

PHYSICIAN ASSISTANT BOARD

2005 Evergreen Street, Suite 1100, Sacramento, CA 95815

Telephone: 916 561-8780 Fax: 916 263-2671 Website: www.pac.ca.gov



MEETING NOTICE

May 20, 2013

PHYSICIAN ASSISTANT BOARD
2005 Evergreen Street – Hearing Room #1150
Sacramento, CA 95815
9:00 A.M. – 3:00 P.M.

AGENDA

(Please see below for Webcast information)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1. Call to Order by President (Sachs)
2. Roll Call (Forsyth)
3. Approval of February 11, 2013, Meeting Minutes (Sachs)
4. Public Comment on Items not on the Agenda (Sachs)
5. Reports
 - a. President Report (Sachs)
 - b. Executive Officer Report (Mitchell)
 - c. Licensing Program Activity Report (Caldwell)
 - d. Diversion Program Activity Report (Mitchell)
 - e. Enforcement Program Activity Report (Tincher)
6. Department of Consumer Affairs
 - a. Director's Update (Reichel Everhart)
 - b. Executive Officer Performance Evaluation Process and Discussion (Sachs)
7. Nomination and Election of Physician Assistant Board Vice-President (Sachs)
8. Update on Current Budget and Presentation on the Budget Process (Tincher/Jennifer Espera, DCA Budget Office)
9. Presentation from the Department of Public Health on Fluoroscopy Permit Requirements for PAs (Phillip Scott)
10. **CLOSED SESSION:** Pursuant to Section 11126(c)(3) of the Government Code, the Board will move into closed session to deliberate on disciplinary matters

11. Discussion on Proposed Personal Presence Regulations (Freedman/Mitchell)
12. Discussion of Title 16, California Code of Regulations Section 1399.546 – Reporting of Physician Assistant Supervision as it Relates to New Electronic Medical Records Technology (Sachs)
13. Requests for Interviews of Board Members (Sachs)
14. Update on BreEZe Implementation (Mitchell)
15. Consideration of Establishing a Legislation Committee and Appointment of Committee Members (Sachs)
16. Consideration of Legislation of Interest to the Physician Assistant Board (Sachs) AB 154, AB 186, AB 1057, SB 305, SB 352, SB 491, SB 492, SB 493, SB 494, SB 809, other bills introduced or amended after publication of the agenda
17. Review of and Discussion of Updating the Board's Strategic Plan (Sachs)
18. Agenda Items for Next Meeting (Sachs)
19. Adjournment (Sachs)

Note: Agenda discussion and report items are subject to action being taken on them during the meeting by the Board at its discretion. All times when stated are approximate and subject to change without prior notice at the discretion of the Board. Agenda items may be taken out of order and total time allocated for public comment on particular issues may be limited.

While the Board intends to webcast this meeting, it may not be possible to webcast the meeting due to limitations on resources. The webcast can be located at www.dca.ca.gov. If you would like to ensure participation, please plan to attend at the physical location.

Notice: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Lynn Forsyth at (916) 561-8785 or email Lynn.Forsyth@mbc.ca.gov or send a written request to the Physician Assistant Board, 2005 Evergreen Street, Suite 1100, Sacramento, California 95815. Providing your request at least five (5) business days before the meeting will help to ensure availability of the request.



MEETING MINUTES

February 11, 2013

PHYSICIAN ASSISTANT BOARD
2005 Evergreen Street – Hearing Room #1150
Sacramento, CA 95815
9:00 A.M. – 3:00 P.M.

1. **Call to Order by President**

President Sachs called the meeting to order at 9:10 a.m.

2. **Roll Call**

Staff called the roll. A quorum was present.

Board Members Present: Robert Sachs, PA-C
Cristina Gomez-Vidal Diaz
Sonya Earley, PA
Jed Grant, PA -C
Catherine Hazelton
Rosalee Shorter, PA

Board Member Absent: Charles Alexander, Ph.D.

Staff Present: Glenn Mitchell, Executive Officer
Laura Freedman, Senior Staff Counsel, Dept.
of Consumer Affairs (DCA)
Lynn Forsyth, Staff Services Analyst

3. **Approval of December 10, 2012 Meeting Minutes**

The December 10, 2012 minutes were approved as drafted.
(m/Diaz, s/Earley, motion passes)

4. **Public Comment on Items not on the Agenda**

Bob Miller, PA, California Academy of Physician Assistants (CAPA) Professional
Training Chair, spoke briefly regarding the long-standing relationship between the

5. **Reports**

a. **President Report**

President Sachs thanked the Governor's Office for their efforts in appointing new members to the Board. President Sachs also thanked the new members for rearranging their schedules to attend the meeting.

President Sachs provided the new members with an overview of the Board. He also emphasized the primary function of the Board is consumer protection.

Ms. Diaz also provided a brief overview of the Board from the perspective of a public board member.

b. **Executive Officer Report**

Mr. Mitchell provided the members with an update on several new licensing requirements. Mr. Mitchell explained that AB 1588 allows the Board, under specific conditions, to waive certain renewal requirements for licensees who have been called to active duty military service.

Mr. Mitchell also discussed the implementation of AB 1904, which requires that Boards within the Department of Consumer Affairs, including the Physician Assistant Board, to expedite physician assistant applications for spouses of active duty military personnel.

Mr. Mitchell also reported that Governor Brown signed SB 1236 (Price) on September 14, 2012. The legislation adds physician assistants to 800-series reporting requirements. (Business and Professions Code sections 800, 801.01, 802.1, 802.5, 803, 803.1, 803.5, 803.6, and 805)

These changes became effective 1 January 2013.

These reporting requirements include mandatory malpractice reporting to the Board and apply to professional liability insurers, self-insured governmental agencies, physician assistants and/or their attorneys and employers. Reporting also includes peer review bodies, such as in hospitals to report specific disciplinary, restrictions, revoked privileges, suspensions. Physician assistant self-reporting of indictments and convictions is also included.

The Board's website will be updated to reflect this new requirement.

Mr. Mitchell reported that effective January 2013, all licensees must now report compliance with the Board's continuing medical education requirements when renewing their licenses. The Board's renewal notices have been updated to reflect this new reporting requirement.

Mr. Mitchell reported that Dianne Tincher is working with the Department of Consumer Affairs Internet Team to update the Board's website to reflect the

Mr. Mitchell also reported that the Office of Administrative Law approved the Board's rulemaking file regarding amendments to California Code of Regulations Title 16, Section 1399.536 – Requirements for Preceptors. Mr. Mitchell explained that this amendment allows a variety of licensed health care providers to provide training and experience to students who are attending physician assistant training programs. The regulatory change will become effective April 1, 2013.

c. Licensing Program Activity Report

Between October 1, 2012 and January 1, 2013, 157 physician assistant licenses were issued. As of January 1, 2013, 8,901 physician assistant licenses are renewed and current.

d. Diversion Program Activity Report

As of January 1, 2013, the Diversion Program has 18 participants, which includes 3 self-referred participants and 15 Board referrals, for a total of 107 participants since program implementation in 1990.

e. Enforcement Program Activity Report

Between July 1, 2012 and December 31, 2012, 146 complaints were received; 91 complaints are pending; 43 investigations are pending; 48 probationers, and 28 cases awaiting administrative adjudication at the Office of the Attorney General.

6. **Department of Consumer Affairs Director's Update**

Reichel Everhart, Deputy Director, Board Relations, Department of Consumer Affairs, reported that on March 3, 2013 the quarterly Bureau Chiefs and Executive Officer meeting will be conducted at the Department of Consumer Affairs headquarters.

Ms. Everhart also reported that the Department is also working on the Governor's state agency re-organization plan scheduled to go into effect July 1, 2013.

On behalf of the Director, Ms. Everhart also congratulated the new members on their appointments to the Board.

7. **Report from Educational Subcommittee**

7a. Report on Collection of Workplace Data

7b. Discussion of possible Physician Assistant Survey

Following a brief discussion and due to the lack of new information on this topic, this agenda item will be discussed at a future meeting.

8. **CLOSED SESSION:** Pursuant to Section 11126(c) (3) of the Government Code

RETURN TO OPEN SESSION

9. **Discussion and Consideration of Changes in Accreditation Requirements Affecting Two Year Programs**

Following a brief discussion and due to a lack of new information on this topic, this agenda item will be discussed at a future meeting.

10. **Discussion of PA/MD Education/Residency: Medical School Graduates Licensed as PAs**

It was discussed that due to the shortage of residency programs for new medical graduates, there was legislative interest in gathering information regarding possible legislation which would allow medical school graduates to obtain licensure as physician assistants based on their medical school education. This would enable them to work in the health care field until they complete their residency program and, ultimately, obtain their physician and surgeons license.

11. **Discussion on Proposed Personal Presence regulations**

Ms. Freeman provided the members with an overview and history of proposed personal presence regulations. Following a discussion it was determined that a meeting may be conducted in the future with representatives of the executive staff and legal counsel of the Medical Board of California to seek further clarification of this issue and arrive at acceptable language.

12. **NCCPA Exam Development and Scoring**

Mr. Mitchell explained that the National Commission on the Certification of Physician Assistants (NCCPA) has an established, scientifically based process for examination question development and scoring of the Physician Assistant National Certifying Examination (PANCE). The PANCE examination is currently used as the Board's licensing examination.

A brief overview was also provided on the procedures and costs involved in the creating a Board-developed and administered licensing examination.

13. **Update on Current Budget**

Mr. Mitchell provided the members with an update on the current Board budget. Following a discussion it was requested that representatives from the Department of Consumer Affairs Budget Office provide a presentation on the budget process at the next Board meeting.

14. **Fluoroscopy Permit Requirements for PAs: Proposed Department of Public Health Regulations: Status**

Mr. Mitchell provided a brief history of the fluoroscopy permit legislation and status of the Department of Public Health's proposed regulations.

California Academy of Physician Assistants sponsored AB 356 (Statutes of 2009, Chapter 434) which implemented provisions in the Health and Safety Code to permit physician assistants who meet certain standards of education, training, and experience to operate fluoroscopy equipment. The California Department of Public Health is proposing regulations to implement the provisions of AB 356. The regulatory package is still pending as of today's meeting.

The Board requested that a representative from the Department of Public Health provide a presentation on this issue at the next meeting.

15. **Update on BreEZe Implementation**

Mr. Mitchell provided the new members with a brief overview of the BreEZe project. Mr. Mitchell explained that BreEZe will replace two legacy computer systems that are based on older computer programming language. It is becoming difficult and expensive to find programmers who are proficient in these archaic computer languages to update the current systems. Mr. Mitchell also explained that user acceptance testing is in progress. Due to the amount of testing still required an implementation date has not yet been established.

16. **Discussion and Consideration of New Logos**

Mr. Mitchell briefly informed the members that the Department of Consumer Affairs working on additional sample logos for Board member review.

17. **Consideration of Legislation of Interest to the Physician Assistant Board**

AB 1588 (Chaptered)

AB 1904 (Chaptered)

The Board briefly discussed current legislation of interest. No Board positions were taken on the above-mentioned bills.

18. **Review of and Discussion of Updating the Board's Strategic Plan**

President Sachs provided the new Board members with a brief overview of the Board's current Strategic Plan and the process of possibly updating the plan.

Following a brief discussion, it was determined that this item will be discussed at a future Board meeting pending the revision of the Department of Consumer Affairs Strategic Plan.

19. **Schedule of 2013 Meeting Dates and Locations**

Following a brief discussion, it was agreed that the meeting dates and locations would remain as previously established. Future 2013 meeting dates include:

May 20, 2013 (Monday in Sacramento

August 26, 2013 (Monday) in Sacramento

20. **Agenda Items for Next Meeting**

- a. Educational Subcommittee
- b. Changes in Accreditation Requirements
- c. Budget Presentation
- d. Legislation

21. **Adjournment**

The meeting adjourned at 12:30 P.M.

PHYSICIAN ASSISTANT BOARD
LICENSING PROGRAM ACTIVITY REPORT

INITIAL LICENSES ISSUED

	1 January 2013 – 1 April 2013	1 January 2012 – 1 April 2012
Initial Licenses	130	173

SUMMARY OF RENEWED/CURRENT LICENSES

	As of 1 April 2013	As of 1 April 2012
Physician Assistant	8,961	8,520

**PHYSICIAN ASSISTANT BOARD
DIVERSION PROGRAM**

ACTIVITY REPORT

California licensed physician assistants participating in the Physician Assistant Board drug and alcohol diversion program:

	As of 1 April 2013	As of 1 April 2012	As of 1 April 2011
Voluntary referrals	02	06	05
Committee referrals	15	20	20
Total number of participants	17	26	25

HISTORICAL STATISTICS
(Since program inception: 1990)

Total intakes into program as of 1 April 2013.....	107
Closed Cases as of 1 April 2013	
• Participant expired.....	1
• Successful completion.....	32
• Dismissed for failure to receive benefit.....	4
• Dismissed for non-compliance.....	23
• Voluntary withdrawal.....	20
• Not eligible.....	8
Total closed cases.....	88

OTHER DCA BOARD DIVERSION PROGRAM PARTICIPANTS
(As of 1 April 2013)

Dental Board of California.....	34
Osteopathic Medical Board of California.....	11

