
<td></td>
<td></td>
<td>Dead</td>
</tr>
<tr>
<td>AB 2028</td>
<td>Aguilar-Curry</td>
<td>State agencies: meetings</td>
<td>Oppose unless amended 03/12/20</td>
<td>Support as Amended June 24, 20</td>
<td>Dead</td>
</tr>
<tr>
<td>AB 2113</td>
<td>Low</td>
<td>Refugees, asylees, and immigrants: professional licensing</td>
<td></td>
<td></td>
<td>Chaptered</td>
</tr>
<tr>
<td>AB 2288</td>
<td>Low</td>
<td>Nursing Programs: Clinical hours</td>
<td>Support with Amendments 08/4/2020</td>
<td></td>
<td>Chaptered</td>
</tr>
<tr>
<td>AB 2549</td>
<td>Salas</td>
<td>Department of Consumer Affairs: temporary licenses</td>
<td>Watch 6/24/20</td>
<td></td>
<td>Dead</td>
</tr>
<tr>
<td>AB 3016</td>
<td>Dahle</td>
<td>Board of Registered Nursing: online license verification</td>
<td>Oppose 03/12/20</td>
<td>Oppose 6/24/20</td>
<td>Dead</td>
</tr>
<tr>
<td>AB 3045</td>
<td>Gray</td>
<td>Boards: veterans: military spouses: licenses</td>
<td></td>
<td></td>
<td>Dead</td>
</tr>
<tr>
<td>BILL #</td>
<td>AUTHOR/BILL SPONSOR</td>
<td>SUBJECT</td>
<td>COM POSITION/DATE</td>
<td>BOARD POSITION/DATE</td>
<td>BILL STATUS as of September 30, 2020</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------</td>
<td>---------</td>
<td>-------------------</td>
<td>--------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>SB 3</td>
<td>Allen/Glazer</td>
<td>Office of Higher Education Coordination, Accountability, and performance</td>
<td></td>
<td></td>
<td>Dead</td>
</tr>
<tr>
<td>SB 808</td>
<td>Mitchell</td>
<td>Budget Act of 2020</td>
<td></td>
<td></td>
<td>Dead</td>
</tr>
<tr>
<td>SB 878</td>
<td>Jones</td>
<td>Department of Consumer Affairs Licensing: applications: wait times</td>
<td></td>
<td></td>
<td>Chaptered</td>
</tr>
<tr>
<td>SB 1053</td>
<td>Moorlach</td>
<td>Licensed registered nurses and licensed vocational nurses: Nurse Licensure Compact</td>
<td>Oppose 03/12/20</td>
<td>Oppose 6/24/20</td>
<td>Dead</td>
</tr>
<tr>
<td>SB 1237</td>
<td>Dodd</td>
<td>Nurse-Midwives: scope of practice</td>
<td>Support if amended 03/12/20</td>
<td>Support if amended 6/24/20</td>
<td>Chaptered</td>
</tr>
</tbody>
</table>
ASSEMBLY BILL No. 890

Introduced by Assembly Member Wood
(Coauthors: Assembly Members Aguiar-Curry, Berman, Eggman, Friedman, Gallagher, and Gipson, Grayson, Levine, Quirk, Luz Rivas, Robert Rivas, Santiago, and Wicks)
(Coauthors: Senators Allen, Caballero, Hill, Leyva, McGuire, Moorlach, and Stone)

February 20, 2019

An act to amend Sections 650.01, 805, and 805.5 of, and to add Article 8.5 (commencing with Section 2837.100) to Chapter 6 of Division 2 of, and to repeal Section 2837.101 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL’S DIGEST


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, until January 1, 2026, would establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members. Nurse Practitioner Advisory Committee to advise and give recommendations to the board on matters relating to nurse practitioners. The bill would require the board, by regulation, to define minimum standards for a nurse practitioner to transition to practice without the routine presence of a physician and surgeon: independently. The bill would authorize a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances. The bill would also authorize a nurse practitioner to perform those functions without standardized procedures outside of specified settings or organizations in accordance with specified conditions and requirements if the nurse practitioner holds an active certification issued by the board.

The bill would require the board to issue that certification to a nurse practitioner who meets additional specified education and experience requirements.

The bill would also require the board to request the department’s Office of Professional Examination Services, or an equivalent organization, to perform an occupational analysis of nurse practitioners performing certain functions. The bill would require the board to take specified measures to identify and assess competencies. The bill would require the board to identify and develop a supplemental examination for licensees if needed based on the assessment, as provided.

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 requires certain peer review organizations responsible for reviewing the medical care provided by specified healing arts licentiates to file with the relevant agency an “805 report,” which is a report of certain adverse actions taken against a licentiate for a medical disciplinary cause or reason.

Existing law exempts a peer review body from the requirement to file an 805 report for an action taken as a result of a revocation or suspension, without stay, of a physician and surgeon’s license by the Medical Board of California or a licensing agency of another state. Existing law requires the licensing agency to disclose, among other things, a copy of any 805 report of a licensee upon a request made by specified institutions prior to granting or renewing staff privileges for the licentiate. Existing law specifies certain penalties for failing to file an 805 report, and requires the action or proceeding to be brought by the Medical Board of California if the person who failed to file an 805 report is a licensed physician and surgeon. Existing law defines “licentiate” for those purposes.

This bill would include as a licentiate a nurse practitioner practicing pursuant to the bill's provisions, and make conforming changes. The bill would exempt a peer review body from the requirement to file an 805 report for an action taken as a result of a revocation or suspension, without stay, of a nurse practitioner’s license by the Advanced Practice Board of the Registered Nursing Board or a licensing agency of another state. The bill would require the action or proceeding to be brought by the Advanced Practice Board of the Registered Nursing Board if the person who failed to file an 805 report is a licensed nurse practitioner.

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:

1 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 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 2837.103 or 2837.104.

(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 2837.104 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
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) (1) 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.

(2) 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.

(3) 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.