**PHYSICIAN ASSISTANT BOARD
ENFORCEMENT ACTIVITY REPORT**

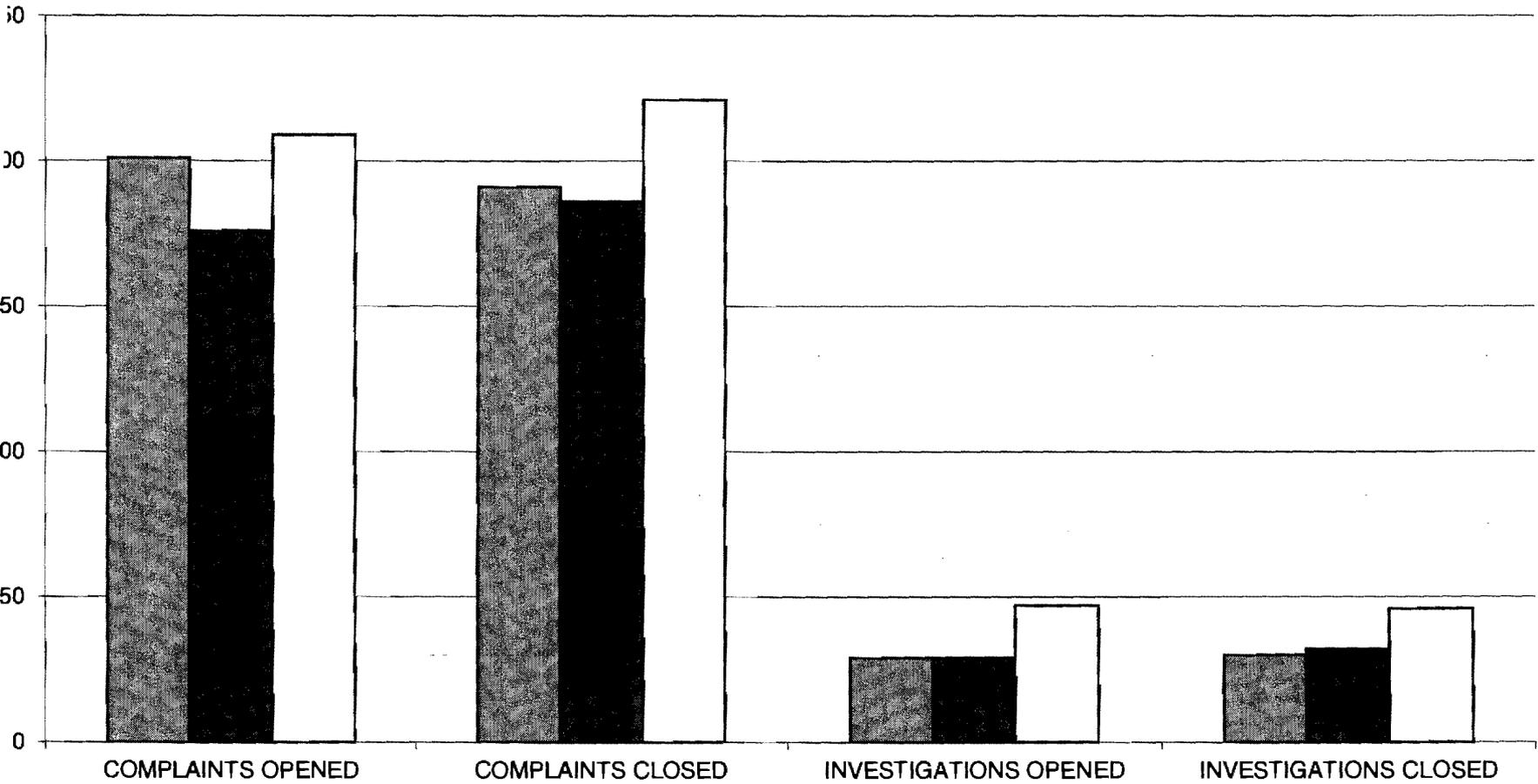
July 1 through March 31, 2013

Submitted by: Dianne Tincher

<u>Complaint Statistics</u>		<u>Disciplinary Decisions</u>	
Pending From Previous FY	108	License Denied	0
Received	209	Nonadopted	2
Closed	221	Probation	6
Pending	96	Public Reprimand/Reproval	2
At Expert Consultant	10	Revocation	3
<u>Violation Category of Complaints Received</u>		Voluntary Surrender	2
Substance Abuse	2	Probationary Licenses	3
Drug Related	13	Petition for Reinstatement Denied	0
Fraud	2	Petition for Reinstatement Granted	0
Non Jurisdictional	37	Petition for Termination of Probation Denied	0
Incompetence/Negligence	83	Petition for Termination of Probation Granted	0
Other	1	Other	0
Unprofessional Conduct	30	Out for Vote	4
Sexual Misconduct	2	<u>Accusation/Statement of Issues</u>	
Discipline by Another State	3	Accusation Filed	16
Unlicensed	8	Accusation Withdrawn	0
Criminal	28	Statement of Issues Filed	2
<u>Investigations</u>		Statement of Issues Withdrawn	0
Pending from Previous FY	40	Petition to Revoke Probation Filed	1
Opened	47	Petition to Compel Psychiatric Exam	0
Closed	46	Interim Suspension Orders (ISO)/PC23	3
Pending	41	<u>Pending Cases</u>	
<u>Disposition of Closed Complaint</u>		Attorney General	25
Closed with merit	107	<u>Citation and Fines</u>	
Closed/Insufficient Evidence	114	Pending from previous FY	0
<u>Criminal Complaint</u>		Issued	5
Referred to District Attorney	0	Closed	3
<u>Current Probationers</u>		Withdrawn	0
Active	43	Sent to AG/noncompliance	0
Tolled	13	Pending	2
Cost Recovery Ordered	\$28,816	Initial Fines Issued	\$4350
Cost Recovery Received	\$37,441	Modified Amount Due	\$0
		Fines Received	\$3000

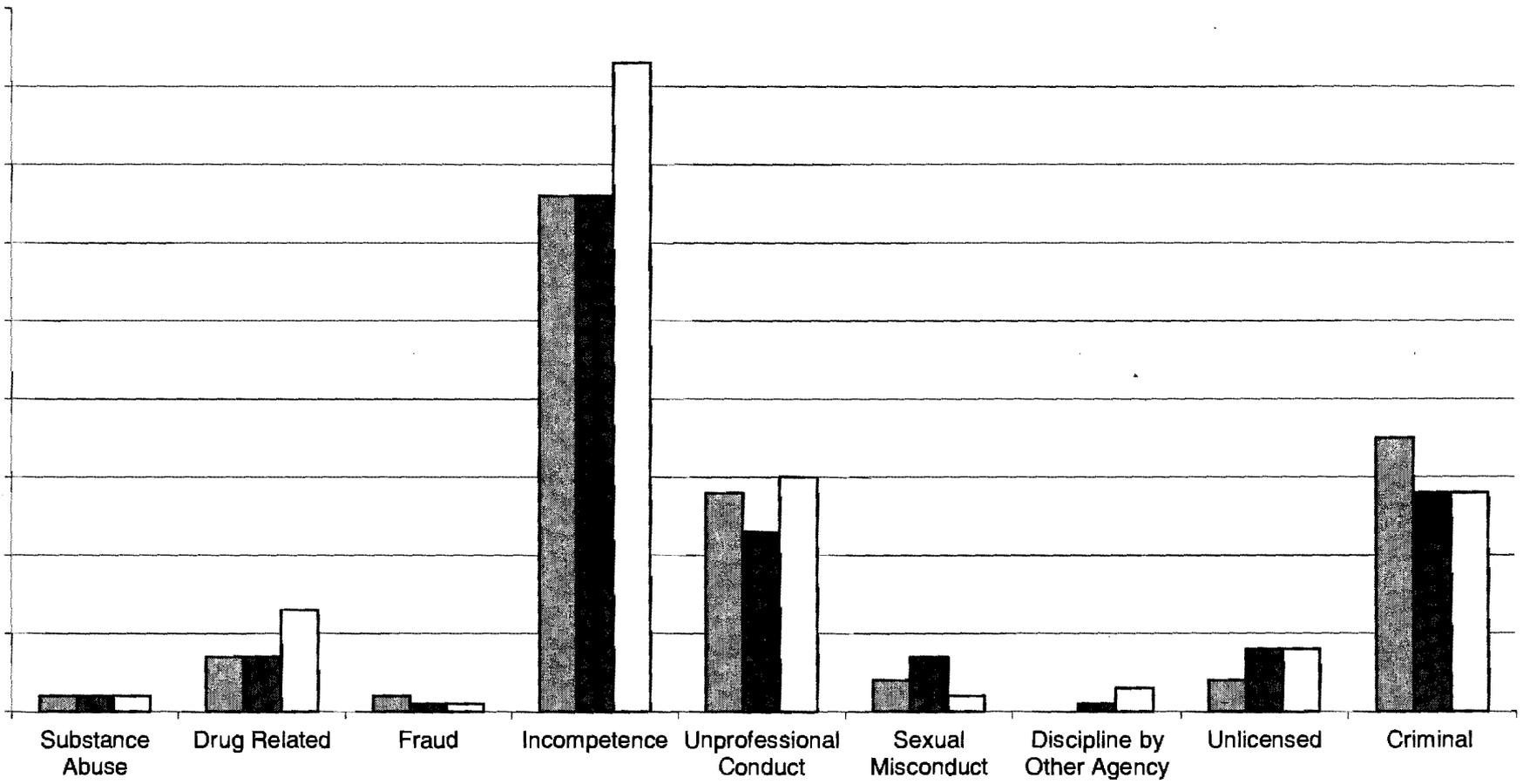
PHYSICIAN ASSISTANT BOARD COMPLAINTS AND INVESTIGATION JULY 1 THROUGH MARCH 31

■ FY 10/11 ■ FY 11/12 □ FY 11/13



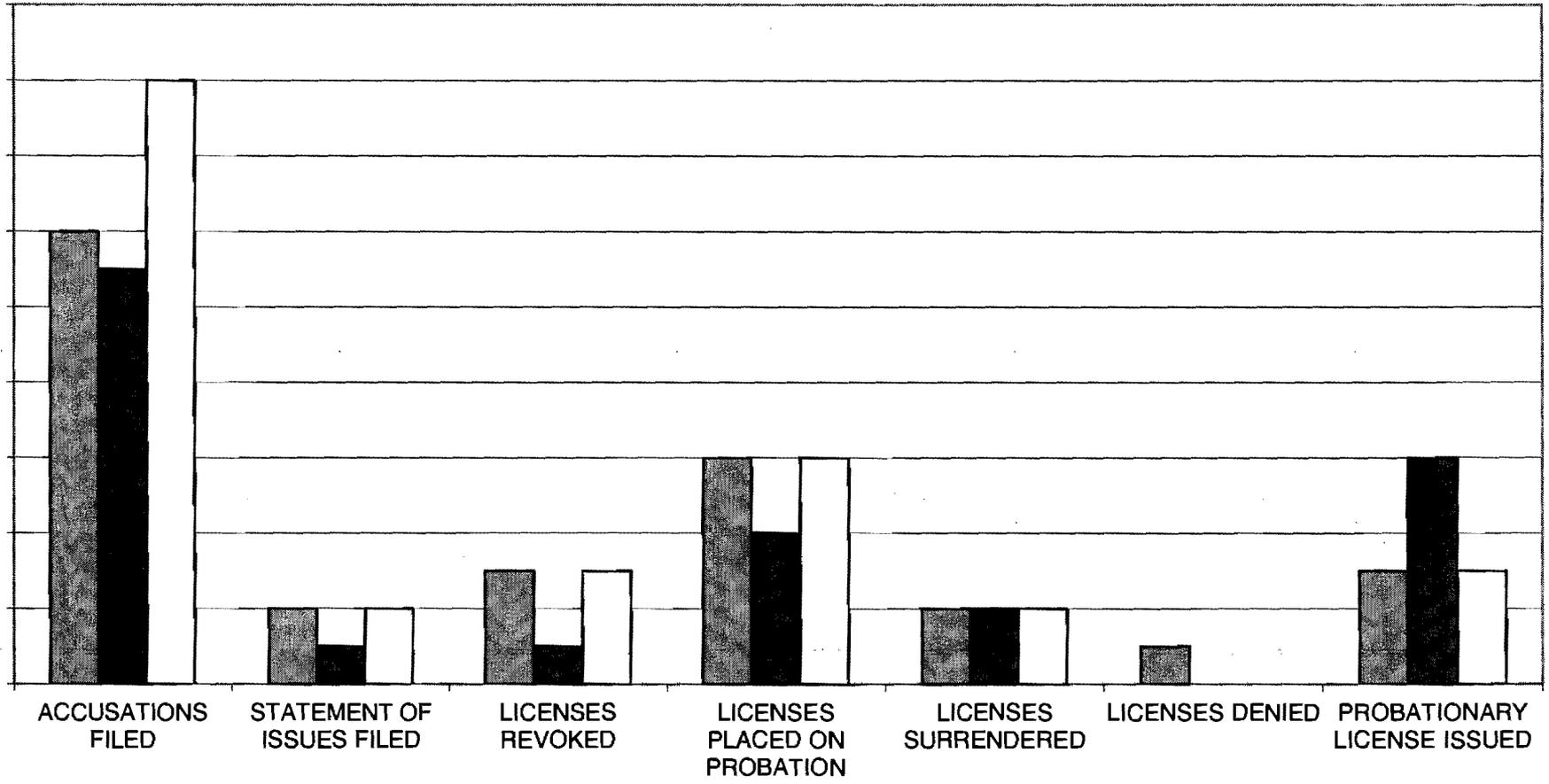
**PHYSICIAN ASSISTANT BOARD
CATEGORY OF COMPLAINTS RECEIVED
JULY 1 THROUGH MARCH 31**

■ FY 10/11 ■ FY 11/12 □ FY 12/13



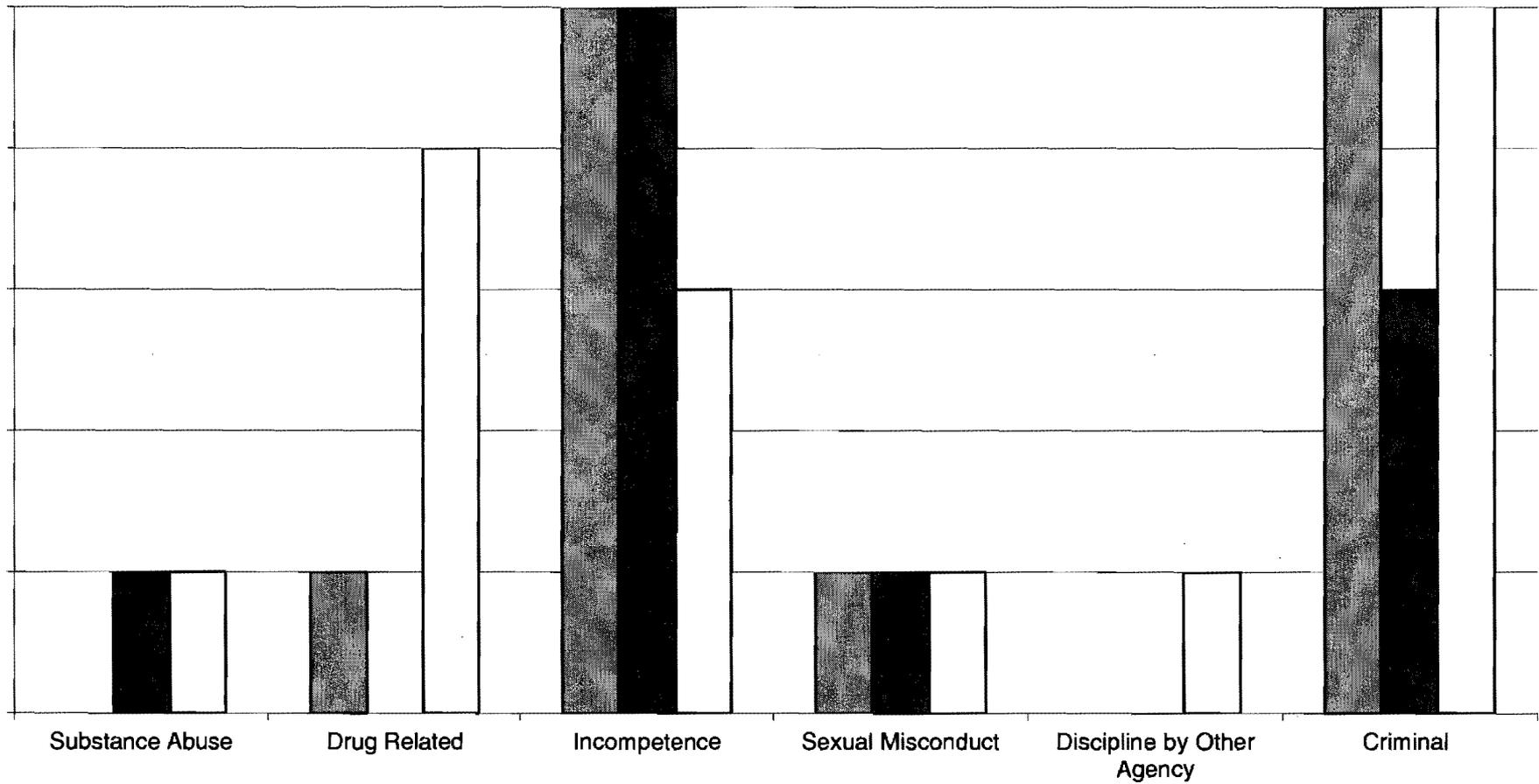
**PHYSICIAN ASSISTANT BOARD
DISCIPLINARY ACTIONS
JULY 1 THROUGH MARCH 31**

■ FY 10/11 ■ FY 11/12 □ FY 12/13



**PHYSICIAN ASSISTANT BOARD
CATEGORY OF ACCUSATIONS FILED
JULY 1 THROUGH MARCH 31**

■ FY 10/11 ■ FY 11/12 □ FY 12/13



**Physician Assistant Board
Cost Recovery
As of March 31, 2013**

<u>Cost Recovery</u>	<u>Amount</u>	<u># of Licensee</u>
Ordered over last 5 years	\$ 429,071	54
Received over last 5 years	\$ 145,616	45
Outstanding balance (Current Probationers)	\$ 106,788	22
Uncollectable amount*	\$ 250,207	21

*The uncollectable amount is from licensees that surrendered the license, were revoked, and/or sent to FTB over the last 5 years. The cost recovery would be required to be paid in full if they apply for reinstatement of the license.

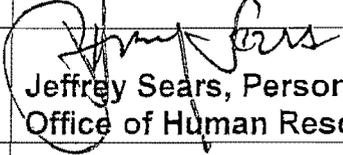
**Physician Assistant Board
Cost Recovery
As of March 31, 2013**

<u>Cost Recovery</u>	<u>Amount</u>	<u># of Licensee</u>
Ordered over last 5 years	\$ 429,071	54
Received over last 5 years	\$ 145,616	45
Outstanding balance (Current Probationers)	\$ 106,788	22
Uncollectable amount*	\$ 250,207	21

*The uncollectable amount is from licensees that surrendered the license, were revoked, and/or sent to FTB over the last 5 years. The cost recovery would be required to be paid in full if they apply for reinstatement of the license.



MEMORANDUM

DATE	February 14, 2013
TO	Executive Officers
FROM	 Jeffrey Sears, Personnel Officer Office of Human Resources
SUBJECT	EXECUTIVE OFFICER PERFORMANCE EVALUATIONS

The Department of Consumer Affairs (DCA), Office of Administrative Services (OAS), reviewed the current Executive Officer (EO) Performance Evaluation Form, which is used by Boards to conduct their annual evaluation of their EO.

In order to meet Bagley-Keene Open Meeting Act requirements, the previous Executive Officer Performance Evaluation process developed by the DCA Office of Human Resources (OHR) is revised herein. The **Executive Officer Performance Evaluation Form** is attached to this revision, and will also be available on the DCA Intranet.

EO Evaluation Procedures:

A Board evaluating its Executive Officer should use the following procedures:

1. Annually, each Board should provide the EO with a written evaluation of his or her performance. The Board President/Chairperson should contact the DCA OHR to obtain a copy of the **Executive Officer Performance Evaluation Form**.
2. The Board President/Chairperson may request Board staff or OHR send out the **Executive Officer Performance Evaluation Form** to each Board Member to obtain an evaluation of the EO's performance.
3. Board Members should complete the **Executive Officer Performance Evaluation Form**, rating and commenting on the EO's performance in each category the Board Member can evaluate.
4. The Board President/Chairperson can collate all Board Member ratings and comments for discussion. In order not to violate the Open Meeting Act, the Board must discuss the EO ratings and the evaluation only during a properly

EXECUTIVE OFFICER PERFORMANCE EVALUATIONS
February 15, 2013

Evaluations are usually discussed in a closed session under Government Code section 11126(a). Your assigned counsel may assist you during this process, if desired.

5. After the Board determines the contents of the final **EO Performance Evaluation Form** and any outcome, **it should determine who will** meet with the EO to discuss his/her performance, which must also be in compliance with the Open Meeting Act. When the EO's performance meets or exceeds the expectations of the Board, the Board may authorize a salary increase not to exceed 5%, and, which may not exceed the maximum of the salary range for the exempt level assigned to the EO for that Board. Any increase is reported on the **EO Performance Evaluation Form**. [Note: as of the publication of this memo, the Governor has frozen compensation increases for all exempt employees. Board approved increases will be held in abeyance until this freeze is lifted.]
6. The original **EO Performance Evaluation Form**, signed by both the Board President/Chairperson and the EO, is forwarded to the OHR to be filed in the EO's Official Personnel File. The EO must also receive a final signed copy of the Evaluation.
7. Reporting Board Action at Next Board Meeting. The Open Meeting Act requires that after a closed session where there was an action taken to appoint, employ, or dismiss a public employee, the Board must, during open session at a subsequent public meeting, report that action and the roll call vote, if any was taken. If a Board meeting was held via teleconference, a roll call vote is required, and it will therefore be reported.

DCA recommends this memo be placed on the agenda for the next Board Meeting, and annually thereafter, to ensure all Board Members are aware of the EO Evaluation Process and to provide the Board an opportunity to discuss the process.

If you have any questions regarding this process, please contact your assigned Classification and Pay Analyst at (916) 574-8300.

cc: Denise Brown, Director
Awet Kidane, Chief Deputy Director
Sandra Mayorga, Deputy Director, Office of Administrative Services
Reichel Everhart, Deputy Director, Board/Bureau Relations
Doreathea Johnson, Deputy Director, Legal Affairs
All Board Presidents/Chairpersons

STATE OF CALIFORNIA



DEPARTMENT OF CONSUMER AFFAIRS

PERFORMANCE APPRAISAL

FOR

EXECUTIVE OFFICER

Prepared by
Department of Consumer Affairs
Office of Human Resources
1625 N. Market Blvd. Suite N-321
Sacramento, CA 95834



Executive Officer
PERFORMANCE APPRAISAL

BOARD OF _____

Name of EO: _____ Date of Report: _____

INSTRUCTIONS

1. The Performance Appraisal process system is based on the principle that performance should be evaluated on a regular basis in order to provide recognition of effective performance and as a tool to provide guidance in improving future performance.
2. The Performance Appraisal may also be used relative to salary issues. For example, if the Executive Officer is not at the maximum range of salary, the Board may empowered grant a salary increase for the Executive Officer. To qualify for such increases, the Executive Officer must meet or exceed performance expectations, as determined by the Board. This form can thus also document the Board's recommendation to grant or deny a salary increase. [Note: As of 2012, the Governor has frozen all salary increases for exempt employees, including Executive Officers. This may be subject to change in the future.]
3. To indicate the rating of any performance factor, an "X" mark should be placed in the appropriate rating column and in the "Overall Rating" column on each page. Additional spaces have been provided to accommodate other critical performance factors identified by the Board.
4. Comments to the Executive Officer should:
 - include factual examples of work especially well or poorly done, and
 - give suggestions as to how performance can be improved.
5. The Overall Ratings must be consistent with the factor ratings and comments, but there is no prescribed formula for computing the overall rating.
6. Overall Comments may consist of a summary of comments from specific categories, general comments or comments on other job-related factors which the rater wishes to discuss. Additional pages may be attached.
7. The Board President/Chairperson will discuss the appraisal with the Executive Officer and give him or her a copy. In signing the appraisal, the Executive Officer merely acknowledges that s/he has seen the appraisal and has discussed it with the rater. His/her signature does not indicate agreement with the ratings or comments.
8. The original copy of the appraisal will be maintained by the Department of Consumer Affairs, in the Executive Officer's Official Personnel File.



EXECUTIVE OFFICER PERFORMANCE APPRAISAL RATING SYSTEM

The rating system consists of five (5) Ratings Categories, as defined below:

Outstanding

Performance significantly exceeds the Board's expectations due to the efforts and ability of the employee when considering the job in its entirety. Significantly above-standard performance may be exhibited by consistently completing assignments in advance of deadlines; implementing plans and/or procedures to increase efficiency or effectiveness of work; working independently with little direction; and consistently meeting Board goals.

Above Average

Performance exceeds the Board's expectations due to the efforts and ability of the Executive Officer when considering the job in its entirety. Performance is beyond what is expected of an Executive Officer in this position.

Average

Performance of the Executive Officer meets the minimum expectations of the Board. The Executive Officer adequately performs the duties and responsibilities of the position.

Needs Improvement

The Executive Officer's performance fails to meet the Board's minimum expectations due to lack of effort and/or ability when considering the job in its entirety. Performance requires improvement in numerous and/or important aspects of the position.

Not Applicable

Rater is unable to assess the Executive Officer in this area, or the area is not applicable to the employee's job.

**Executive Officer
PERFORMANCE APPRAISAL**

OVERALL RATING for

NAME: _____

BOARD OF _____

The overall rating must be consistent with the factor rating and comments, but there is no prescribed formula for computing the overall rating. The rating system is described on page 2.

- OUTSTANDING**
- ABOVE AVERAGE**
- AVERAGE**
- NEEDS IMPROVEMENT**

OVERALL COMMENTS *(Attach additional pages, if necessary)*

I HAVE PARTICIPATED IN A DISCUSSION OF OVERALL JOB PERFORMANCE

Signature of Employee: _____

Date: _____

Signature of Rater: _____

Date: _____

Title: _____

Salary Increase recommendation (if applicable):



Executive Officer
PERFORMANCE APPRAISAL

Performance Factor		Ratings				
1. Relationship with the Board		Outstanding	Above Average	Average	Needs Improvement	Not Applicable
1	Maintains respect and trust of Board members.					
2	Provides Board with advice during consideration of issues.					
3	Keeps Board informed of progress of Board programs on a regular basis.					
4	Remains impartial and treats all Board members in a professional manner.					
5	Functions as effective liaison between Board and Board Staff.					
6	Provides Board with complete, clear, and accurate reports, minutes, etc.					
7	Responds promptly to requests for information.					
8	Is readily available to Board members.					
9	Responds to constructive suggestions or criticism.					
OVERALL RATING: Relationship with the Board						

Comments: (Attach additional pages, if necessary)



Executive Officer
PERFORMANCE APPRAISAL

Performance Factor		Ratings				
3. Board Programs		Outstanding	Above Average	Average	Needs Improvement	Not Applicable
1	Ensures effective and efficient management of enforcement programs.					
2	Keeps Board apprised of enforcement program and process developments.					
3	Maintains security of examination process.					
4	Monitors validity/defensibility of examinations and provides appropriate recommendations for action.					
5	Monitors and identifies trends in candidate qualifications, pass/fail rates, etc.					
6	Resolves problems which arise in the exam process.					
7	Keeps Board apprised of exam program and process developments.					
8	Keeps Board apprised of licensing program and process developments.					
OVERALL RATING: Board Programs						

Comments: (Attach additional pages, if necessary)



**Executive Officer
PERFORMANCE APPRAISAL**

Performance Factor		Ratings				
4. Governmental Relations		Outstanding	Above Average	Average	Needs Improvement	Not Applicable
1	Keeps the Department of Consumer Affairs informed of Board issues, problems, and accomplishments.					
2	Maintains a positive working relationship with other State Agencies.					
3	Manages Board legislative program and efforts.					
4	Manages sunset review process.					
5	Acts a liaison and participates in national organizations, federations or alliances.					
6	Represents the Board before the Legislature.					
	OVERALL RATING: Governmental Relations					

Comments: (Attach additional pages, if necessary)



Executive Officer
PERFORMANCE APPRAISAL

Performance Factor		Ratings				
5. Administrative Functions		Outstanding	Above Average	Average	Needs Improvement	Not Applicable
1	Plans, organizes and directs Board administrative functions and staff.					
2	Provides oversight, direction and management of the Board's annual budget, expenditures and revenues.					
3	Keeps Board apprised of budget developments.					
4	Identifies, recommends and, as directed, seeks necessary changes to laws and regulations through proposed legislation and/or the OAL.					
5	Ensures compliance and enforcement of departmental, state and federal policies and procedures.					
6	Develops and executes sound personnel practices and procedures.					
OVERALL RATING: Administrative Functions						

Comments: (Attach additional pages, if necessary)



**Executive Officer
PERFORMANCE APPRAISAL**

Performance Factor		Ratings				
6. Public Liaison		Outstanding	Above Average	Average	Needs Improvement	Not Applicable
1	Represents the Board before the public					
2	Directs consumer outreach programs.					
3	Manages Board's public relations effort.					
4	Directs liaison with educational institutions.					
5	Solicits and gives attention to problems and opinions of all groups and individuals.					
6	Represents the Board before industry associations to provide information regarding the Board's laws, regulations, programs and policies.					
OVERALL RATING: Public Liaison						

Comments: (Attach additional pages, if necessary)

**PHYSICIAN ASSISTANT BOARD - FUND 0280
BUDGET REPORT
FY 2012-13 EXPENDITURE PROJECTION**

March 31, 2013

OBJECT DESCRIPTION	FY 2011-12		FY 2012-13				
	ACTUAL EXPENDITURES (MONTH 13)	PRIOR YEAR EXPENDITURES 3/31/2012	BUDGET STONE 2012-13	CURRENT YEAR EXPENDITURES 3/31/2013	PERCENT SPENT	PROJECTIONS TO YEAR END	UNENCUMBERED BALANCE
PERSONNEL SERVICES							
Civil Service-Perm	178,909	133,483	186,848	112,129	59%	173,309	15,539
Statutory Exempt (EO)	80,473	60,040	81,732	110,059	135%	131,616	(49,884)
Temp Help - Expert Examiner (903)		0		0			0
Temp Help Reg (907)	34,855	20,084		31,665		46,306	(46,306)
Bd / Commsn (901, 920)		0		0			0
Comm Member (911)	2,800	2,100	1,530	1,600	105%	3,000	(1,470)
Overtime		0		2,477		3,500	(3,500)
Staff Benefits	101,204	74,392	114,098	78,673	69%	121,599	(7,501)
Salary Savings		0		0		0	0
TOTALS, PERSONNEL SVC	398,241	290,099	386,208	336,603	87%	479,330	(93,122)
OPERATING EXPENSE AND EQUIPMENT							
General Expense	6,389	2,275	14,030	12,066	86%	18,000	(3,970)
Fingerprint Reports	10,038	6,222	24,890	7,546	30%	12,400	12,490
Minor Equipment	721	0	5,350	1,723	32%	2,024	3,326
Printing	11,774	10,459	3,442	1,760	51%	11,800	(8,358)
Communication	7,944	4,225	7,838	1,855	24%	8,000	(162)
Postage	6,168	4,862	8,281	5,101	62%	7,652	630
Insurance		0	0	0		0	0
Travel In State	11,405	7,767	28,299	6,195	22%	11,500	16,799
Travel, Out-of-State		0	0	0		0	0
Training	50	50	1,096	0	0%	100	996
Facilities Operations	43,585	32,556	55,958	37,721	67%	44,564	11,394
Utilities		0	0	0			0
C & P Services - Interdept.	0	8,135	1,899	0	0%	0	1,899
C & P Services - External	76,180	76,180	45,129	110,518	245%	112,000	(66,871)
DEPARTMENTAL SERVICES:							
OIS Pro Rata	53,692	38,798	72,509	54,143	75%	72,509	0
Indirect Distributed Cost	39,994	30,165	38,631	28,973	75%	38,631	0
Interagency Services	0	0	7,717	0	0%	30,360	(22,643)
Shared Svcs - MBC Only	79,802	79,802	79,802	111,054	139%	111,054	(31,252)
DOI - Pro Rata	1,345	1,241	1,570	1,178	75%	1,570	0
Public Affairs Pro Rata	2,688	2,107	2,202	1,652	75%	2,202	0
CCED Pro Rata	2,802	2,176	2,763	2,072	75%	2,763	0
INTERAGENCY SERVICES:							
Consolidated Data Center	2,294	1,865	4,810	1,313	27%	2,300	2,510
DP Maintenance & Supply	1,455	60	3,086	160	5%	1,500	1,586
Statewide - Pro Rata	56,134	42,101	68,655	51,491	75%	68,655	0
EXAMS EXPENSES:							
Exam Supplies			0	0		0	0
OTHER ITEMS OF EXPENSE:							
ENFORCEMENT:							
Attorney General	199,376	125,444	271,418	157,119	58%	230,000	41,418
Office Admin. Hearings	48,386	33,564	75,251	34,852	46%	50,000	25,251
Court Reporters	2,390	960		873		2,500	(2,500)
Evidence/Witness Fees	15,901	9,939	492	19,188	3900%	24,000	(23,508)
Investigative Svcs - MBC Only	92,468	55,512	250,122	60,663	24%	93,000	157,122
Vehicle Operations		0		0			0
Major Equipment		0		0			0
TOTALS, OE&E	772,981	576,465	1,075,240	709,216	66%	959,084	116,157
TOTAL EXPENSE	1,171,222	866,564	1,461,448	1,045,819	153%	1,438,413	23,035
Sched. Reimb. - Fingerprints	(9,928)	(7,038)	(25,000)	(7,793)	31%	(25,000)	0
Sched. Reimb. - Other	(22,946)	(20,050)	(25,000)	(29,172)	117%	(25,000)	0
Unsched. Reimb. - ICR	(52,707)	(26,033)		(35,284)			0
NET APPROPRIATION	1,085,641	813,443	1,411,448	973,570	69%	1,388,413	23,035
SURPLUS/(DEFICIT):							1.6%

FM 09

MAN ASSISTANT COMMITTEE

DESCRIPTION		BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
PERSONAL SERVICES								
SALARIES AND WAGES								
003 00	CIVIL SERVICE-PERM	188,848	9,342	112,129	0	112,129	76,719	
033 04	TEMP HELP (907)	0	3,476	31,665	0	31,665	(31,665)	
063 00	STATUTORY-EXEMPT	81,732	6,006	110,059	0	110,059	(28,327)	
063 03	COMM MEMBER (911)	1,530	0	1,600	0	1,600	(70)	
083 00	OVERTIME	0	0	2,477	0	2,477	(2,477)	
TOTAL	SALARIES AND WAGES	272,110	18,823	257,929	0	257,929	14,181	5.21%
STAFF BENEFITS								
103 00	OASDI	15,411	1,035	14,386	0	14,386	1,025	
104 00	DENTAL INSURANCE	1,758	90	1,053	0	1,053	705	
105 00	HEALTH/WELFARE INS	38,664	995	11,291	0	11,291	27,374	
106 01	RETIREMENT	53,275	3,466	37,389	0	37,389	15,886	
125 00	WORKERS' COMPENSAT	4,472	0	0	0	0	4,472	
125 15	SCIF ALLOCATION CO	0	120	1,177	0	1,177	(1,177)	
134 00	OTHER-STAFF BENEFI	0	730	9,270	0	9,270	(9,270)	
134 01	TRANSIT DISCOUNT	0	0	65	0	65	(65)	
135 00	LIFE INSURANCE	0	7	62	0	62	(62)	
136 00	VISION CARE	445	26	285	0	285	160	
137 00	MEDICARE TAXATION	73	270	3,695	0	3,695	(3,622)	
TOTAL	STAFF BENEFITS	114,098	6,738	78,673	0	78,673	35,425	31.05%
TOTAL	PERSONAL SERVICES	386,208	25,561	336,602	0	336,602	49,606	12.84%
OPERATING EXPENSES & EQUIPMENT								
FINGERPRINTS								
213 04	FINGERPRINT REPORT	24,890	1,519	7,546	0	7,546	17,344	
TOTAL	FINGERPRINTS	24,890	1,519	7,546	0	7,546	17,344	69.68%
GENERAL EXPENSE								
201 00	GENERAL EXPENSE	14,030	0	0	0	0	14,030	
206 00	MISC OFFICE SUPPLI	0	458	1,583	0	1,583	(1,583)	
207 00	FREIGHT & DRAYAGE	0	163	1,130	0	1,130	(1,130)	
213 02	ADMIN OVERHEAD-OTH	0	33	1,134	0	1,134	(1,134)	
217 00	MTG/CONF/EXHIBIT/S	0	752	3,782	4,437	8,219	(8,219)	
TOTAL	GENERAL EXPENSE	14,030	1,405	7,629	4,437	12,066	1,964	14.00%