(4) 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. If the Advanced Practice Registered Nursing Board Board of
Registered Nursing or a licensing agency of another state revokes or suspends, without a stay, the license of a nurse practitioner, 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, the Dental Board of California, and the Advanced Practice Registered Nursing Board of Registered Nursing 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. If the person who is designated or otherwise required to file an 805 report is a licensed nurse practitioner, the action or proceeding shall be brought by the Advanced Practice Registered Nursing Board of Registered Nursing. 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. If the person who is designated or otherwise required to file an 805 report is a licensed nurse practitioner, the action or proceeding shall be brought by the Advanced Practice Registered Nursing Board. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.
(m) A health care service plan 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 805.5 of the Business and Professions Code is amended to read:

805.5. (a) Prior to granting or renewing staff privileges for any physician and surgeon, psychologist, podiatrist, dentist, or nurse practitioner, any health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code, any health care service plan or medical care foundation, the medical staff of the institution, a facility certified to participate in the federal Medicare Program as an ambulatory surgical center, or an outpatient setting accredited pursuant to Section 1248.1 of the Health and Safety Code shall request a report from the Medical Board of California, the Board of Psychology, the California Board of Podiatric Medicine, the Osteopathic Medical Board of California, the Dental Board of California, or the Advanced Practice Registered Nursing Board of Registered Nursing to determine if any report has been made pursuant to Section 805 indicating that the applying physician and surgeon, psychologist, podiatrist, dentist, or nurse practitioner, has been denied staff privileges, been removed from a medical staff, or had their staff privileges restricted as provided in Section 805. The request shall include the name and California license number of the physician and surgeon, psychologist, podiatrist, dentist, or nurse practitioner. Furnishing of a copy of the 805 report shall not cause the 805 report to be a public record.

(b) Upon a request made by, or on behalf of, an institution described in subdivision (a) or its medical–staff staff, the board shall furnish a copy of any report made pursuant to Section 805 as well as any additional exculpatory or explanatory information submitted electronically to the board by the licensee pursuant to subdivision (f) of that section. However, the board shall not send a copy of a report (1) if the denial, removal, or restriction was imposed solely because of the failure to complete medical records,
(2) if the board has found the information reported is without merit,
(3) if a court finds, in a final judgment, that the peer review, as
defined in Section 805, resulting in the report was conducted in
bad faith and the licensee who is the subject of the report notifies
the board of that finding, or (4) if a period of three years has
elapsed since the report was submitted. This three-year period shall
be tolled during any period the licentiate has obtained a judicial
order precluding disclosure of the report, unless the board is finally
and permanently precluded by judicial order from disclosing the
report. If a request is received by the board while the board is
subject to a judicial order limiting or precluding disclosure, the
board shall provide a disclosure to any qualified requesting party
as soon as practicable after the judicial order is no longer in force.

If the board fails to advise the institution within 30 working days
following its request for a report required by this section, the
institution may grant or renew staff privileges for the physician
and surgeon, psychologist, podiatrist, dentist, or nurse practitioner.

(c) Any institution described in subdivision (a) or its medical
staff that violates subdivision (a) is guilty of a misdemeanor and
shall be punished by a fine of not less than two hundred dollars
($200) nor more than one thousand two hundred dollars ($1,200).

SEC. 4. 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 an undue or unnecessary burden to
licensure or practice. The requirements are intended to ensure the
new category of licensed nurse practitioners—have has 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) —
2837.101. For purposes of this article, the following terms have
the following meanings:
(1) “Board” means the Advanced Practice Registered Nursing Board.

(a) “Committee” means the Nurse Practitioner Advisory Committee.

(b) “Standardized procedures” has the same meaning as that term is defined in Section 2725.

(c) “Transition to practice” means additional clinical experience and mentorship provided to prepare a nurse practitioner to practice without the routine presence of a physician and surgeon: independently. The board shall, by regulation, define minimum standards for transition to practice. Clinical experience may include experience obtained before January 1, 2021, if the experience meets the requirements established by the board.

(e) 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 certified 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.

(e) 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.

2837.102. (a) The board shall establish a Nurse Practitioner Advisory Committee to advise and make recommendations to the board on all matters relating to nurse practitioners, including, but
not limited to, education, appropriate standard of care, and other
matters specified by the board.
(b) A majority of the members of the committee shall be nurse
practitioners and the committee shall include physicians and
surgeons with demonstrated experience working with nurse
practitioners.

2837.104. (a) (1) Notwithstanding any other law, a nurse
practitioner may perform the functions specified in subdivision
(c) pursuant to that subdivision, in a setting or organization
specified in paragraph (2) pursuant to that paragraph, if the nurse
practitioner has successfully satisfied the following requirements:
(A) Passed a national nurse practitioner board certification
examination and, if applicable, any supplemental examination
developed pursuant to paragraph (3) of subdivision (a) of Section
2837.106. 2837.105.
(B) Holds a certification as a nurse practitioner from a national
certifying body recognized by the board.
(C) Provides documentation that educational training was
consistent with standards established by the board pursuant to
Section 2836 and any applicable regulations as they specifically
relate to requirements for clinical practice hours. Online educational
programs that do not include mandatory clinical hours shall not
meet this requirement.
(D) Has completed a transition to practice in California of a
minimum of three full-time equivalent years of practice or 4600
hours.
(2) A nurse practitioner who meets all of the requirements of
paragraph (1) may practice, including, but not limited to,
performing the functions authorized pursuant to subdivision (c),
in one of the following settings or organizations in which one or
more physicians and surgeons practice with the nurse practitioner
without standardized procedures:
(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, except for a correctional treatment center,
as defined in paragraph (1) of subdivision (j) of Section 1250 of
the Health and Safety Code, or a state hospital, as specified in
Section 4100 of the Welfare and Institutions 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.

(E) A home health agency, as defined in Section 1727 of the Health and Safety Code.

(F) A hospice facility licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(3) 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 applicable bylaws.

(B) A nurse practitioner shall be eligible to serve on medical staff and hospital committees.

(C) A nurse practitioner shall be eligible to attend meetings of the department to which the nurse practitioner is assigned. A nurse practitioner shall not vote at department, division, or other meetings unless the vote is regarding the determination of nurse practitioner privileges with the organization, peer review of nurse practitioner clinical practice, whether a licensee’s employment is in the best interest of the communities served by a hospital pursuant to Section 2401 2041, or the vote is otherwise allowed by the applicable bylaws.

(b) An entity described in subparagraphs (A) to (D), inclusive, of paragraph (2) 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 paragraph (1) of subdivision (a) may perform the following functions without standardized procedures in accordance with their education and training:
(1) Conduct an advanced assessment.

(2) Order, perform, and interpret diagnostic procedures. *Diagnostic procedures involving imaging refers to x-rays, mammography, and ultrasounds.*

(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 inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase “enfermera especializada.”

(e) 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.

(f) A nurse practitioner practicing under this section shall maintain have professional liability insurance appropriate for the practice setting.
2837.104. (a) Notwithstanding any other law, the following apply to a nurse practitioner who holds an active certification issued by the board pursuant to subdivision (b):

1. The nurse practitioner may perform the functions specified in subdivision (c) of Section 2837.104 if the nurse practitioner satisfies all of the following requirements:

   (1) Has practiced as a nurse practitioner in good standing for at least three years, not inclusive of the transition to practice required pursuant to subparagraph (D) of paragraph (1) of subdivision (a) of Section 2837.104. The board may, at its discretion, lower this requirement for a nurse practitioner holding a Doctorate of Nursing Practice degree (DNP) based on practice experience gained in the course of doctoral education experience.