FM 09

AN ASSISTANT COMMITTEE

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
PRINTING								
241 00	PRINTING	3,442	0	0	0	0	3,442	
242 02	REPRODUCTION SVS	0	0	15	0	15	(15)	
242 04	EDD PRODUCTIONS	0	0	399	0	399	(399)	
244 00	OFFICE COPIER EXP	0	0	308	1,012	1,320	(1,320)	
245 00	PRINTED FORM/STATN	0	26	26	0	26	(26)	
TOTAL	PRINTING	3,442	26	748	1,012	1,760	1,682	48.87%
COMMUNICATIONS								
251 00	COMMUNICATIONS	7,838	0	0	0	0	7,838	
252 00	CELL PHONES,PDA,PA	0	68	537	0	537	(537)	
254 00	FAX	0	0	4	0	4	(4)	
257 01	TELEPHONE EXCHANGE	0	153	1,315	0	1,315	(1,315)	
TOTAL	COMMUNICATIONS	7,838	221	1,855	0	1,855	5,983	76.33%
POSTAGE								
261 00	POSTAGE	8,281	0	0	0	0	8,281	
262 00	STAMPS, STAMP ENVE	0	0	1,253	0	1,253	(1,253)	
263 05	DCA POSTAGE ALLO	0	565	2,355	0	2,355	(2,355)	
263 06	EDD POSTAGE ALLO	0	173	1,493	0	1,493	(1,493)	
TOTAL	POSTAGE	8,281	737	5,101	0	5,101	3,180	38.41%
TRAVEL: IN-STATE								
291 00	TRAVEL: IN-STATE	28,299	0	0	0	0	28,299	
292 00	PER DIEM-I/S	0	629	1,690	0	1,690	(1,690)	
294 00	COMMERCIAL AIR-I/S	0	0	2,433	0	2,433	(2,433)	
296 00	PRIVATE CAR-I/S	0	217	1,108	0	1,108	(1,108)	
297 00	RENTAL CAR-I/S	0	109	964	0	964	(964)	
TOTAL	TRAVEL: IN-STATE	28,299	954	6,195	0	6,195	22,104	78.11%
TRAINING								
331 00	TRAINING	1,096	0	0	0	0	1,096	
TOTAL	TRAINING	1,096	0	0	0	0	1,096	100.00%
FACILITIES OPERATIONS								
341 00	FACILITIES OPERATI	55,958	0	0	0	0	55,958	
343 00	RENT-BLDG/GRND(NON	0	3,714	33,328	3,573	36,901	(36,901)	
346 00	RECURRING MAINT SV	0	272	272	0	272	(272)	
347 00	FACILITY PLNG-DGS	0	69	548	0	548	(548)	
TOTAL	FACILITIES OPERATIONS	55,958	4,054	34,147	3,573	37,721	18,237	32.59%

FM 09

MAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
C/P SVS - INTERDEPARTMENTAL							
382 00 CONSULT/PROF-INTER	1,899	0	0	0	0	1,899	
TOTAL C/P SVS - INTERDEPARTMENTAL	1,899	0	0	0	0	1,899	100.00%
C/P SVS - EXTERNAL							
402 00 CONSULT/PROF SERV-	28,561	0	0	0	0	28,561	
404 05 C&P EXT ADMIN CR C	16,568	0	4	20,996	21,000	(4,432)	
409 00 INFO TECHNOLOGY-EX	0	0	352	0	352	(352)	
418 02 CONS/PROF SVS-EXTR	0	0	20,845	68,321	89,166	(89,166)	
TOTAL C/P SVS - EXTERNAL	45,129	0	21,200	89,318	110,518	(65,389)	-144.89%
DEPARTMENTAL SERVICES							
424 03 OIS PRO RATA	72,509	0	54,143	0	54,143	18,366	
427 00 INDIRECT DISTRB CO	38,631	0	28,973	0	28,973	9,658	
427 01 INTERAGENCY SERVS	7,717	0	0	0	0	7,717	
427 02 SHARED SVS-MBC ONL	79,802	27,764	83,290	27,764	111,054	(31,252)	
427 30 DOI - PRO RATA	1,570	0	1,178	0	1,178	392	
427 34 PUBLIC AFFAIRS PRO	2,202	0	1,652	0	1,652	550	
427 35 CCED PRO RATA	2,763	0	2,072	0	2,072	691	
TOTAL DEPARTMENTAL SERVICES	205,194	27,764	171,308	27,764	199,072	6,122	2.98%
CONSOLIDATED DATA CENTERS							
428 00 CONSOLIDATED DATA	4,810	12	1,313	0	1,313	3,497	
TOTAL CONSOLIDATED DATA CENTERS	4,810	12	1,313	0	1,313	3,497	72.70%
DATA PROCESSING							
431 00 INFORMATION TECHNO	3,086	0	0	0	0	3,086	
435 00 NOC-SERV-IT (SECUR	0	0	0	92	92	(92)	
436 00 SUPPLIES-IT (PAPER	0	0	68	0	68	(68)	
TOTAL DATA PROCESSING	3,086	0	68	92	160	2,926	94.82%
CENTRAL ADMINISTRATIVE SERVICES							
438 00 PRO RATA	68,655	0	51,491	0	51,491	17,164	
TOTAL CENTRAL ADMINISTRATIVE SERVICES	68,655	0	51,491	0	51,491	17,164	25.00%
ENFORCEMENT							
396 00 ATTORNEY GENL-INTE	271,418	26,850	144,156	0	144,156	127,262	
397 00 OFC ADMIN HEARNG-I	75,251	678	34,852	0	34,852	40,399	
414 31 EVIDENCE/WITNESS F	492	0	19,188	0	19,188	(18,696)	
418 97 COURT REPORTER SER	0	0	873	0	873	(873)	

FM 09

PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
427 32 INVEST SVS-MBC ONL	250,122	0	60,663	0	60,663	189,459	
<u>TOTAL</u> ENFORCEMENT	597,283	27,528	259,732	0	259,732	337,551	56.51%
MINOR EQUIPMENT							
226 00 MINOR EQUIPMENT	5,350	0	0	0	0	5,350	
226 45 MIN EQPMT-DP-REPL	0	0	1,723	0	1,723	(1,723)	
<u>TOTAL</u> MINOR EQUIPMENT	5,350	0	1,723	0	1,723	3,627	67.79%
<u>TOTAL</u> OPERATING EXPENSES & EQUIPMENTS	1,075,240	64,220	570,056	126,196	696,252	378,988	35.25%
<hr/>							
PHYSICIAN ASSISTANT COMMITTEE	1,461,448	89,781	906,659	126,196	1,032,854	428,594	29.33%
<hr/>							
	1,461,448	89,781	906,659	126,196	1,032,854	428,594	29.33%
<hr/>							

0280 - Physician Assistant Board
Analysis of Fund Condition

Prepared 05/01/2013

(Dollars in Thousands)

NOTE: \$1.5 Million General Fund Repayment Outstanding

Governor's Budget 2013-14	Governor's Budget						
	Actual 2011-12	CY 2012-13	BY 2013-14	BY + 1 2014-15	BY + 2 2015-16	BY + 3 2016-17	BY + 4 2017-18
BEGINNING BALANCE	\$ 2,174	\$ 973	\$ 991	\$ 1,108	\$ 1,198	\$ 1,260	\$ 1,293
Prior Year Adjustment	\$ 21	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 2,195	\$ 973	\$ 991	\$ 1,108	\$ 1,198	\$ 1,260	\$ 1,293
REVENUES AND TRANSFERS							
Revenues:							
125600 Other regulatory fees	\$ 10	\$ 9	\$ 8	\$ 8	\$ 8	\$ 8	\$ 8
125700 Other regulatory licenses and permits	\$ 155	\$ 160	\$ 162	\$ 162	\$ 162	\$ 162	\$ 162
125800 Renewal fees	\$ 1,193	\$ 1,263	\$ 1,332	\$ 1,332	\$ 1,332	\$ 1,332	\$ 1,332
125900 Delinquent fees	\$ 3	\$ 3	\$ 3	\$ 3	\$ 3	\$ 3	\$ 3
141200 Sales of documents	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
142500 Miscellaneous services to the public	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
150300 Income from surplus money investments	\$ 5	\$ 3	\$ 3	\$ 4	\$ 4	\$ 4	\$ 4
160400 Sale of fixed assets	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 1	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
161400 Miscellaneous revenues	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
164300 Penalty Assessments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Totals, Revenues	\$ 1,367	\$ 1,438	\$ 1,508	\$ 1,509	\$ 1,509	\$ 1,509	\$ 1,509
Transfers from Other Funds							
Proposed GF Loan Repay	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Transfers to Other Funds	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Transfers to other Funds	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
GF Loan per item 1110-011-0280, Budget Act of 2011	\$ -1,500	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Proposed GF Loan Repayment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Totals, Revenues and Transfers	\$ -133	\$ 1,438	\$ 1,508	\$ 1,509	\$ 1,509	\$ 1,509	\$ 1,509
Totals, Resources	\$ 2,062	\$ 2,411	\$ 2,499	\$ 2,617	\$ 2,707	\$ 2,769	\$ 2,802
EXPENDITURES							
Disbursements:							
0840 State Controllers	\$ 1	\$ 1	\$ -	\$ -	\$ -	\$ -	\$ -
8880 FISCAL (State Operations)	\$ 3	\$ 8	\$ -	\$ -	\$ -	\$ -	\$ -
1110 Program Expenditures (State Operations)	\$ 1,085	\$ 1,411	\$ 1,391	\$ 1,419	\$ 1,447	\$ 1,476	\$ 1,506
Total Disbursements	\$ 1,089	\$ 1,420	\$ 1,391	\$ 1,419	\$ 1,447	\$ 1,476	\$ 1,506
FUND BALANCE							
Reserve for economic uncertainties	\$ 973	\$ 991	\$ 1,108	\$ 1,198	\$ 1,260	\$ 1,293	\$ 1,296
Months in Reserve	8.2	8.5	9.4	9.9	10.2	10.3	10.1

NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2012-13 AND ON-GOING.
- B. ASSUMES INTEREST RATE AT .30%
- C. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR



AB 356: Implementation

Phillip L. Scott, MA, CRT
Radiologic Health Branch
California Department of Public Health



Radiologic Health Branch

- Who are we?
- What do we do?
- What is AB 356
- What are we doing to implement AB 356?
- What are we doing to inform the industry and health community of the new program?

Radiologic Health Branch

- Center for Environmental Health
 - Division of Food, Drug & Radiation Safety.
- RHB administers and enforces the following laws for the protection of the public health and safety, radiation workers and the environment:
 - Radiation Control Law
 - Radiation sources – X-ray machines, Radioactive material
 - Radiologic Technology Act
 - Diagnostic & therapeutic human use of X-ray machines
 - Nuclear Medicine Technology Certification.

Radiologic Health Branch

- Under those laws, RHB:
 - Inspects users of radiation.
 - Certifies and permits individuals to use diagnostic and therapeutic X-ray on humans.
 - Certifies individuals performing industrial radiography.
 - Approves schools providing X-ray training.
 - Registers users of X-ray machines
 - Licenses users of radioactive materials
 - Investigates complaints pertaining to radiation use.
 - Performs environmental surveys.

AB 356 (Stats. 2009, ch. 434)

- Sponsored by California Academy of Physician Assistants (CAPA).
- Effective 1-1-2010.
- AB 356 amended Radiologic Technology Act to mandate CDPH to issue to qualified PAs a fluoroscopy permit.
- Proposed regulations were published for a 45-day public comment on November 30, 2012.
- Conducting a 15-day public comment period (TBD).
- Estimated effective date for regulations: 10-1-13.

Proposed Regulations

- Package #: DPH-10-006.
- Licensed PA may use fluoroscopy only if:
 - Hold PA fluoro permit; or RT fluoro permit
 - Is performing only those fluoro procedures:
 - The PA's supervising physician determines the PA can competently perform;
 - Identified on the PA's Delegation of Services Agreement;
 - The PA's supervising physician holds a fluoro permit or radiology certificate; and
 - Keeps certain documents on file at each practice site.

Proposed Regulations

- Coursework: 40 hours didactic and 40 hours supervised clinical from Diagnostic Radiologic Technology (RT) school or RT fluoro school.
 - Coursework is the Fluoroscopy Educational Framework for the Physician Assistant developed by American Academy of Physician Assistants & American Society of Radiologic Technologists.
- Pass written examination.
- May not:
 - Act as a Certified Supervisor and Operator.
 - Perform mammography
 - Perform any radiologic procedures except as specified above.
 - Perform radiography
- Other administrative items: renewal, continuing education, fees, validity, grounds to suspend/revoke.

CDPH Outreach

- Informed CDPH-approved RT and RT fluoro schools.
- Informed PA Board-approved PA schools of the opportunity to apply to CDPH for approval to provide coursework curriculum to PA students.
- Provided information to CDPH advisory committee, Radiologic Technology Certification Committee, at the April 17, 2013 meeting.
- Will provide short article to CAPA for their newsletter.
- Present material at CAPA's annual conference in October.



CDPH Outreach

- Prepare and disseminate information package to PAs to include:
 - Adopted regulations
 - Applications
 - Known coursework providers
 - General information.
- Update CDPH website and post information package and other pertinent documents.



Website & Questions

- RHB website: www.cdph.ca.gov/rhb
- Questions?

**DISCUSSION OF CALIFORNIA CODE OF REGULATIONS SECTION
1399.546 – REPORTING OF PHYSICIAN ASSISTANT SUPERVISION –
AS IT RELATES TO NEW ELECTRONIC MEDICAL RECORDS TECHNOLOGY**

1399.546. Reporting of Physician Assistant Supervision.

Each time a physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When a physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

Note: Authority cited: Sections 2018 and 3510, Business and Professions Code.
Reference: Section 3502, Business and Professions Code.

HISTORY

1. New section filed 1-4-87; effective thirtieth day thereafter (Register 87, No. 3).
2. Change without regulatory effect filed 2-5-91 pursuant to section 100, Title 1, California Code of Regulations (Register 91, No. 11).
3. Change without regulatory effect amending section filed 3-3-2005 pursuant to section 100, title 1, California Code of Regulations (Register 2005, No. 9).

GENERAL AREA: Legislation

SPECIFIC SUBJECT: Definition of the Positions Taken by the Physician
Assistant Committee Regarding Proposed Legislation

STATEMENT:

As required the Physician Assistant Committee will adopt by the Committee as a whole, requiring a forum, the following positions regarding pending or proposed legislation.

Oppose: The Committee will actively oppose proposed legislation and demonstrate opposition through letters, testimony and other action necessary to communicate the oppose position taken by the PAC.

Disapprove: The Committee will communicate a general disapprove position but will not actively lobby the legislature regarding the proposed legislation.

Watch: The watch position adopted by the Committee will indicate concern regarding the proposed legislation. The PAC staff and members will closely monitor the progress of the proposed legislation and amendments before taking an oppose, disapprove, approve, or support position.

Approve: The Committee will communicate a general approve position but will not actively lobby the legislature regarding the proposed legislation.

Support: The Committee will actively support proposed legislation and demonstrate support through letters, testimony and any other action necessary to communicate the support position taken by the PAC.

NECESSITY:

The Physician Assistant Committee needs clearly defined positions to adopt regarding proposed legislation. Defining the level of activity involved in any position taken allows the committee to take considered, reasoned, and consistent positions and actions regarding proposed legislation.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 10/05/95

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/27/95

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/6/05



California
LEGISLATIVE INFORMATION

AB-154 Abortion. (2013-2014)

AMENDED IN ASSEMBLY APRIL 30, 2013

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

ASSEMBLY BILL

No. 154

Introduced by Assembly Member Atkins
(Principal Coauthor(s): Senator Jackson)
(Coauthor(s): Assembly Member Mitchell, Skinner)

January 22, 2013

An act to amend Section 2253 of, and to add Sections ~~734~~, 2725.4, and 3502.4 to, the Business and Professions Code, and to amend Section 123468 of the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 154, as amended, Atkins. Abortion.

Existing law makes it a public offense, punishable by a fine not exceeding \$10,000 or imprisonment, or both, for a person to perform or assist in performing a surgical abortion if the person does not have a valid license to practice as a physician and surgeon, or to assist in performing a surgical abortion without a valid license or certificate obtained in accordance with some other law that authorizes him or her to perform the functions necessary to assist in performing a surgical abortion. Existing law also makes it a public offense, punishable by a fine not exceeding \$10,000 or imprisonment, or both, for a person to perform or assist in performing a nonsurgical abortion if the person does not have a valid license to practice as a physician and surgeon or does not have a valid license or certificate obtained in accordance with some other law authorizing him or her to perform or assist in performing the functions necessary for a nonsurgical abortion. Under existing law, nonsurgical abortion includes termination of pregnancy through the use of pharmacological agents.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of registered nurses, including nurse practitioners and certified nurse-midwives, by the Board of Registered Nursing. Existing law, the Physician Assistant Practice Act, provides for the licensure and regulation of physician assistants by the Physician Assistant Committee Board within the jurisdiction of the Medical Board of California.

This bill would instead make it a public offense, punishable by a fine not exceeding \$10,000 or imprisonment, or both, for a person to perform an abortion if the person does not have a valid license to practice as a physician and surgeon, except that it would not be a public offense for a person to perform an abortion by medication or

would also require a nurse practitioner, certified nurse-midwife, or physician assistant to complete training, as specified, *and to comply with standardized procedures or protocols, as specified*, in order to perform an abortion by aspiration techniques, and would indefinitely authorize a nurse practitioner, certified nurse-midwife, or physician assistant who completed a specified training program and achieved clinical competency to continue to perform abortions by aspiration techniques. The bill would delete the references to a nonsurgical abortion and would delete the restrictions on assisting with abortion procedures. The bill would also make technical, nonsubstantive changes.

Because the bill would change the definition 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.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

~~SECTION 1. Section 734 is added to the Business and Professions Code, to read: 734.
It is unprofessional conduct for any nurse practitioner, certified nurse-midwife, or physician assistant to perform an abortion pursuant to Section 2253, without prior completion of training and validation of clinical competency.~~

~~SEC. 2.~~ **SECTION 1.** Section 2253 of the Business and Professions Code is amended to read:

2253. (a) Failure to comply with the Reproductive Privacy Act (Article 2.5 (commencing with Section 123460) of Chapter 2 of Part 2 of Division 106 of the Health and Safety Code) constitutes unprofessional conduct.

(b) (1) Except as provided in paragraph (2), a person is subject to Section 2052 if he or she performs an abortion, and at the time of so doing, does not have a valid, unrevoked, and unsuspended license to practice as a physician and surgeon.

(2) A person shall not be subject to Section 2052 if he or she performs an abortion by medication or aspiration techniques in the first trimester of pregnancy, and at the time of so doing, has a valid, unrevoked, and unsuspended license or certificate obtained in accordance with some other provision of law, including, but not limited to, the Nursing Practice Act (Chapter 6 (commencing with Section 2700)) or the Physician Assistant Practice Act (Chapter 7.7 (commencing with Section 3500)), that authorizes him or her to perform the functions necessary for an abortion by medication or aspiration techniques.

(c) In order to perform an abortion by aspiration techniques pursuant to paragraph (2) of subdivision (b), a person shall comply with Section 2725.4 or 3502.4.

~~SEC. 3.~~ **SEC. 2.** Section 2725.4 is added to the Business and Professions Code, to read:

2725.4. (a) In order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall complete training recognized by the Board of Registered Nursing. Beginning January 1, 2014, and until January 1, 2016, the competency-based training protocols established by Health Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development shall be used.

(b) In order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall adhere to standardized procedures developed in compliance with subdivision (c) of Section 2725 that specify all of the following:

- (1) The extent of supervision by a physician and surgeon with relevant training and expertise.
- (2) Procedures for transferring patients to the care of the physician and surgeon or a hospital.
- (3) Procedures for obtaining assistance and consultation from a physician and surgeon.
- (4) Procedures for providing emergency care until physician assistance and consultation is available.
- (5) The method of periodic review of the provisions of the standardized procedures.

(c) A nurse practitioner or certified nurse-midwife who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques *pursuant to Section 2253, in adherence to standardized procedures described in subdivision (b)*.

(d) *It is unprofessional conduct for any nurse practitioner or certified nurse-midwife to perform an abortion by aspiration techniques pursuant to Section 2253 without prior completion of training and validation of clinical competency.*

SEC. 4.~~SEC. 3.~~ Section 3502.4 is added to the Business and Professions Code, to read:

3502.4. (a) In order to receive authority from his or her supervising physician and surgeon to perform an abortion by aspiration techniques *pursuant to Section 2253*, a physician assistant shall complete training either through training programs approved by the ~~Physician Assistant Board~~ *board* pursuant to Section 3513 or by training to perform medical services which augment his or her current areas of competency pursuant to Section 1399.543 of Title 16 of the California Code of Regulations. Beginning January 1, 2014, and until January 1, 2016, the training and clinical competency protocols established by Health Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development shall be used as training and clinical competency guidelines to meet this requirement.

(b) *In order to receive authority from his or her supervising physician and surgeon to perform an abortion by aspiration techniques pursuant to Section 2253, a physician assistant shall comply with protocols developed in compliance with Section 3502 that specify:*

- (1) *The extent of supervision by a physician and surgeon with relevant training and expertise.*
- (2) *Procedures for transferring patients to the care of the physician and surgeon or a hospital.*
- (3) *Procedures for obtaining assistance and consultation from a physician and surgeon.*
- (4) *Procedures for providing emergency care until physician assistance and consultation is available.*
- (5) *The method of periodic review of the provisions of the protocols.*

(b)

(c) The training protocols established by HWPP No. 171 shall be deemed to meet the standards of the ~~Physician Assistant Board~~ *board*. A physician assistant who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques *pursuant to Section 2253, in adherence to protocols described in subdivision (b)*.

(d) *It is unprofessional conduct for any physician assistant to perform an abortion by aspiration techniques pursuant to Section 2253 without prior completion of training and validation of clinical competency.*

SEC. 5.~~SEC. 4.~~ Section 123468 of the Health and Safety Code is amended to read:

123468. The performance of an abortion is unauthorized if either of the following is true:

- (a) The person performing the abortion is not a health care provider authorized to perform an abortion pursuant to Section 2253 of the Business and Professions Code.
- (b) The abortion is performed on a viable fetus, and both of the following are established:
 - (1) In the good faith medical judgment of the physician, the fetus was viable.
 - (2) In the good faith medical judgment of the physician, continuation of the pregnancy posed no risk to life or health of the pregnant woman.

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

Date of Hearing: May 8, 2013

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Mike Gatto, Chair

AB 154 (Atkins) – As Amended: April 30, 2013

Policy Committee: Business, Professions and Consumer Protection Vote: 9-4
Health 13-6

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY

This bill authorizes a nurse practitioner (NP), certified nurse midwife (CNM), and physician assistant (PA) to perform abortion by medication or aspiration techniques in the first trimester of pregnancy upon completion of training, as specified.

FISCAL EFFECT

Unknown costs or savings, potentially in excess of 150,000. For example, if the number of Medi-Cal first trimester procedures increases by 350 per year, Medi-Cal costs would increase by approximately \$152,000. On the other hand, a similar reduction in second trimester procedures would result in savings of approximately \$212,000, based on data from 2009.

COMMENTS

- 1) Rationale. This bill intends to address the current shortage of health care professionals able to provide early abortion care in California. It will authorize trained Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs) and Physician Assistants (PAs) to provide comprehensive first trimester abortion care, within the scope of their licenses.

According to the Guttmacher Institute, 52% of California counties lack an abortion provider. Lack of access causes women to delay termination into the second, or even third, trimesters. It also forces rural women to travel long distances, in the case of some rural areas, up to five hours; women have to raise money to cover these travel costs, further delaying care. Even women in urban areas face long wait-times to receive first trimester abortion care.

This bill helps to ensure women receive safe, early care and will help provide comprehensive and better coordinated reproductive health care in areas such as miscarriage management, post-abortion follow-up, and contraception.

- 2) Background: UCSF study. The Office of Statewide Health Planning and Development (OSHPD) permits temporary legal waivers of certain practice restrictions or educational requirements to test expanded roles and accelerated training programs for health care professionals. A multi-year study conducted by The University of California's San Francisco's (UCSF) Risk Center for Global Reproductive Health and OSHPD

8,000 patients were provided care by an APC and over 6,000 patients were provided care by a physician. The results of the study show comparable levels of complications and found APCs to be safe and qualified.

- 3) The OSHPD waiver includes numerous requirements to ensure safety. For example, physician trainers are required to have performed at least 200 procedures, have an excellent safety record, and, have received formal "train-the-trainer" instruction prior to training APCs. To participate in the project, NPs, CNMs, and PAs must have at least 12 months successful clinical experience in a health care facility and be licensed to practice in California, demonstrate maintenance of Professional Certification or equivalent credentialing, have at least three months experience in the provision of early medication abortion or equivalent experience, demonstrate maintenance of certification of Basic Life Support, and have a desire to work in the area of women's reproductive health, including provision of early abortion care.
- 4) Related legislation. SB 491 (Ed Hernandez) authorizes NPs to perform some tasks independently, rather than with physician supervision, including examination of patients and establishing a medical diagnosis. SB 491 also requires NPs, after July 1, 2016, to be certified by a national certifying body in order to practice. The bill is pending in Senate Appropriations Committee.
- 5) Previous legislation. SB 623 (Kehoe), Chapter 450, Statutes of 2012, extends, until January 1, 2014, the OSHPD waiver to evaluate NPs, CNMs, and PAs in providing aspiration abortions.

SB 1338 (Kehoe) of 2012 would have allowed NPs, CNMs, and PAs who have completed training in under the OSHPD waiver to continue to perform abortions by aspiration techniques. SB 1338 died in Senate Business, Professions and Economic Development Committee.

Analysis Prepared by: Debra Roth / APPR. / (916) 319-2081

Date of Hearing: May 8, 2013

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Mike Gatto, Chair

AB 154 (Atkins) – As Amended: April 30, 2013

Policy Committee: Business, Professions and Consumer Protection Vote: 9-4
Health 13-6

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY

This bill authorizes a nurse practitioner (NP), certified nurse midwife (CNM), and physician assistant (PA) to perform abortion by medication or aspiration techniques in the first trimester of pregnancy upon completion of training, as specified.

FISCAL EFFECT

Unknown costs or savings, potentially in excess of 150,000. For example, if the number of Medi-Cal first trimester procedures increases by 350 per year, Medi-Cal costs would increase by approximately \$152,000. On the other hand, a similar reduction in second trimester procedures would result in savings of approximately \$212,000, based on data from 2009.

COMMENTS

- 1) Rationale. This bill intends to address the current shortage of health care professionals able to provide early abortion care in California. It will authorize trained Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs) and Physician Assistants (PAs) to provide comprehensive first trimester abortion care, within the scope of their licenses.

According to the Guttmacher Institute, 52% of California counties lack an abortion provider. Lack of access causes women to delay termination into the second, or even third, trimesters. It also forces rural women to travel long distances, in the case of some rural areas, up to five hours; women have to raise money to cover these travel costs, further delaying care. Even women in urban areas face long wait-times to receive first trimester abortion care.

This bill helps to ensure women receive safe, early care and will help provide comprehensive and better coordinated reproductive health care in areas such as miscarriage management, post-abortion follow-up, and contraception.

- 2) Background: UCSF study. The Office of Statewide Health Planning and Development (OSHPD) permits temporary legal waivers of certain practice restrictions or educational requirements to test expanded roles and accelerated training programs for health care professionals. A multi-year study conducted by The University of California's San

8,000 patients were provided care by an APC and over 6,000 patients were provided care by a physician. The results of the study show comparable levels of complications and found APCs to be safe and qualified.

- 3) The OSHPD waiver includes numerous requirements to ensure safety. For example, physician trainers are required to have performed at least 200 procedures, have an excellent safety record, and, have received formal "train-the-trainer" instruction prior to training APCs. To participate in the project, NPs, CNMs, and PAs must have at least 12 months successful clinical experience in a health care facility and be licensed to practice in California, demonstrate maintenance of Professional Certification or equivalent credentialing, have at least three months experience in the provision of early medication abortion or equivalent experience, demonstrate maintenance of certification of Basic Life Support, and have a desire to work in the area of women's reproductive health, including provision of early abortion care.
- 4) Related legislation. SB 491 (Ed Hernandez) authorizes NPs to perform some tasks independently, rather than with physician supervision, including examination of patients and establishing a medical diagnosis. SB 491 also requires NPs, after July 1, 2016, to be certified by a national certifying body in order to practice. The bill is pending in Senate Appropriations Committee.
- 5) Previous legislation. SB 623 (Kehoe), Chapter 450, Statutes of 2012, extends, until January 1, 2014, the OSHPD waiver to evaluate NPs, CNMs, and PAs in providing aspiration abortions.

SB 1338 (Kehoe) of 2012 would have allowed NPs, CNMs, and PAs who have completed training in under the OSHPD waiver to continue to perform abortions by aspiration techniques. SB 1338 died in Senate Business, Professions and Economic Development Committee.



California
LEGISLATIVE INFORMATION

AB-186 Professions and vocations: military spouses: temporary licenses. (2013-2014)

AMENDED IN ASSEMBLY APRIL 22, 2013

AMENDED IN ASSEMBLY APRIL 01, 2013

CALIFORNIA LEGISLATURE— 2013-2014 REGULAR SESSION

ASSEMBLY BILL

No. 186

Introduced by Assembly Member Maienschein

(Principal Coauthor(s): Assembly Member Hagman)

(Coauthor(s): Assembly Member Chávez, Dahle, Donnelly, Beth Gaines, Grove, Harkey, Olsen, Patterson)

(Coauthor(s): Senator Fuller, Huff)

January 28, 2013

An act to amend Section 115.5 of the Business and Professions Code, relating to professions and vocations, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 186, as amended, Maienschein. Professions and vocations: military spouses: temporary licenses.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law provides for the issuance of reciprocal licenses in certain fields where the applicant, among other requirements, has a license to practice within that field in another jurisdiction, as specified. *Existing law requires that the licensing fees imposed by certain boards within the department be deposited in funds that are continuously appropriated.* Existing law requires a board within the department to expedite the licensure process for an applicant who holds a current license in another jurisdiction in the same profession or vocation and who supplies satisfactory evidence of being married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders.

~~This bill would authorize a board within the department to issue a provisional license to an applicant who qualifies for an expedited license pursuant to the above-described provision. The~~

This bill would require a board within the department to issue a temporary license to an applicant who qualifies for, and requests, expedited licensure pursuant to the above-described provision if he or she meets specified requirements. The bill would require the temporary license to expire 12 months after issuance, upon issuance of the expedited license, or upon denial of the application for expedited licensure by the board, whichever occurs first. The bill would authorize a board to conduct an investigation of an applicant for purposes of denying or revoking a temporary license, and would authorize a criminal background check as part of that investigation.

includes a signed affidavit attesting to the fact that he or she meets all of the requirements for the temporary license and that the information submitted in the application is accurate, as specified. The bill would also require the application to include written verification from the applicant's original licensing jurisdiction stating that the applicant's license is in good standing.