(c) 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 not practice within the scope of their clinical care.
and professional education and training, including specific areas of concentration during their transition to practice, and shall only practice 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.

(d) A nurse practitioner shall inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase “enfermera especializada.”

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

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

(g) Subdivision (f) shall not apply to a nurse practitioner if either 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.

2837.105. (a) (1) The board shall request the department’s Office of Professional Examination Services, or an equivalent organization, to perform an occupational analysis of nurse practitioners performing the functions specified in subdivision (c) of Section 2837.104 pursuant to that subdivision.

(2) The board, together with the Office of Professional Examination Services, shall assess the alignment of the competencies tested in the national nurse practitioner certification examination required by subparagraph (A) of paragraph (1) of subdivision (a) of Section 2837.104 with the occupational analysis performed according to paragraph (1).
(3) If the assessment performed according to paragraph (2) identifies additional competencies necessary to perform the functions specified in subdivision (c) of Section 2837.104, pursuant to that subdivision that are not sufficiently validated by the national nurse practitioner board certification examination required by subparagraph (A) of paragraph (1) of subdivision (a) of Section 2837.104, 2837.103, the board shall identify and develop a supplemental exam that properly validates identified competencies.

(b) The examination process shall be regularly reviewed pursuant to Section 139.

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.
An act to add Section 2786.3 to the Business and Professions Code, relating to healing arts, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL’S DIGEST

AB 2288, as amended, Low. Nursing programs: state of emergency. Existing law, the Nursing Practice Act, provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing and requires an applicant for licensure to have completed a nursing program at a school of nursing that is approved by the board. Existing regulatory law sets forth curriculum requirements for nursing programs, including preceptorships and clinical practice hours, and also requirements for clinical facilities that may be used for clinical experience.

This bill would authorize an approved nursing program to submit a request to a board nursing education consultant to revise certain clinical
experience requirements, including reducing the required direct patient hours and using preceptorships without maintaining specified written policies, for enrolled students until the end of the 2020–21 academic year and whenever the Governor declares a state of emergency in the county where an agency or facility used by the approved nursing program is located. The bill would require the board nursing education consultant to approve the request if specified conditions are satisfied and to reject the request if the approved nursing program fails to meet the conditions or fails to submit information satisfactory to the board. The bill would require the board to notify the appropriate policy committees of the Legislature if a board nursing education consultant denies a request.

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. It is the intent of the Legislature that the provisions of this bill be used solely for the purpose of progressing nursing students who are displaced from clinical experiences during the COVID-19 pandemic and future state of emergencies and not for purposes of increasing student enrollment.

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

2786.3. (a) Until the end of the 2020–21 academic year, and whenever the Governor declares a state of emergency for a county in which an agency or facility used by an approved nursing program for direct patient care clinical practice is located and is no longer available due to the conditions giving rise to the state of emergency, the director of the approved nursing program may submit to a board nursing education consultant requests to do any of the following for no more than the existing number of enrolled students:

(1) Utilize a clinical setting during the state of emergency or until the end of the academic term without the following:
(A) Approval by the board.
(B) Written agreements with the clinical facility.
(C) Submitting evidence of compliance with board regulations relating to the utilization of clinical settings, except as necessary for a board nursing education consultant to ensure course objectives and faculty responsibilities will be met.

(2) Utilize preceptorships during the state of emergency or until the end of the academic term without having to maintain written policies relating to the following:

(A) Identification of criteria used for preceptor selection.

(B) Provision for a preceptor orientation program that covers the policies of the preceptorship and preceptor, student, and faculty responsibilities.

(C) Identification of preceptor qualifications for both the primary and the relief preceptor.

(D) Description of responsibilities of the faculty, preceptor, and student for the learning experiences and evaluation during preceptorship.

(E) Maintenance of preceptor records that includes names of all current preceptors, registered nurse licenses, and dates of preceptorships.

(F) Plan for an ongoing evaluation regarding the continued use of preceptors.

(3) Request that the approved nursing program be allowed to reduce the required number of direct patient care hours to 50 percent in geriatrics and medical-surgical and 25 percent in mental health-psychiatric nursing, obstetrics, and pediatrics if all of the following conditions are met:

(A) No alternative agency or facility located within 25 miles of the impacted approved nursing program, campus, or location, as applicable, has a sufficient number of open placements that are available and accessible to the approved nursing program for direct patient care clinical practice hours in the same subject matter area. An approved nursing program shall submit, and not be required to contact a clinical facility that the program has previously contacted, the following:

(i) The list of alternative agencies or facilities listed within 25 miles of the impacted approved nursing program, campus, or location, as applicable, using the facility finder on the Office of Statewide Health Planning and Development’s website.
(ii) The list of courses impacted by the loss of clinical placements due to the state of emergency and the academic term the courses are offered.

(iii) Whether each of the listed alternative agencies or facilities would meet the course objectives for the courses requiring placements.

(iv) Whether the approved nursing program has contacted each of the listed alternative agencies or facilities about the availability of clinical placements. The approved nursing program shall not be required to contact a clinical facility that would not meet course objectives.

(v) The date of contact or attempted contact.

(vi) The number of open placements at each of the listed alternative agencies or facilities that are available for the academic term for each course. If an alternative agency or facility does not respond within 48 hours, the approved nursing program may list the alternative agency or facility as unavailable. If the alternative agency or facility subsequently responds prior to the submission of the request to a board nursing education consultant, the approved nursing program shall update the list to reflect the response.

(vii) Whether the open and available placements are accessible to the students and faculty. An open and available placement is accessible if there are no barriers that otherwise prohibit a student from entering the facility, including, but not limited to, the lack of personal protective equipment or cost-prohibitive infectious disease testing. An individual’s personal unwillingness to enter an alternative agency or facility does not make a placement inaccessible.

(viii) The total number of open and available placements that are accessible to the students and faculty compared to the total number of placements needed.

(B) The substitute clinical practice hours not in direct patient care provide a learning experience, as defined by the board consistent with Section 2708.1, that is at least equivalent to the learning experience provided by the direct patient care clinical practice hours.

(C) Once the applicable state of emergency is lifted, clinical practice hours not in direct patient care shall cease as soon as practicable, a sufficient number of clinical placements are
available and accessible, once the applicable state of emergency has terminated pursuant to Section 8629 of the Government Code, or by the end of the academic term, whichever is sooner.

(D) The simulation experiences are based on the best practices published by the International Nursing Association for Clinical Simulation and Learning, the National Council of State Boards of Nursing, the Society for Simulation in Healthcare, or equivalent standards approved by the board, except those relating to the number of direct patient care hours.

(E) A minimum of 25 percent of the remaining direct patient care hours are completed in an in-person setting.

(4) Request that the approved nursing program be allowed to reduce the required number of direct patient care hours to 25 percent for students in their graduating academic term if all of the following conditions are met:

(A) The approved program meets the requirements of paragraph (3).

(B) All courses in the students’ earlier terms met a minimum of 50 percent direct patient care hours.

(C) The number of placements available at agencies or facilities being used by the approved nursing program for direct patient care are insufficient to meet the 50 percent direct patient care requirement.

(D) The approved program has maintained a minimum first-time pass rate of 80 percent for the licensing examination under this chapter for the last two consecutive academic years.

(5) Request that the approved nursing program allow theory to precede clinical practice for purposes of placing students in the remaining clinical placement settings if all of the following conditions are met:

(A) No alternative agency or facility located within 25 miles of the impacted approved nursing program, campus, or location, as applicable, has a sufficient number of open placements that are available and accessible to the approved nursing program for direct patient care clinical practice hours in the same subject matter area. An approved program shall not be required to contact a clinical facility that the program has previously contacted. submit more than required under subparagraph (A) of paragraph (3.)
(B) Clinical practice takes place in the quarter or semester immediately following theory.

(C) Theory is taught concurrently with nondirect patient care clinical experiences if no direct patient care experiences are available.

(b) If the conditions in paragraphs (1), (2), (3), (4), or (5) of subdivision (a), as applicable to the request, are met, a board nursing education consultant shall approve the request. If an approved nursing program fails to submit information satisfactory to the board nursing education consultant, or fails to meet the conditions specified, the board nursing education consultant shall deny the request. If the request is not approved or denied on or before 5:00 p.m. on the date seven business days after receipt of the request, the request shall be deemed approved.

(c) A board nursing education consultant shall use a uniform method consistent with all other board nursing education consultants for granting approvals under this section.

(d) If a board nursing education consultant denies a request under this section, the board shall notify the appropriate policy committees of each house of the Legislature. The notice shall be delivered electronically within seven calendar days and include the reason for the denial.

SEC. 3. 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 protect public health and preserve the future health care workforce by providing flexibility in the way nursing students obtain clinical experience during the COVID-19 pandemic as soon as possible, it is necessary that this act take effect immediately.
AN ACT TO AMEND SECTIONS 650.01, 2746.2, 2746.5, 2746.51, AND 2746.52 OF, AND TO ADD SECTIONS 2746.54 AND 2746.55 TO, THE BUSINESS AND PROFESSIONS CODE, AND TO AMEND SECTION 102415 OF THE HEALTH AND SAFETY CODE, RELATING TO HEALING ARTS.

LEGISLATIVE COUNSEL’S DIGEST


(1) Existing law, the Nursing Practice Act, establishes the Board of Registered Nursing within the Department of Consumer Affairs for the licensure and regulation of the practice of nursing. A violation of the act is a crime. Existing law requires the board to issue a certificate to practice nurse-midwifery to a person who, among other qualifications, meets educational standards established by the board or the equivalent of those educational standards. Existing law authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn. Existing law defines the practice of nurse-midwifery as the furthering or undertaking by a
certified person, under the supervision of licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. Existing law requires all complications to be referred to a physician immediately. Existing law excludes the assisting of childbirth by any artificial, forcible, or mechanical means, and the performance of any version from the definition of the practice of nurse-midwifery.

This bill would delete the above-described provisions defining the practice of nurse-midwifery, would delete the condition that a certified nurse-midwife practice under the supervision of a physician and surgeon, and would instead authorize a certified nurse-midwife to attend cases of low-risk pregnancy, as defined, and childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning services, interconception care, and immediate care of the newborn, consistent with standards adopted by a specified professional organization, or its successor, as approved by the board. The bill would authorize a certified nurse-midwife to practice with a physician and surgeon under mutually agreed-upon policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient’s care, signed by both the certified nurse-midwife and a physician and surgeon to provide a patient with specified services. The bill, except as specified, would require the patient to be transferred to the care of a physician and surgeon to provide those services if the nurse-midwife does not have those mutually agreed-upon policies and protocols in place, and would authorize the return of that patient to the care of the nurse-midwife after the physician and surgeon has determined that the condition or circumstance that required, or would require, the transfer is resolved. The bill would authorize a certified nurse-midwife to continue to attend the birth of the newborn and participate in physical care, counseling, guidance, teaching, and support, if a physician and surgeon assumes care of the patient, as indicated by the mutually agreed-upon policies and protocols. The bill would authorize a certified nurse-midwife, after referring a patient to a physician and surgeon, to continue care of a patient during a reasonable interval between the referral and the initial appointment with the physician and surgeon. The bill would authorize a certified nurse-midwife to attend pregnancy and childbirth in an out-of-hospital setting if consistent with the above-described provisions. Under the bill, a certified nurse-midwife would not be authorized to assist childbirth by vacuum or forceps extraction, or to perform any external cephalic version. The bill would
require a certified nurse-midwife to refer all emergencies to a physician and surgeon immediately, and would authorize a certified nurse-midwife to provide emergency care until the assistance of a physician and surgeon is obtained.

This bill would require a certified nurse-midwife who is not under the supervision of a physician and surgeon to provide oral and written disclosure to a patient and obtain a patient’s written consent, as specified. By expanding the scope of a crime, the bill would impose a state-mandated local program.

(2) Existing law authorizes the board to appoint a committee of qualified physicians and nurses, including, but not limited to, obstetricians and nurse-midwives, to develop the necessary standards relating to educational requirements, ratios of nurse-midwives to supervising physicians, and associated matters. Existing law, additionally, authorizes the committee to include family physicians.