This bill would prohibit a ~~provisional~~ temporary license from being provided to any applicant who has committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license at the time the act was ~~committed, or committed~~. The bill would provide that a violation of the above-described provision may be grounds for the denial or revocation of a temporary license. The bill would further prohibit a temporary license from being provided to any applicant who has been disciplined by a licensing entity in another jurisdiction, or is the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction. ~~The bill would require the board to approve a provisional license based on an application that includes an affidavit that the information submitted in the application is accurate and that verification documentation from the other jurisdiction has been requested. The bill would require the provisional license to expire after 18 months or at the issuance of the expedited license. The bill would require an applicant, upon request by a board, to furnish a full set of fingerprints for purposes of conducting a criminal background check.~~

By creating ~~provisional licenses for which a fee may be collected and deposited into a continuously appropriated fund, this bill would make an appropriation.~~

Because the bill would authorize the expenditure of continuously appropriated funds for a new purpose, the bill would make an appropriation.

Vote: majority Appropriation: yes Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 115.5 of the Business and Professions Code is amended to read:

115.5. (a) A board within the department shall expedite the licensure process for an applicant who meets both of the following requirements:

(1) Supplies evidence satisfactory to the board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders.

(2) Holds a current license in another state, district, or territory of the United States in the profession or vocation for which he or she seeks a license from the board.

~~(b)(1) For each applicant who is eligible for an expedited license pursuant to subdivision (a) and meets the requirements in paragraph (2), the board shall provide a provisional license while the board processes the application for licensure. The board shall approve a provisional license based on an application that includes an affidavit that the information submitted in the application is accurate and that verification documentation from the other jurisdiction has been requested. The provisional license shall expire 18 months after issuance or upon issuance of the expedited license.~~

(b) (1) A board shall, after appropriate investigation, issue a temporary license to an applicant who is eligible for, and requests, expedited licensure pursuant to subdivision (a) if the applicant meets the requirements described in paragraph (3). The temporary license shall expire 12 months after issuance, upon issuance of the expedited license, or upon denial of the application for expedited licensure by the board, whichever occurs first.

(2) The board may conduct an investigation of an applicant for purposes of denying or revoking a temporary license issued pursuant to this subdivision. This investigation may include a criminal background check.

(3) (A) An applicant seeking a temporary license issued pursuant to this subdivision shall submit an application to the board which shall include a signed affidavit attesting to the fact that he or she meets all of the requirements for the temporary license and that the information submitted in the application is accurate, to the best of his or her knowledge. The application shall also include written verification from the applicant's original licensing jurisdiction stating that the applicant's license is in good standing in that jurisdiction.

~~(2)(A)~~

(B) The applicant shall not have committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license under this code at the time the act was committed. A violation of this subparagraph may be grounds for the denial or revocation of a temporary license issued by the board.

~~(B)~~

(C) The applicant shall not have been disciplined by a licensing entity in another jurisdiction and shall not be the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction.

(D) The applicant shall, upon request by a board, furnish a full set of fingerprints for purposes of conducting a criminal background check.

(c) A board may adopt regulations necessary to administer this section.

Date of Hearing: April 30, 2013

ASSEMBLY COMMITTEE ON BUSINESS, PROFESSIONS AND CONSUMER
PROTECTION

Richard S. Gordon, Chair

AB 186 (Maienschein) – As Amended: April 22, 2013

SUBJECT: Professions and vocations: military spouses: temporary licenses.

SUMMARY: Requires boards under the Department of Consumer Affairs (DCA) to issue a 12-month temporary license to the spouse or domestic partner of a military member on active duty licensed in another state if they are eligible to have their application for a permanent license expedited. Specifically, this bill:

- 1) Requires the board to issue a 12-month temporary license to an applicant who is a military spouse or domestic partner while the license application is being processed, if
 - a) The applicant submits an affidavit attesting that the information submitted in the application is accurate;
 - b) The applicant submits written verification from the applicant's original licensing jurisdiction stating that the applicant's license is in good standing;
 - c) The applicant, upon the board's request, submits fingerprints for a background check;
 - d) The applicant has not committed any act in any jurisdiction that constitutes grounds for the denial, suspension, or revocation of the professional license by the board under the Business and Professions Code (BPC) at the time the act was committed; and,
 - e) The applicant was not disciplined by a licensing entity in another jurisdiction and is not the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction.
- 2) Requires the temporary license to expire 12 months after issuance, upon issuance of an expedited permanent license, or upon denial of a permanent license, whichever occurs first.
- 3) Authorizes a board to conduct an investigation or criminal background check on the applicant.

EXISTING LAW:

- 1) Generally provides for the licensing and regulation of various professions and businesses by 36 regulatory entities (23 boards, six bureaus, four committees, two programs, and one commission) within the DCA under various licensing acts within the BPC.
- 2) Defines a "board" as including a "bureau," "commission," "committee," "department,"

- 3) Requires a licensing and regulatory board under the DCA to issue an expedited license to the spouse or domestic partner of a military member on active duty. (BPC 115.5)
- 4) Authorizes the California Board of Registering Nursing (BRN) to issue a temporary six-month license to practice professional nursing, and a temporary certificate to practice as a certified nurse midwife, certified nurse practitioner, certified public health nurse, certified clinical nurse specialist, or certified nurse anesthetist, to an individual applying for permanent licensure. The BRN may reissue a temporary six-month license or certificate to an applicant, but no more than twice to any one person. (BPC 2732.1 and 2733)
- 5) Authorizes the BRN to issue a six-month interim permit to a nursing school graduate applying for permanent licensure, in order to practice nursing pending the results of the required licensing examination. If the applicant passes the examination, the interim permit shall remain in effect until the BRN issues a permanent license; if the applicant fails the examination, the interim permit shall terminate upon notice by first-class mail. (BPC 2732.1)

FISCAL EFFECT: Unknown

COMMENTS:

- 1) Purpose of this bill. This bill would require a licensing board, bureau or commission under DCA to issue a 12-month temporary license to the spouse or domestic partner of a military member on active duty if he or she is eligible to have their application for a permanent license expedited. The intent of this bill is to assist military families who are moving to California from another state by allowing military spouses and domestic partners to begin working in their professional occupations with a temporary license while they work to meet any California licensing requirements. This bill is author sponsored.
- 2) Author's Statement. According to the author's office, "Current law allows spouses of active duty members, who have been stationed in California from another state, to get an expedited professional license if they have a valid professional license in another state. Still, the wait time for this can be very long, and spouses can't even begin seeking employment [in their professional occupation] until their license has been approved... The unemployment rate among military spouses is estimated to be about 26% - three times the national average. AB 186 would provide military spouses who have a valid professional license in another state, an 12-month temporary license from the [appropriate licensing board under] DCA. This [bill] would allow them to immediately look for employment while taking all the necessary steps to apply [for] and receive a [permanent] license from the state."
- 3) Federal efforts to facilitate occupational licensure of military spouses. The U.S. Department of Treasury (Treasury Department) and the U.S. Department of Defense (DOD) issued a joint report in 2012 highlighting the impact of state occupational licensing requirements on the careers of military spouses who frequently move across state lines. Released in February 2012, the report, "Supporting our Military Families: Best Practices for Streamlining Occupational Licensing Across State Lines" revealed that approximately 35% of military spouses work in professions that require state licensure or certification and that military spouses are ten times more likely to have moved to another state in the last year compared to

- 4) Professional licensure of military spouses and the effect on military re-enlistment. The Treasury Department/DOD report highlighted the employment problems of military spouses and the correlation to a military member's decision to remain active in the military: "More than half of all active duty military personnel are married, and 91% of employed military spouses indicated that they wanted to work and/or needed to work. Research suggests that [spousal] dissatisfaction with the ability to pursue career objectives may hinder re-enlistment. Not only are military spouses highly influential regarding re-enlistment decisions, but more than two-thirds of married service members reported that their decision to re-enlist was largely or moderately affected by their spouses' career prospects."

The report issued several recommendations, including the authorization of temporary licenses for military spouses if the applicant has met state requirements. That recommendation stated, "Temporary licenses allow applicants to be employed while they fulfill all of the requirements for a permanent license, including examinations or endorsement, applications and additional fees. In developing expedited approaches that save military spouses time and money, DOD does not want to make licensure easier for military spouses to achieve at the expense of degrading their perceived value in their profession."

- 5) Temporary licenses. Temporary licenses are typically issued to applicants seeking permanent licensure within a professional occupation who meet some – but not yet all – of the qualifications for permanent licensure in that state. For example, applicants who hold an active professional license in another state and have passed a national licensing examination may still have educational requirements to meet in order to become licensed in California. DCA has indicated that there are few professional boards or bureaus under their jurisdiction that issue temporary licenses, but the precise number are currently unknown.
- 6) Expedited licensure for military spouses. AB 1904 (Block), Chapter 399, Statutes of 2012, requires boards under DCA to issue an expedited license to the spouse or domestic partner of a military member on active duty, beginning January 1, 2013. This bill attempts to take the provisions of AB 1904 further by requiring boards to issue a 12-month temporary license to the spouse or domestic partner of a military member on active duty if they are eligible to have their application for a permanent license expedited.
- 7) Questions for the Committee. The Committee may wish to consider the following issues and questions:
- a) Board licensing authority. Licensing boards under DCA operate semi-autonomously and have specified statutory authority to license and regulate their professions. This bill would restrict a board's discretionary authority to issue, deny, suspend, or revoke a license by automatically requiring a temporary license with full practice privileges to be granted to a specific category of individuals – military spouses and domestic partners – that is not currently offered for military members, veterans, or other civilians. This bill may also be difficult for boards to implement if they do not now issue temporary licenses, or have supplemental requirements unique to California.

- b) Consumer protection issues. In addition, this bill may raise consumer protection concerns if military spouses or domestic partners ultimately do not need to meet state

requirements and those who are military spouses or domestic partners who have not yet met standards. This may result in confusion among consumers, who would expect that any licensed professional has fulfilled state requirements.

- c) Funding for the temporary licenses. This bill does not provide a funding mechanism for the issuance of temporary licenses. The Legislature has historically approved license fees for each board, and without a statute that sets the fee for the temporary license, this would be an unfunded mandate for boards that would have to issue the temporary fee and absorb the costs.
 - d) Conflict with boards that offer temporary licenses. Some boards, such as the BRN and the Board for Professional Engineers, Land Surveyors, and Geologists already have a process under existing law to issue temporary licenses to out-of-state applicants that expire within a specified time frame. This bill would conflict with those laws.
 - e) Unclear need for this bill. Licensing boards under DCA have been required to expedite the applications of military spouse and domestic partners since January 1, 2013. It is unclear how many military spouses or domestic partners have applied for licensure and have been unable to obtain a license in a timely manner.
 - f) Effect on processing times. The goal of this bill is to expedite licensure. However, requiring all boards to issue temporary licenses would increase the total number of licenses that would need to be processed, and could therefore delay the processing time for permanent licensure, which is contrary to the author's intent.
- 8) Arguments in support. According to the DOD, "Temporary licensure would allow a [military] spouse [or domestic partner] to work while additional requirements are met or [while] the license from [another] state is being validated... 27 states have already enacted such legislation... [and] 14 additional states are considering temporary licenses this legislative session.

"[The DOD] appreciates any concern for protecting the public and would not want a [military] spouse [or domestic partner] to be licensed when they are unqualified or would pose a danger to those they serve. The [military] spouses [and domestic partners] we are referring to in this bill are licensed in another state. [The DOD] understands that the reason for licensing is to safeguard the public, and [the DOD] and other states believe that providing a temporary license to a military spouse [or domestic partner] who is already licensed in another state and who has had experience in that licensed occupation presents little risk to the public...

"Military spouses relocate on average every two to three years. The annual percentage of the military spouse population that moves across state lines is 14.5% compared to 1.1% for civilian spouses."

- 9) Arguments in opposition. According to the California Nurses Association (CNA), "The BRN currently has a process in place by which it may grant 'temporary' licenses to those who

the state's board of nursing or the Nursys verification system... Additionally, if granted by the BRN, a temporary RN license is valid for a period of six months. Upon expiration of that six-month period, the BRN may, under its own discretion, grant up to two additional six-month extensions."

The CNA also notes that AB 186 eliminates the BRN's discretion in granting temporary licensure, provides for a less stringent temporary licensure process than that currently employed by the BRN, and that the bill's provision requiring the expiration of a temporary license after 12 months conflicts with the BRN's current [discretionary] process to extend temporary licenses beyond six months.

- 10) Related Legislation. SB 532 (De León) of 2013, would make a non-substantive change to the provisions of law requiring a board under the DCA to issue an expedited license to the spouse or domestic partner of a military member on active duty.
- 11) Previous Legislation. AB 1904 (Block), Chapter 399, Statutes of 2012, requires a board under DCA to issue an expedited license to the spouse or domestic partner of a military member on active duty. As introduced, this bill would have authorized DCA to issue a temporary license to the spouse or domestic partner of a military member on active duty. This bill was amended to remove an additional layer in the issuance of a license.

REGISTERED SUPPORT / OPPOSITION:

Support

California Architects Board
California Association for Health Services at Home
Department of Defense (DOD)
National Military Family Association
San Diego Military Advisory Council

Opposition

American Association for Marriage and Family Therapy, California Division
Board for Professional Engineers, Land Surveyors, and Geologists
California Nurses Association

Analysis Prepared by: Joanna Gin / B.,P. & C.P. / (916) 319-3301



California
LEGISLATIVE INFORMATION

AB-1057 Professions and vocations: licenses: military service. (2013-2014)

AMENDED IN ASSEMBLY APRIL 09, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

ASSEMBLY BILL

No. 1057

Introduced by Assembly Member Medina

February 22, 2013

An act to add Section 114.5 to the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 1057, as amended, Medina. Professions and vocations: licenses: military service.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes a licensee or registrant whose license expired while the licensee or registrant was on active duty as a member of the California National Guard or the United States Armed Forces to, upon application, reinstate his or her license without penalty and without examination, if certain requirements are satisfied, unless the licensing agency determines that the applicant has not actively engaged in the practice of his or her profession while on active duty, as specified.

This bill would require each board, *commencing January 1, 2015*, to inquire in every application for licensure if the applicant is serving in, or has previously served in, the military.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 114.5 is added to the Business and Professions Code, to read:

114.5. ~~Each~~ *Commencing January 1, 2015*, each board shall inquire in every application for licensure if the applicant is serving in, or has previously served in, the military.

Date of Hearing: April 17, 2013

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Mike Gatto, Chair

AB 1057 (Medina) – As Amended: April 9, 2013

Policy Committee: Business and Professions

Vote: 13 – 0

Urgency: No State Mandated Local Program: No

Reimbursable:

SUMMARY

This bill requires, after January 1, 2015, every licensing board under the Department of Consumer Affairs (DCA) to inquire in every license application if the applicant is serving in, or has previously served in, the military.

FISCAL EFFECT

Costs should be minor and absorbable within existing resources.

COMMENTS

- 1) Rationale. The author intends for this bill to help military personnel make a successful transition from military to civilian life by creating an efficient process for licensing veterans in professional careers who have acquired new work skills while in the military.

Toward that end, the bill requires every licensing board under DCA to affirmatively inquire in every license application if the applicant is serving in, or has previously served in, the military, in order to better identify and assist active military members and veterans applying for professional licensure.

The author notes that most of DCA's licensing programs already have some process for accepting military service credit towards licensure for one or all of its license types. However, there is nothing on the application for licensure that identifies military experience. This bill will allow DCA to identify veterans in the application process and to ensure that they are counting military credit toward licensure.

- 2) The BreZE System. Currently, DCA is in the process of implementing BreZE, a new database and Web site system that centralizes the licensing and enforcement functions of all the licensing programs under DCA. That implementation is scheduled to take place over an 18-month span during 2013-14 and 2014-15. Once completed, individuals will be able to apply and pay for licenses and consumers can file complaints using a single Web site as a one-stop shop. By delaying implementation until January 1, 2015, costs are significantly minimized and the requirements contained in this bill will not delay the roll-out of the new

Date of Hearing: April 17, 2013

ASSEMBLY COMMITTEE ON APPROPRIATIONS

Mike Gatto, Chair

AB 1057 (Medina) – As Amended: April 9, 2013

Policy Committee: Business and Professions

Vote: 13 – 0

Urgency: No State Mandated Local Program: No

Reimbursable:

SUMMARY

This bill requires, after January 1, 2015, every licensing board under the Department of Consumer Affairs (DCA) to inquire in every license application if the applicant is serving in, or has previously served in, the military.

FISCAL EFFECT

Costs should be minor and absorbable within existing resources.

COMMENTS

- 1) Rationale. The author intends for this bill to help military personnel make a successful transition from military to civilian life by creating an efficient process for licensing veterans in professional careers who have acquired new work skills while in the military.

Toward that end, the bill requires every licensing board under DCA to affirmatively inquire in every license application if the applicant is serving in, or has previously served in, the military, in order to better identify and assist active military members and veterans applying for professional licensure.