This bill would specify the name of the committee as bill, instead, would require the board to appoint a committee of qualified physicians and surgeons and nurses called the Nurse-Midwifery Advisory Committee. The bill would require the committee to consist of 4 qualified nurse-midwives, 2 qualified physicians and surgeons, including, but not limited to, obstetricians or family physicians, and one public member. The bill would delete the provision including ratios of nurse-midwives to supervising physicians and associated matters in the standards developed by the committee, and would instead require the committee to make recommendations to the board on all matters related to midwifery practice, education, appropriate standard of care, and other matters as specified by the board. The bill would authorize require the committee to make recommendations on disciplinary actions at the request of the board. The bill would require a majority of the members of the committee to be nurse-midwives and at least 40% of the members of the committee to be physicians and surgeons. provide recommendations or guidance on care when the board is considering disciplinary action against a certified nurse-midwife. The bill would require authorize the committee to continue to make the recommendations described above if the board, despite good faith efforts, is unable to solicit and appoint the committee members pursuant to these provisions: 4 qualified nurse-midwives, 2 qualified physicians and surgeons, including, but not limited to, obstetricians or family physicians, and one public member.
(3) Existing law authorizes a certified nurse-midwife to furnish drugs or devices, including controlled substances, in specified circumstances, including if drugs or devices are furnished or ordered incidentally to the provision of care in specified settings, including certain licensed health care facilities, birth centers, and maternity hospitals provided that the furnishing or ordering of drugs or devices occur under physician and surgeon supervision. Existing law requires the drugs or devices to be furnished in accordance with standardized procedures or protocols, and defines standardized procedure to mean a document, including protocols, developed and approved by specified persons, including a facility administrator. Existing law requires Schedule II or III controlled substances furnished or ordered by a certified nurse-midwife to be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician and surgeon. Existing law requires a certified nurse-midwife who is authorized to furnish or issue a drug order for a controlled substance to register with the United States Drug Enforcement Administration.

This bill would delete the condition that the furnishing or ordering of drugs or devices occur under physician and surgeon supervision, and would authorize a certified nurse-midwife to furnish drugs or devices incidentally to the provision of care and services allowed by a certificate to practice nurse-midwifery as provided by the bill and when care is rendered in an out-of-hospital setting, as specified. The bill would limit the requirement that the furnishing or ordering of drugs or devices by a certified nurse-midwife be in accordance with the standardized procedures or protocols to the furnishing or ordering of drugs or devices for services that do not fall within the scope of services specified by the bill, and the furnishing of Schedule IV or V controlled substances by a nurse-midwife for any condition. The bill would require Schedule II or III controlled substances furnished or ordered by a certified nurse-midwife for any condition to be furnished or ordered in accordance with a patient-specific protocol approved by a physician and surgeon. The bill would revise the definition of standardized procedure to mean a document, including protocols, developed in collaboration with, and approved by, a physician and surgeon and the certified nurse-midwife. The bill would require a certified nurse-midwife who is authorized to furnish or issue a drug order for a controlled substance to additionally register with the Controlled Substance Utilization Review and Enforcement System (CURES). The bill would authorize a certified nurse-midwife to procure supplies and devices, obtain and administer
diagnostic tests, obtain and administer nonscheduled drugs consistent with the provision of services that fall within the scope of services specified by the bill, order laboratory and diagnostic testing, and receive reports, as specified. The bill would make it a misdemeanor for a certified nurse-midwife to refer a person for specified laboratory and diagnostic testing, home infusion therapy, and imaging goods or services if the certified nurse-midwife or their immediate family member has a financial interest with the person receiving a referral. By expanding the scope of a crime, the bill would impose a state-mandated local program.

(4) Existing law authorizes a certified nurse-midwife to perform and repair episiotomies and repair lacerations of the perineum in specified health care facilities only if specified conditions are met, including that the protocols and procedures ensure that all complications are referred to a physician and surgeon immediately, and that immediate care of patients who are in need of care beyond the scope of practice of the certified nurse-midwife, or emergency care for times when the supervising physician and surgeon is not on the premises.

This bill would delete those conditions, and instead would require a certified nurse-midwife performing and repairing lacerations of the perineum to ensure that all complications are referred to a physician and surgeon immediately, and that immediate care of patients who are in need of care beyond the scope of practice of the certified nurse-midwife, or emergency care when a physician and surgeon is not on the premises.

(5) Existing law requires each live birth to be registered with the local registrar of births and deaths for the district in which the birth occurred within 10 days following the date of the event. Existing law makes the professionally licensed midwife in attendance at a live birth that occurs outside of a hospital or outside of a state-licensed alternative birth center responsible for entering the information on the birth certificate, securing the required signatures, and for registering the certificate with the local registrar.

This bill instead would make the professionally licensed midwife or the certified nurse-midwife in attendance responsible for those duties.

(6) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.
(5) Existing law, the Health Data and Advisory Council Consolidation Act, requires certain health facilities to make and file with the Office of Statewide Health Planning and Development specified reports containing various financial and patient data. Existing law requires a licensed midwife who assists, or supervises a student midwife in assisting, in childbirth that occurs in an out-of-hospital setting to annually report specified information to the Office of Statewide Health Planning and Development.

This bill would require a certified nurse-midwife to report the outcome of a birth in an out-of-hospital setting to ensure consistent reporting of birth outcomes in all settings, consistent with the information currently reported by hospitals to the Office of Statewide Health Planning and Development, who provides labor and delivery services that occurs in an out-of-hospital setting to report patient-level data within 90 days of the birth to the State Department of Public Health, as specified. The bill would require the Board of Registered Nursing to specify the final form of the data submission. The bill would require the department to maintain the confidentiality of that information, and would prohibit the department from permitting any law enforcement or regulatory agency to inspect or have copies made of the contents of the submitted reports for any purpose. The bill would require the department to report to the board by April 30, those licensees who have met the reporting requirement. The bill would prohibit the board from renewing the license of a certified nurse-midwife who has failed to comply with the reporting requirement unless the certified nurse-midwife submits to the department the missing data. The bill would require, for those cases that involve a hospital transfer, the Office of Statewide Health Planning and Development to coordinate the linkage of the data submitted by the certified nurse-midwife with the vital records data and patient discharge data that reflects the hospitalization. The bill would require the department to report the aggregate information collected pursuant to these provisions to the board by July 30 of each year. The bill would require the board to include this information in its annual report to the Legislature.

(6) 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. The Legislature hereby finds and declares the following:

(a) It is the intent of the Legislature to ensure the preservation of nurse-midwifery care in both the hospital and out-of-hospital setting by delineating the scope of practice for certified nurse-midwives.

(b) There is a maternity care workforce crisis in California. At least nine counties have no obstetrician at all, and many more counties fall below the national average for obstetricians. Nurse-midwives and physicians and surgeons can work together to innovatively address this issue and fill gaps in care, before California reaches the point of a critical provider shortage.

(c) California has made great strides in reducing maternal mortality. Nonetheless, there remains a large disparity for Black and indigenous birthing people, and other birthing people of color. The maternal mortality rate for Black women in California is still three to four times higher than White women. Within an integrated model of care, physicians and surgeons and nurse-midwives can work together with patients and community leaders to eradicate this disparity. This measure will set the foundation for that work.