The author notes that most of DCA's licensing programs already have some process for accepting military service credit towards licensure for one or all of its license types. However, there is nothing on the application for licensure that identifies military experience. This bill will allow DCA to identify veterans in the application process and to ensure that they are counting military credit toward licensure.

- 2) The BreEZe System. Currently, DCA is in the process of implementing BreEZe, a new database and Web site system that centralizes the licensing and enforcement functions of all the licensing programs under DCA. That implementation is scheduled to take place over an 18-month span during 2013-14 and 2014-15. Once completed, individuals will be able to apply and pay for licenses and consumers can file complaints using a single Web site as a one-stop shop. By delaying implementation until January 1, 2015, costs are significantly minimized and the requirements contained in this bill will not delay the roll-out of the new



California.
LEGISLATIVE INFORMATION

SB-305 Healing arts: boards. (2013-2014)

AMENDED IN SENATE APRIL 25, 2013

AMENDED IN SENATE APRIL 15, 2013

CALIFORNIA LEGISLATURE— 2013-2014 REGULAR SESSION

SENATE BILL

No. 305

**Introduced by Senator Price
(Principal Coauthor(s): Assembly Member Gordon)**

February 15, 2013

An act to amend Sections 2450, 2450.3, ~~2569~~, 3010.5, 3014.6, 3685, 3686, 3710, 3716, and ~~3765~~ of, 3765 of, and to add Section 144.5 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 305, as amended, Price. Healing arts: boards.

Existing law requires specified regulatory boards within the Department of Consumer Affairs to require an applicant for licensure to furnish to the board a full set of fingerprints in order to conduct a criminal history record check.

This bill would additionally authorize those boards to request and receive from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation and would authorize a local or state agency to provide those records to the board upon request.

Existing law, the Osteopathic Act, provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California.

This bill would require that the powers and duties of the board, as provided, be subject to review by the appropriate policy committees of the Legislature. The bill would require that the review be performed as if these provisions were scheduled to be repealed as of January 1, 2018.

Existing law, the Naturopathic Doctors Act, until January 1, 2014, provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California. Existing law also specifies that the repeal of the committee subjects it to review by the appropriate policy committees of the Legislature.

This bill would extend the operation of these provisions until January 1, 2018, and make conforming changes

~~Existing law provides for the regulation of dispensing opticians, as defined, by the Medical Board of California.~~

~~This bill would require that the powers and duties of the board, as provided, be subject to review by the appropriate policy committees of the Legislature. The bill would require that the review be performed as if these provisions were scheduled to be repealed as of January 1, 2018.~~

Existing law, the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. The Respiratory Care Act provides for the licensure and regulation of respiratory care practitioners by the Respiratory Care Board of California. Each of those acts authorizes the board to employ an executive officer. Existing law repeals these provisions on January 1, 2014 and subjects the boards to review by the Joint Committee on Boards, Commissions, and Consumer Protection.

This bill would extend the operation of these provisions until January 1, 2018, and provide that the repeal of these provisions subjects the boards to review by the appropriate policy committees of the Legislature.

The Respiratory Care Act also prohibits a person from engaging in the practice of respiratory care unless he or she is a licensed respiratory care practitioner. However, the act does not prohibit specified acts, including, among others, the performance of respiratory care services in case of an emergency or self-care by a patient.

This bill would additionally authorize the performance of pulmonary function testing by persons who are currently employed by Los Angeles county hospitals and have performed pulmonary function testing for at least 15 years.

This bill would make legislative findings and declarations as to the necessity of a special statute for the persons described above.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 144.5 is added to the Business and Professions Code, to read:

144.5. Notwithstanding any other law, a board described in Section 144 may request, and is authorized to receive, from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation. A local or state agency may provide those records to the board upon request.

SEC. 2. Section 2450 of the Business and Professions Code is amended to read:

2450. There is a Board of Osteopathic Examiners of the State of California, established by the Osteopathic Act, which shall be known as the Osteopathic Medical Board of California which enforces this chapter relating to persons holding or applying for physician's and surgeon's certificates issued by the Osteopathic Medical Board of California under the Osteopathic Act.

Persons who elect to practice using the term of suffix "M.D.," as provided in Section 2275, shall not be subject to this article, and the Medical Board of California shall enforce the provisions of this chapter relating to persons who made the election.

Notwithstanding any other law, the powers and duties of the Osteopathic Medical Board of California, as set forth in this article and under the Osteopathic Act, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2018.

SEC. 3. Section 2450.3 of the Business and Professions Code is amended to read:

2450.3. There is within the jurisdiction of the Osteopathic Medical Board of California a Naturopathic Medicine Committee authorized under the Naturopathic Doctors Act (Chapter 8.2 (commencing with Section 3610)). This section shall become inoperative on January 1, 2018, and, as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other provision of law, the repeal of this section renders the Naturopathic Medicine Committee subject to review by the appropriate policy committees of the Legislature.

~~Notwithstanding any other law, the powers and duties of the board, as set forth in this chapter, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2018.~~

~~SEC. 6.~~**SEC. 4.** Section 3010.5 of the Business and Professions Code is amended to read:

3010.5. (a) There is in the Department of Consumer Affairs a State Board of Optometry in which the enforcement of this chapter is vested. The board consists of 11 members, five of whom shall be public members.

Six members of the board shall constitute a quorum.

(b) The board shall, with respect to conducting investigations, inquiries, and disciplinary actions and proceedings, have the authority previously vested in the board as created pursuant to Section 3010. The board may enforce any disciplinary actions undertaken by that board.

(c) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

~~SEC. 6.~~**SEC. 5.** Section 3014.6 of the Business and Professions Code is amended to read:

3014.6. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

~~SEC. 7.~~**SEC. 6.** Section 3685 of the Business and Professions Code is amended to read:

3685. Notwithstanding any other law, the repeal of this chapter renders the committee subject to review by the appropriate policy committees of the Legislature.

~~SEC. 8.~~**SEC. 7.** Section 3686 of the Business and Professions Code is amended to read:

3686. This chapter shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

~~SEC. 9.~~**SEC. 8.** Section 3710 of the Business and Professions Code is amended to read:

3710. (a) The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

~~SEC. 10.~~**SEC. 9.** Section 3716 of the Business and Professions Code is amended to read:

3716. The board may employ an executive officer exempt from civil service and, subject to the provisions of law relating to civil service, clerical assistants and, except as provided in Section 159.5, other employees as it may deem necessary to carry out its powers and duties.

This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

~~SEC. 11.~~**SEC. 10.** Section 3765 of the Business and Professions Code is amended to read:

- (a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.
- (b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold himself or herself out to be a respiratory care practitioner licensed under the provisions of this chapter.
- (c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.
- (d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their speciality.
- (e) Respiratory care services in case of an emergency. "Emergency," as used in this subdivision, includes an epidemic or public disaster.
- (f) Persons from engaging in cardiopulmonary research.
- (g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.
- (h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department of Health Services of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the board.
- (i) The performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

SEC. 12.~~SEC. 11.~~ The Legislature finds and declares that a special law, as set forth in Section ~~11~~ 10 of this act, is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances relating to persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

**SENATE COMMITTEE ON BUSINESS, PROFESSIONS
AND ECONOMIC DEVELOPMENT
Senator Curren D. Price, Jr., Chair**

Bill No: SB 305 Author: Price
As Amended: April 25, 2013 Fiscal: Yes

SUBJECT: Healing arts: boards.

SUMMARY: Extends until January 1, 2018, the provisions establishing the Naturopathic Medicine Committee and the Respiratory Care Board of California, and extends the term of the executive officers of the Respiratory Care Board of California and the California State Board of Optometry. Specifies that the Osteopathic Medical Board of California is subject to review by the appropriate policy committees of the Legislature. Exempts individuals who have performed pulmonary function tests in Los Angeles county facilities for at least 15 years, from licensure as a respiratory care therapist. Specifies that any board under the Department of Consumer Affairs is authorized to receive certified records from a local or state agency to complete an applicant or licensee investigation and authorizes them to provide those records to the board.

Existing law:

- 1) Requires and board, bureau or program within the Department of Consumer Affairs (DCA) to require an applicant for licensure to furnish to the board a full set of fingerprints in order to conduct a criminal history record check. (Business and Professions Code (BPC) § 144)
- 2) Provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California (OMB) (BPC § 2450)
- 3) Establishes the Naturopathic Medicine Committee, within the Osteopathic Medical Board of California, under the DCA, and permits the committee to license and regulate naturopathic doctors until January 1, 2014. (BPC § 3610 et seq.)
- 4) Specifies that the repeal of the Naturopathic Medicine Committee subjects it to review by the appropriate policy committees of the Legislature (BPC § 2450.3)
- 5) Provides for the licensure and regulation of optometrists by the California State Board of Optometry and authorizes the California Board of Optometry to employ an executive officer until January 1, 2014. (BPC § 3010 et seq.; 3014.6)
- 6) Provides for the licensure and regulation of respiratory care practitioners by the Respiratory Care Board of California and authorizes the board to employ and executive officer until

- 7) Specifies activities that are not prohibited by the Respiratory Care Act including: (BPC § 3765)
- a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs;
 - b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold himself or herself out to be a respiratory care practitioner;
 - c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training;
 - d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed;
 - e) Respiratory care services in case of an emergency; "emergency" includes an epidemic or public disaster;
 - f) Persons from engaging in cardiopulmonary research;
 - g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication; and
 - h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department of Health Services of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the Respiratory Care Board.

This bill:

- 1) Revises the provisions of the Naturopathic Medicine Act as follows:
 - a) Extends, until January 1, 2018, the provisions establishing the Naturopathic Medicine Committee.
 - b) Specifies that the Naturopathic Medicine Committee is subject to be reviewed by the appropriate policy committees of the Legislature.
- 2) Revises the provisions of the Optometry Act as follows:
 - a) Extends, until January 1, 2018, the term of the executive officers of the California State Board of Optometry.
 - b) Specifies that the California State Board of Optometry is subject to be reviewed by the appropriate policy committees of the Legislature.

- 3) Revises the provisions of the Respiratory Care Act as follows:
 - a) Extends, until January 1, 2018, the provisions establishing the Respiratory Care Board of California.
 - b) Extends, until January 1, 2018, the term of the executive officers of the Respiratory Care Board of California.
 - c) Specifies that the Respiratory Care Board of California is subject to be reviewed by the appropriate policy committees of the Legislature.
 - d) Exempts individuals who have performed pulmonary function tests in Los Angeles county facilities for at least 15 years, from licensure as a respiratory care therapist.
- 4) Revises the provisions related to the Osteopathic Medical Board of California as follows:
 - a) Requires that the powers and duties of the Osteopathic Medical Board of California would be subject to review by the appropriate policy committees of the Legislature and requires that the review of the Board be performed as if these provisions were scheduled to be repealed January 1, 2018.
- 5) Specifies that any board under the DCA is authorized to receive certified records from a local or state agency of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation.
- 6) Specifies that a local or state agency is authorized to provide those records to a board upon receipt of such a request.

FISCAL EFFECT: Unknown. This bill has been keyed fiscal by Legislative Counsel.

COMMENTS:

1. **Purpose.** This bill is one of six “sunset review bills” authored by the Chair of this Committee. Unless legislation is carried this year to extend the sunset dates for the Naturopathic Medicine Committee, the Respiratory Care Board of California and the California State Board of Optometry, they will be repealed on January 1, 2014. Because it was created via initiative act, the Osteopathic Medical Board of California does not have a sunset date. This bill will specify that as of January 1, 2018, the Osteopathic Medical Board of California will be reviewed consistent with other healing arts boards under the DCA that are subject to a 4 year sunset review period. This bill will exempt certain employees from going through the laborious process of becoming certified respiratory therapists when they have been safely and reliably performing services for over 15 years at LA County safety net hospitals. This bill will allow all DCA boards to receive certified records from a local or state agency of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation.

2. **Oversight Hearings and Sunset Review of Licensing Boards and Commission of DCA.** In 2013, this Committee conducted oversight hearings to review 14 regulatory boards within the DCA. The Committee began its review of these licensing agencies in March and conducted three days of hearings. This bill, and the accompanying sunset bills, is intended to implement legislative changes as recommended in the Committee's Background/Issue Papers for all of the agencies reviewed by the Committee this year.
3. **Review of the Naturopathic Medicine Committee (NMC), Issues Identified and Recommended Changes.** Although the Committee addressed several issues regarding the NMC during its review of this Committee, the only statutory change necessary was the extension of their sunset dates.

a) **Issue: Should the current NMC continue to license and regulate Naturopathic Doctors?**

Background: The health and safety of consumers is protected by well-regulated professions. The NMC is charged with protecting the consumer from unprofessional and unsafe licensees. It appears that the NMC has had significant difficulty operating as an effective and efficient regulatory body for the profession that falls under its purview. Many of the issues are related to a lack of staff. Immediate attention should be paid to increasing the staff of the NMC and focusing on salient enforcement tasks.

Recommendation: The Committee staff recommended that NDs continue to be regulated by the current NMC in order to protect the interests of consumers and be reviewed once again in four years. [The current language in this measure reflects this recommended change.]

4. **Review of the Respiratory Care Board of California (RCB), Issues Identified and Recommended Changes.** The following are some of the pertaining to the RCB in which statutory changes were considered necessary, or areas of concern reviewed and discussed by the Committee during the review of the RCB, along with background information concerning each particular issue. Recommendations were made by Committee staff and members regarding the particular issues or problem areas which needed to be addressed.

a) **Issue: Difficulty for RCB and Other Board in Obtaining Local Agency Records.**

Background: It is customary for most boards and bureaus to obtain complete arrest, conviction and other related documentation as part of an applicant's or licensee's investigation. As such, boards rely on various authorities and local law enforcement agencies to provide documentation. Lately the RCB, as well as others at the DCA, have been refused access to records, with local government agencies justifying this refusal based on the RCB's perceived lack of authorization to obtain records without approval by the individual in question. This situation causes delays in investigations and can even potentially prevent the RCB from taking appropriate disciplinary action.

The RCB states that it is crucial to its consumer safety mission to be able to access all arrest, court and other related documentation through the course of an applicant or

information impedes the ability of licensing entities to efficiently take appropriate disciplinary action or thoroughly investigate applicants.

The RCB cites a recent example where a local agency required the RCP's staff to obtain authorization from the licensee for the RCB to access the information. In that case, the RCB ended up getting the records from the district attorney. The RCP also states that it has had issues with some local agencies requiring a fee from the RCB prior to their releasing of records which also slows down the process. In one situation, a local government agency provided the following language to the RCB when it refused to produce records:

"The arrest record(s) cannot be released pursuant to Section 432.7(g)(1) of the Labor Code which reads that "no peace officer or employee of a law enforcement agency with access to criminal offender record information maintained by a local law enforcement criminal justice agency shall knowingly disclose, with intent to affect a person's employment, any information contained therein pertaining to an arrest or detention or proceeding that did not result in a conviction, including information pertaining to a referral to, and participation in, any pretrial or post trial diversion program, to any person not authorized by law to receive that information."

Recommendation: Committee staff recommended that Section 144.5 be added to the Business and Professions Code as follows:

Notwithstanding any other provision of law, a board described in Section 144 is authorized to receive certified records from a local or state agency of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation. The local or state agency is authorized to provide those records to the board upon receipt of such a request.

[The current language in this measure reflects this recommended change.]

b) **Issue: Pulmonary Function Technologists (PFTs).**

Background: When the RCB was instituted, several unlicensed individuals, including those who solely performed pulmonary function tests were grandfathered and issued a license as a RCB. However, the requirement to be grandfathered was not communicated to PFTs who were employed at certain Los Angeles County safety-net hospitals. As a result, these employees continued to practice for several years without knowledge that their practice was illegal. In the late 1990's the RCB was made aware of the issue and it was reviewed during the 2002 sunset review of the RCB. At that time, the Joint Legislative and Sunset Review Committee asked the RCB to examine the issue of unlicensed professionals who were performing pulmonary function tests. The RCB attempted to seek legislation to exempt certain pulmonary function testing from being regulated. However, the RCB was unable to get DCA approval to pursue legislation. During the 2013 sunset review process, staff from the RCB worked with Committee staff to draft language that would exempt these skilled professionals who have performed pulmonary function testing for over 15 years from the licensure requirements of the RCB. In addition, the RCB agreed to continue

Recommendation: The Committee staff recommended that BPC § 3765 be amended to exempt pulmonary function technologists at Los Angeles County hospitals who have performed pulmonary function testing for at least 15 years, from the requirement of becoming a licensed Respiratory Care Therapist. [The current language in this measure reflects this recommended change.]

c) **Issue: Should the current RCB continue to license and regulate Respiratory Care Therapists?**

Background: The health and safety of consumers is protected by well-regulated professions. The RCB is charged with protecting the consumer from unprofessional and unsafe licensees.