(d) Structural, systemic, and interpersonal racism, and the resulting economic and social inequities and racial disparities in health care are complex problems requiring multiple, innovative strategies in order to turn the tide. Expansion of care teams, working together in a patient-centered approach, is one of these innovative strategies.

(e) State studies show that successful physician-midwifery integration enhances well-being and maternal and neonatal outcomes.
Nurse-midwives attend 50,000 births a year in California and are currently underutilized.

Supporting vaginal birth could improve health outcomes and save millions in annual health care costs in California.

California is the only western state that still requires nurse-midwives to be supervised by a physician and surgeon and one of only four states in the nation that still requires this. Forty-six other states have removed the requirement for physician and surgeon supervision.

Bodily autonomy including the choice of health care provider and the personalized, shared involvement in health care decisions is fundamental to reproductive rights.

Every person is entitled to access dignified, person-centered childbirth and health care, regardless of race, gender, age, class, sexual orientation, gender identity, ability, language proficiency, nationality, immigration status, gender expression, religion, insurance status, or geographic location.

The core philosophy of nurse-midwifery is to provide patient-centered, culturally sensitive, holistic care in collaboration with physicians and surgeons and other health care providers, all of which are key to reducing disparities in maternal health care.

SEC. 2. Section 650.01 of the Business and Professions Code is amended to read:

(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 
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 certified nurse-midwife as described in
Article 2.5 (commencing with Section 2746) of Chapter 6, acting
within their scope of practice.

(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 (b) 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. In the case of a licensee who is a physician and surgeon, 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. In the case of a licensee who is a certified nurse-midwife, the Board of Registered Nursing 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, the Board of Registered Nursing, 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. 3. Section 2746.2 of the Business and Professions Code is amended to read:

2746.2. (a) An applicant shall show by evidence satisfactory to the board that they have met the educational standards established by the board or have at least the equivalent thereof.

(b) (1) The board may appoint a committee of qualified physicians and surgeons and nurses called the Nurse-Midwifery Advisory Committee.

(2) The committee shall make recommendations to the board on all matters related to midwifery practice, education, appropriate standard of care, and other matters as specified by the board. At the request of the board, the committee may make recommendations on disciplinary actions. The committee shall provide recommendations or guidance on care when the board is considering disciplinary action against a certified nurse-midwife.

(3) (A) The committee shall include, but not be limited to, qualified nurses and consist of four qualified nurse-midwives, two qualified physicians and surgeons, including, but not limited to, obstetricians or family physicians, and one public member.

(B) A majority of the members of the committee shall be nurse-midwives.

(C) At least 40 percent of the members of the committee shall be physicians and surgeons.

(4) If the board is unable, despite good faith efforts, to solicit and appoint committee members pursuant to the specifications in
subparagraph (B) or (C) of paragraph (3), the committee shall *may* continue to make recommendations pursuant to paragraph (2).

SEC. 4. Section 2746.5 of the Business and Professions Code is amended to read:

2746.5. (a) The certificate to practice nurse-midwifery authorizes the holder to attend cases of low-risk pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including *family planning services, interconception care, family planning care,* and immediate care for the newborn, consistent with the Core Competencies for Basic Midwifery Practice adopted by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board. For purposes of this subdivision, “low-risk pregnancy” means a pregnancy in which all of the following conditions are met:

(1) There is a single fetus.

(2) There is a cephalic presentation at onset of labor.

(3) The gestational age of the fetus is greater than or equal to 37 weeks and zero days and less than or equal to 42 weeks and zero days at the time of delivery.

(4) Labor is spontaneous or induced.

(5) The patient has no preexisting disease or condition, whether arising out of the pregnancy or otherwise, that adversely affects the pregnancy and that the certified nurse-midwife is not qualified to independently address pursuant to *consistent with* this section.

(b) (1) The certificate to practice nurse-midwifery authorizes the holder to practice with a physician and surgeon under mutually agreed-upon policies and protocols that delineate the parameters for consultation, collaboration, referral, and transfer of a patient’s care, signed by both the certified nurse-midwife and a physician and surgeon to do either of the following:

(A) Provide a patient with care that falls outside the scope of services specified in subdivision (a).

(B) Provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium.

(2) If a physician and surgeon assumes care of the patient, the certified nurse-midwife may continue to attend the birth of the newborn and participate in physical care, counseling, guidance, teaching, and support, as indicated by the mutually agreed-upon...
policies and protocols signed by both the certified nurse-midwife
and a physician and surgeon.

(3) After a certified nurse-midwife refers a patient to a physician
and surgeon, the certified nurse-midwife may continue care of the
patient during a reasonable interval between the referral and the
initial appointment with the physician and surgeon.

(c) (1) If a nurse-midwife does not have in place mutually
agreed-upon policies and protocols that delineate the parameters
for consultation, collaboration, referral, and transfer of a patient’s
care, signed by both the certified nurse-midwife and a physician
and surgeon pursuant to paragraph (1) of subdivision (b), the
patient shall be transferred to the care of a physician and surgeon
to do either or both of the following:

(A) Provide a patient with care that falls outside the scope of
services specified in subdivision (a).

(B) Provide intrapartum care to a patient who has had a prior
cesarean section or surgery that interrupts the myometrium.

(2) After the certified nurse-midwife initiates the process of
transfer pursuant to paragraph (1), for a patient who otherwise
meets the definition of a low-risk pregnancy but no longer meets
the criteria specified in paragraph (3) of subdivision (a) because
the gestational age of the fetus is greater than 42 weeks and zero
days, if there is inadequate time to effect safe transfer to a hospital
prior to delivery or transfer may pose a threat to the health and
safety of the patient or the unborn child, the certified nurse-midwife
may continue care of the patient consistent with the transfer plan
described in subdivision (a) of Section 2746.54.

(2)

(3) A patient who has been transferred from the care of a
certified nurse-midwife to that of a physician and surgeon may
return to the care of the certified nurse-midwife after the physician
and surgeon has determined that the condition or circumstance
that required, or would require, the transfer from the care of the
nurse-midwife pursuant to paragraph (1) is resolved.

(d) The certificate to practice nurse-midwifery authorizes the
holder to attend pregnancy and childbirth in an out-of-hospital
setting if consistent with subdivisions (a), (b), and (c).

(e) This section shall not be interpreted to deny a patient’s right
to self-determination or informed decisionmaking with regard to
choice of provider or birth setting.
(f) The certificate to practice nurse-midwifery does not authorize the holder of the certificate to assist childbirth by vacuum or forceps extraction, or to perform any external cephalic version.

(g) A certified nurse-midwife shall document all consultations, referrals, and transfers in the patient record.

(h) 1. A certified nurse-midwife shall refer all emergencies to a physician and surgeon immediately.
   2. A certified nurse-midwife may provide emergency care until the assistance of a physician and surgeon is obtained.

(i) This chapter does not authorize a nurse-midwife to practice medicine or surgery.

(j) This section shall not be construed to require a physician and surgeon to sign protocols and procedures for a nurse-midwife or to permit any action that violates Section 2052 or 2400.

(k) This section shall not be construed to require a nurse-midwife to have mutually agreed-upon, signed policies and protocols for the provision of services described in subdivision (a).

SEC. 5. Section 2746.51 of the Business and Professions Code is amended to read:

2746.51. (a) Neither this chapter nor any other law shall be construed to prohibit a certified nurse-midwife from furnishing or ordering drugs or devices, including controlled substances classified in Schedule II, III, IV, or V under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code), when all of the following apply:

(1) The drugs or devices are furnished or ordered incidentally to the provision of any of the following:

(A) The care and services described in Section 2746.5.

(B) Care rendered, consistent with the certified nurse-midwife’s educational preparation or for which clinical competency has been established and maintained, to persons within a facility specified in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the Health and Safety Code, a clinic as specified in Section 1204 of the Health and Safety Code, a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code, a licensed birth center as defined in Section 1204.3 of the Health and Safety Code, or a special hospital specified as a maternity
(C) Care rendered in an out-of-hospital setting pursuant to subdivision (d) of Section 2746.5.

(2) The furnishing or ordering of drugs or devices by a certified nurse-midwife for services that do not fall within the scope of services specified in subdivision (a) of Section 2746.5, and the furnishing of Schedule IV or V controlled substances by a nurse-midwife for any condition, including, but not limited to, the furnishing of Schedule IV or V controlled substances for services that fall within the scope of services specified in subdivision (a) of Section 2746.5, are in accordance with the standardized procedures or protocols. For purposes of this section, standardized procedure means a document, including protocols, developed in collaboration with, and approved by, a physician and surgeon and the certified nurse-midwife. The standardized procedure covering the furnishing or ordering of drugs or devices shall specify all of the following:

(A) Which certified nurse-midwife may furnish or order drugs or devices.
(B) Which drugs or devices may be furnished or ordered and under what circumstances.
(C) The method of periodic review of the certified nurse-midwife’s competence, including peer review, and review of the provisions of the standardized procedure.

(3) If Schedule II or III controlled substances, as defined in Sections 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife for any condition, including, but not limited to, the furnishing of Schedule II or III controlled substances for services that fall within the scope of services specified in subdivision (a) of Section 2746.5, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by a physician and surgeon. For Schedule II controlled substance protocols, the provision for furnishing the Schedule II controlled substance shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(b) (1) The furnishing or ordering of drugs or devices by a certified nurse-midwife is conditional on the issuance by the board of a number to the applicant who has successfully completed the
requirements of paragraph (2). The number shall be included on all transmittals of orders for drugs or devices by the certified nurse-midwife. The board shall maintain a list of the certified nurse-midwives that it has certified pursuant to this paragraph and the number it has issued to each one. The board shall make the list available to the California State Board of Pharmacy upon its request. Every certified nurse-midwife who is authorized pursuant to this section to furnish or issue a drug order for a controlled substance shall register with the United States Drug Enforcement Administration and the Controlled Substance Utilization Review and Enforcement System (CURES) pursuant to Section 11165.1 of the Health and Safety Code.

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section, including the risks of addiction and neonatal abstinence syndrome associated with the use of opioids. The board shall establish the requirements for satisfactory completion of this paragraph.

(3) A copy of the standardized procedure or protocol relating to the furnishing or ordering of controlled substances by a certified nurse-midwife shall be provided upon request to any licensed pharmacist who is uncertain of the authority of the certified nurse-midwife to perform these functions.

(4) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) under the following conditions:

(1) The drugs and devices are furnished or ordered in accordance with requirements referenced in subdivisions (a) and (b).
(2) When Schedule II controlled substances, as defined in Section 11055 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by a physician and surgeon.

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient. Use of the term “furnishing” in this section shall include the following:

(1) The ordering of a nonscheduled drug or device for services that fall within the scope of services specified in subdivision (a) of Section 2746.5.

(2) The ordering of a nonscheduled drug or device for services that fall outside the scope of services specified in subdivision (a) of Section 2746.5 in accordance with standardized procedures or protocols pursuant to paragraph (2) of subdivision (a).

(3) The ordering of a Schedule IV or V drug for any condition, including, but not limited to, the furnishing of Schedule IV or V controlled substances for services that fall for care that falls within the scope of services specified in subdivision (a) of Section 2746.5, in accordance with standardized procedures or protocols pursuant to paragraph (2) of subdivision (a).

(4) The ordering of a Schedule II or III drug in accordance with a patient-specific protocol approved by a physician and surgeon pursuant to paragraph (3) of subdivision (a).

(5) Transmitting an order of a physician and surgeon.

(e) “Drug order” or “order” for purposes of this section means an order for medication or for a drug or device that is dispensed to or for an ultimate user, issued by a certified nurse-midwife as an individual practitioner, within the meaning of Section 1306.03 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to “prescription” in this code and the Health and Safety Code shall include drug orders issued by certified nurse-midwives; and (3) the signature of a certified nurse-midwife on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.
(f) Notwithstanding any other law, a certified nurse-midwife may directly procure supplies and devices, obtain and administer diagnostic tests, directly obtain and administer nonscheduled drugs consistent with the provision of services that fall within the scope of services specified in subdivision (a) of Section 2746.5, order laboratory and diagnostic testing, and receive reports that are necessary to their practice as a certified nurse-midwife within their scope of practice, consistent with Section 2746.5.

SEC. 6. Section 2746.52 of the Business and Professions Code is amended to read:

2746.52. (a) Notwithstanding Section 2746.5, the certificate to practice nurse-midwifery authorizes the holder to perform and repair episiotomies, and to repair first-degree and second-degree lacerations of the perineum.

(b) A certified nurse-midwife performing and repairing first-degree and second-degree lacerations of the perineum shall do both of the following:

(1) Ensure that all complications are referred to a physician and surgeon immediately.

(2) Ensure immediate care of patients who are in need of care beyond the scope of practice of the certified nurse-midwife, or emergency care for times when a physician and surgeon is not on the premises.

SEC. 7. Section 2746.54 is added to the Business and Professions Code, to read:

2746.54. (a) A certified nurse-midwife shall disclose in oral and written form to a prospective patient as part of a patient care plan, and obtain informed consent for, all of the following:

(1) The patient is retaining a certified nurse-midwife and the certified nurse-midwife is not supervised by a physician and surgeon.

(2) The certified nurse-midwife’s current licensure status and license number.

(3) The practice settings in which the certified nurse-midwife practices.

(4) If the certified nurse-midwife does not have liability coverage for the practice of midwifery, the certified nurse-midwife shall disclose that fact.
(5) There are conditions that are outside of the scope of practice of a certified nurse-midwife that will result in a referral for a consultation from, or transfer of care to, a physician and surgeon.

(6) The specific arrangements for the referral of complications to a physician and surgeon for consultation. The certified nurse-midwife shall not be required to identify a specific physician and surgeon.

(7) The specific arrangements for the transfer of care during the prenatal period, hospital transfer during the intrapartum and postpartum periods, and access to appropriate emergency medical services for mother and baby if necessary, and recommendations for preregistration at a hospital that has obstetric emergency services and is most likely to receive the transfer.

(8) If, during the course of care, the patient is informed that the patient has or may have a condition indicating the need for a mandatory transfer, the certified nurse-midwife shall initiate the transfer.

(9) The availability of the text of laws regulating certified nurse-midwifery practices and the procedure for reporting complaints to the Board of Registered Nursing, which may be found on the Board of Registered Nursing’s internet website.

(10) Consultation with a physician and surgeon does not alone create a physician-patient relationship or any other relationship with the physician and surgeon. The certified nurse-midwife shall inform the patient that certified nurse-midwife is independently licensed and practicing midwifery and in that regard is solely responsible for the services the certified nurse-midwife provides.

(b) The disclosure and consent shall be signed by both the certified nurse-midwife and the patient and a copy of the disclosure and consent shall be placed in the patient’s medical record.

(c) The Nurse-Midwifery Advisory Committee, in consultation with the board, may recommend to the board the form for the written disclosure and informed consent statement required to be used by a certified nurse-midwife under this section.

(d) This section shall not apply when the intended site of birth is the hospital setting.

SEC. 8. Section 2746.55 is added to the Business and Professions Code, to read:

2746.55. To ensure consistent reporting of birth outcomes in all settings, consistent with the information currently reported by
hospitals to the Office of Statewide Health Planning and Development, a certified nurse-midwife shall report the outcome of a birth in an out-of-hospital setting.

2746.55. (a) Each certified nurse-midwife who provides labor and delivery services that occurs in an out-of-hospital setting, including facilitating transfer of labor and delivery services to a hospital setting, shall report patient-level data within 90 days of the birth to the State Department of Public Health. The final form of the data submission shall be specified by the board but shall represent patient-level data for all patients whose intended place of birth at the onset of labor was an out-of-hospital setting. The data shall include all of the following:

1. The certified nurse-midwife’s name.
2. The certified nurse-midwife’s license number.
3. The newborn’s date of birth.
4. The place of birth.
5. The county in which the place of birth is located.
6. The ZIP Code of the place of birth.
7. The date of birth of the parent giving birth.
8. The ZIP Code of the residence of the parent giving birth.
9. The county in which the residence of the parent giving birth is located.
10. The weight of the parent giving birth.
11. The height of the parent giving birth.
12. The Activity, Pulse, Grimestone, Appearance, and Respiration (APGAR) score.
13. The obstetric estimate of gestational age.
14. The total number of prior live births given by the parent giving birth.
15. The principal source of payment for delivery.
16. The birthweight of the newborn.
17. The method of delivery.
18. Any complications and procedures of pregnancy and concurrent illnesses.
19. Any complications and procedures of labor and delivery.
20. Any abnormal conditions and clinical procedures related to the newborn.
21. Presentation, defined by which anatomical part of the fetus is closest to the pelvic inlet of the birth canal at the time of delivery.

— 21 —
(22) Plurality, defined as the number of fetuses delivered live or dead at any time in the pregnancy.

(23) Whether the birth was both vaginal and given by a parent who has had a prior cesarian section.

(24) The intended place of birth at the onset of labor, including, but not limited to, home, freestanding birth center, hospital, clinic, doctor’s office, or other location.

(25) Whether there was a maternal death.

(26) Whether there was a fetal death.

(27) Whether there was a hospital transfer during the intrapartum or postpartum period, and, if there was a transfer, the following:
   (A) Whether the mother, the newborn or newborns, or a combination thereof was transferred.
   (B) The reason for the transfer.
   (C) The outcome of the transfer.
   (D) The name of the hospital to which the patient or patients were transferred.

(28) The name and title of the delivery provider.

(29) Any other information prescribed by the board in regulations.

(b) For those cases that involve a hospital transfer, the Office of Statewide Health Planning and Development shall coordinate the linkage of the data submitted by the nurse-midwife with the vital records data and patient discharge data that reflects the hospitalization so that additional data reflecting the outcome can be incorporated into the aggregated reports provided pursuant to subdivision (f).

(c) The State Department of Public Health shall maintain the confidentiality of the information submitted pursuant to this section, and shall not permit any law enforcement or regulatory agency to inspect or have copies made of the contents of any reports submitted pursuant to subdivision (a) for any purpose, including, but not limited to, investigations for licensing, certification, or regulatory purposes.

(d) The State Department of Public Health shall report to the board, by April 30, those licensees who have met the requirements of subdivision (a) for that year.

(e) The board shall send a written notice of noncompliance to each licensee who fails to meet the reporting requirement of
subdivision (a). The board shall not renew the certificate of a certified nurse-midwife who has failed to comply with subdivision (a) unless the certified nurse-midwife submits to the department the missing data.

(f) The State Department of Public Health shall report the aggregate information, including, but not limited to, birth outcomes of patients under the care of a certified nurse-midwife, collected pursuant to this section to the board by July 30 of each year. The board shall include this information in its annual report to the Legislature. The report shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 9. Section 102415 of the Health and Safety Code is amended to read:

102415. For live births that occur outside of a hospital or outside of a state-licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Section 1204, the physician in attendance at the birth or, in the absence of a physician, the professionally licensed midwife or the certified nurse-midwife in attendance at the birth or, in the absence of a physician or midwife, either one of the parents shall be responsible for entering the information on the certificate, securing the required signatures, and for registering the certificate with the local registrar.

SEC. 10. The Legislature finds and declares that Section 8 of this act, which adds Section 2746.55 of the Business and Professions Code, imposes a limitation on the public’s right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

This act is necessary to protect sensitive material from public disclosure.

SEC. 9.

SEC. 11. 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.