Recommendation: The Committee staff found that the RCB has shown the ability to regulate Respiratory Care Therapists. As such, the Committee staff recommended that Respiratory Care Therapists continue to be regulated by the current RCB and be renewed again in four years. [The current language in this measure reflects this recommended change.]

5. **Review of the California Board of Optometry (CBO), Issues Identified and Recommended Changes.** Although the Committee addressed several issues regarding the CBO during its review, the only statutory change necessary was the extension of their sunset dates.

d) **Issue: Should the current CBO continue to license and regulate Optometrists?**

Background: The health and safety of consumers is protected by well-regulated professions. The CBO is charged with protecting the consumer from unprofessional and unsafe licensees.

Recommendation: The Committee staff found that despite a lack of staff, the CBO has shown the ability to regulate Optometrists. As such, the Committee staff recommended that Optometrists continue to be regulated by the current CBO and be renewed again in four years. [The current language in this measure reflects this recommended change.]

6. **Review of the Osteopathic Medical Board of California (OMB), Issues Identified and Recommended Changes.** Although the Committee addressed several issues regarding the OMB during its review, the only statutory change necessary was the extension of their sunset dates.

a) **Issue: Should the current OMB continue to license and regulate Osteopathic Physicians and Surgeons ?**

Background: The health and safety of consumers is protected by well-regulated professions. The OMB is charged with protecting the consumer from unprofessional and unsafe licensees. It appears that the OMB has had difficulty operating as an effective and efficient regulatory body primarily due to a lack of staff. Immediate attention should be

Recommendation: The Committee staff recommended that Osteopathic Physicians and Surgeons continue to be regulated by the current OMB in order to protect the interests of consumers and be reviewed once again in four years. [The current language in this measure reflects this recommended change.]

7. **Current Related Legislation.** SB 304 (Price, 2013). Makes various changes to the Medical Practice Act and to the Medical Board of California. (Note: *This bill will also be heard before the BP&ED Committee during today's hearing*)

SB 306 (Price, 2013). Extends until January 1, 2018, the provisions establishing the State Board of Chiropractic Examiners, Speech Language Pathology and Audiology and Hearing Aid Dispensers Board the Physical Therapy Board of California and the California Board of Occupational Therapy and extends the terms of the executive officers of the Physical Therapy Board of California and the Speech Language Pathology and Audiology and Hearing Aid Dispensers Board. This bill also subjects the boards to be reviewed by the appropriate policy committees of the Legislature. (Note: *This bill will also be heard before the BP&ED Committee during today's hearing*)

SB 307 (Price, 2013) Extends, until January 1, 2018, the term of the Veterinary Medicine Board, which provides for the licensure and registration of veterinarians and registered veterinary technicians and the regulation of the practice of veterinary medicine by the Veterinary Medical Board. (Note: *This bill will also be heard before the BP&ED Committee during today's hearing*)

SB 308 (Price, 2013) Extends, until January 1, 2018, the term of the Interior Design Law. Specifies that a certified interior designer provides plans and documents that collaborates with other design professionals. Requires a certified interior designer to use a written contract when contracting to provide interior design services to a client. Extends, until January 1, 2018, the State Board of Guide Dogs for the Blind and extends an arbitration procedure for the purpose of resolving disputes between a guide dog user and a licensed guide dog school.

Extends until January 1, 2018, the State Board of Barbering and Cosmetology and requires a school to be approved by the board before it is approved by the Bureau for Private Postsecondary Education. The bill would also authorize the board to revoke, suspend, or deny its approval of a school on specified grounds. (Note: *This bill will also be heard before the BP&ED Committee during today's hearing*)

SB 309 (Price, 2013) Extends the term of the State Athletic Commission, which is responsible for licensing and regulating boxing, kickboxing, and martial arts matches and is required to appoint an executive officer until January 1, 2018. (Note: *This bill will also be heard before the BP&ED Committee during today's hearing*)

8. **Arguments in Support.** SEIU California supports the bill. In their letter they write, "The affected pulmonary technicians at the Los Angeles County + University of Southern California Healthcare Network and Harbor-University of California Los Angeles Medical Center average 25 years' worth of experience in pulmonary function testing at the two largest public hospitals in Southern California. These professionals are an integral part of the care team. According

worked for decades before DHS determined that the affected employees are technically practicing without appropriate licensure. Despite their years of service and contributions to the delivery of health care, they have been temporarily reassigned to different roles pending resolution of the matter. SB 305 would narrowly apply to this cohort and remedy this oversight by providing that they can resume their work in pulmonary function testing. Failure to do so would adversely impact the quality of access of patients.”

The Naturopathic Medicine Committee supports SB 305. They indicate, “The NMC has nursed the growing profession of naturopathic medicine in California... Licensure and regulation of naturopathic doctors ensures that only those individuals who meet all the education and competency standards explicit in [the Naturopathic Practice Act] are eligible for a license, and that those who are granted a license continue to meet the ongoing continuing medical education requirements outlined in statute.”

The California Naturopathic Doctors Association also supports the bill. They note, “Licensure and regulation of the California naturopathic doctor profession by the Naturopathic Medicine Committee provides the citizens of California safe access to well-trained primary care providers that specialize in cost-saving, effective, natural medicine focused healthcare.” The Osteopathic Physicians and Surgeons of California support SB 305. They state, “With more than 6500 osteopathic physicians currently licensed by the State of California, and growing by approximately 10% annually, it is appropriate for the OMBC to continue serving in its role of consumer protection.”

The California Optometric Association supports the bill. They note, “COA strongly supports the State Board of Optometry and its endeavors to protect Californians and ensure they receive high standards of eye care.”

The California State Board of Optometry indicates their support when they state, “Please vote yes on SB 305, which will continue the oversight duties of the Board of Optometry and ensure consumer protection in the area of vision care.”

The National Board of Examiners in Optometry indicates that it provides the assessments for entry into the practice of optometry for those optometrists seeking licensure in California as well as 51 other jurisdictions. The significant time, effort, commitment and expertise required to develop the Parts I, II, III and TMOD examinations render its assessments particularly valuable and relevant as part of the process that the California Board of Optometry uses for granting a license to practice optometry.”

Western University of Health Sciences supports SB 305. In their letter they write, “The functions of the State Board of Optometry are essential to the residents of the State of California to ensure access to high quality eye care. The State Board is essential for licensure and regulation of doctors of optometry.”

The Association of Regulatory Boards of Optometry supports the bill. In their letter they write, “In ARBO’s experience, the health and safety of Californians will be well served by SB 305. The vision care services provided by doctors of optometry both expand the range of options and increase access to vision care services for all Californians. Optometrists have the

practice. SB 305 will reduce costs for Californians and increase both the quantity and quality of their health care.”

SUPPORT AND OPPOSITION:

Support:

Association of Regulatory Boards of Optometry
California Naturopathic Doctors Association
California Optometric Association
California State Board of Optometry
National Board of Examiners in Optometry
Osteopathic Physicians & Surgeons of California
SEIU California
Western University of Health Sciences

Opposition:

None on file as of April 24, 2013

Consultant: Le Ondra Clark, Ph.D.



California
LEGISLATIVE INFORMATION

SB-352 Medical assistants: supervision. (2013-2014)

AMENDED IN SENATE APRIL 10, 2013

CALIFORNIA LEGISLATURE— 2013-2014 REGULAR SESSION

SENATE BILL

No. 352

**Introduced by Senator Pavley
(Principal Coauthor(s): Senator Hernandez)**

February 20, 2013

An act to amend Section 2069 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 352, as amended, Pavley. Medical assistants: supervision.

Existing law authorizes a medical assistant to perform specified services relating to the administration of medication and performance of skin tests and simple routine medical tasks and procedures upon specific authorization from and under the supervision of a licensed physician and surgeon or podiatrist, or in a specified clinic upon specific authorization of a physician assistant, nurse practitioner, or nurse-midwife. *Existing law requires the Board of Registered Nursing to issue a certificate to practice nurse-midwifery to a qualifying applicant who is licensed pursuant to the Nursing Practice Act.*

This bill would delete the requirement that the services performed by the medical assistant be in a specified clinic when under the specific authorization of a physician assistant, nurse practitioner, or *certified* nurse-midwife. The bill would also delete several obsolete references and make other *conforming, technical, and* nonsubstantive changes.

Vote: majority Appropriation: no Fiscal Committee: no Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. *Section 2069 of the Business and Professions Code is amended to read:*

2069. (a) (1) Notwithstanding any other ~~provision of law~~, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services ~~in a clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code~~ upon the specific authorization of a

(2) The supervising physician and surgeon ~~at a clinic described in paragraph (1)~~ may, at his or her discretion, in consultation with the nurse practitioner, *certified* nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, *certified* nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the supervising physician and surgeon is not onsite, ~~so long as~~ *if either of the following apply:*

(A) The nurse practitioner or *certified* nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725, or protocol. The standardized procedures or protocol shall be developed and approved by the supervising physician and ~~surgeon, surgeon and~~ the nurse practitioner or *certified* nurse-midwife, ~~and the facility administrator or his or her designee.~~

(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502 and is approved to do so by the supervising physician ~~or~~ and surgeon.

(b) As used in this section and Sections 2070 and 2071, the following definitions ~~shall~~ apply:

(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a *certified* nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the ~~Division of Licensing~~ *board*. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

(2) "Specific authorization" means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the *certified* nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the *certified* nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

(3) "Supervision" means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

(C) A physician assistant, nurse practitioner, or *certified* nurse-midwife as provided in subdivision (a).

(4) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a *certified* nurse-midwife as provided in subdivision (a).

(c) Nothing in this section shall be construed as authorizing ~~the~~ *any of the following:*

(1) ~~The licensure of medical assistants. Nothing in this section shall be construed as authorizing the~~

(2) ~~The administration of local anesthetic agents by a medical assistant. Nothing in this section shall be construed as authorizing the division to~~

(3) ~~The board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.~~

(4) ~~A medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1200).~~

~~(5) A nurse practitioner, certified nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.~~

~~(d) Notwithstanding any other provision of law, a medical assistant may shall not be employed for inpatient care in a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code.~~

~~(e) Nothing in this section shall be construed as authorizing a medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1206.5). Nothing in this section shall be construed as authorizing a nurse practitioner, nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.~~

~~SECTION 1. Section 2069 of the Business and Professions Code is amended to read: 2069.~~

~~(a)(1) Notwithstanding any other law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a nurse-midwife.~~

~~(2) The supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the supervising physician and surgeon is not onsite, if either of the following apply:~~

~~(A) The nurse practitioner or nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725, or protocol. The standardized procedures or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner or nurse-midwife, and the facility administrator or his or her designee.~~

~~(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502 and is approved to do so by the supervising physician and surgeon.~~

~~(b) As used in this section and Sections 2070 and 2071, the following definitions apply:~~

~~(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.~~

~~(2) "Specific authorization" means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.~~

~~(3) "Supervision" means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:~~

~~(A) A licensed physician and surgeon.~~

~~(C) A physician assistant, nurse practitioner, or nurse midwife as provided in subdivision (a).~~

~~(4) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a nurse midwife as provided in subdivision (a).~~

~~(e) Nothing in this section shall be construed as authorizing any of the following:~~

~~(1) The licensure of medical assistants.~~

~~(2) The administration of local anesthetic agents by a medical assistant.~~

~~(3) The board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.~~

~~(e) Nothing in this section shall be construed as authorizing a medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1206.5). Nothing in this section shall be construed as authorizing a nurse practitioner, nurse midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.~~

~~(d) Notwithstanding any other law, a medical assistant shall not be employed for inpatient care in a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code.~~

~~(4) A medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1200).~~

~~(5) A nurse practitioner, nurse midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.~~

SENATE RULES COMMITTEE

SB 352

Office of Senate Floor Analyses

1020 N Street, Suite 524

(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: SB 352
Author: Pavley (D), et al.
Amended: 4/10/13
Vote: 21

SENATE BUSINESS, PROF. & ECON. DEV. COMM.: 9-1, 4/8/13

AYES: Price, Emmerson, Block, Corbett, Galgiani, Hernandez, Hill, Padilla,
Wyland

NOES: Yee

SUBJECT: Medical assistants: supervision

SOURCE: California Academy of Physician Assistants
California Association of Physician Groups

DIGEST: This bill allows medical assistants (MAs) to perform technical supportive services, in doctor's offices and all medical clinics, under the supervision of a physician assistant (PA), nurse practitioner or certified nurse-midwife without a physician on the premises; and makes other conforming, technical, and nonsubstantive changes.

ANALYSIS:

Existing law:

1. Authorizes a medical assistant, as defined, to perform specified services relating to the administration of medication and performance of skin tests and simple routine medical tasks and procedures upon specific authorization from and under the supervision of a licensed physician and surgeon or podiatrist, or

2. Defines “specific authorization” as a specific written order prepared by the supervising physician, surgeon, podiatrist, nurse practitioner or nurse-midwife authorizing the procedures to be performed on a patient.
3. Requires the Board of Registered Nursing to issue a certificate to practice nurse-midwifery to a qualifying applicant who is licensed pursuant to the Nursing Practice Act.
4. Authorizes MAs to perform additional technical supportive services, as specified.

This bill:

1. Expands the types of settings where MAs can provide technical supportive services from community and free clinics to any medical setting.
2. Authorizes a physician or surgeon to authorize a nurse practitioner, certified nurse-midwife or PA to provide supervision of MAs as they follow written instructions provided by the physician when the physician is not on site, if either:
 - A. The nurse practitioner or certified nurse-midwife is functioning pursuant to standardized procedures, as defined by Business and Professions Code (BPC) Section 2725, or protocol. The standardized procedures or protocol shall be developed and approved by the supervising physician and surgeon and the nurse practitioner or certified nurse-midwife.
 - B. The PA is functioning pursuant to regulated services defined in BPC Section 3502 and is approved to do so by the supervising physician and surgeon.
3. Specifies that the standards established for MAs will be established by the Medical Board of California (MBC), and specifies that the MBC shall not adopt regulations that violate prohibitions on diagnosis or treatment.
4. Specifies that MAs shall not perform any tests or examinations for which he/she is not authorized.

5. Prohibits a nurse practitioner, certified nurse-midwife, or PA to be a laboratory

Background

MAs and their scope of practice. According to the United States Bureau of Labor and Statistics (BLS), the medical assisting professions continue to be some of the fastest growing employment categories. The BLS projects that the number of MAs will grow by 34%, from 483,600 in 2008, to 647,500 by 2018. California employs nearly 82,000 MAs. MAs are unlicensed personnel who work in physician, podiatrist or optometrist offices and clinics. MAs may not work for inpatient care in licensed general acute care hospitals. MAs can perform basic administrative, clerical and technical supportive services when conditions regarding supervision, training, specific authorization and records are met.

Training. An MA must receive training either directly from a physician, surgeon, podiatrist, registered nurse, licensed vocational nurse, PA or a qualified MA. Alternatively, an MA may receive training from a secondary, postsecondary or adult education program in a public school authorized by the California Department of Education, in a community college program, or a postsecondary institution accredited by an accreditation agency recognized by the U.S. Department of Education or approved by the Bureau for Private Postsecondary Education.

Certification. MAs are regulated by the MBC and may be certified. There are two MA certifying agencies that are recognized by the National Commission for Certifying Agencies – the American Association of Medical Assistants who provide Certified Medical Assistant certification, and the American Medical Technologists who provide Registered Medical Assistant certification.

Supervision. MAs can be supervised by physicians, surgeons, podiatrists or optometrists. Additionally, if an MA is working in a community or free clinic, they may work under the direct supervision of a PA, nurse practitioner or nurse-midwife when the supervising physician or surgeon is not on site, only if the physician or surgeon has created a written protocol for the activities of the MA.

Authorization. MAs must receive specific authorization before providing any technical services. This authorization may be in the form of a specific written order or standing order prepared by the supervising physician, surgeon or podiatrist. The order must include an authorization for the procedure to be performed and it must be noted in the patient's medical record.

Records. MAs are required to document all technical supportive services in the patient's record. In addition, when practicing in a community or free clinic under the supervision of a PA, nurse practitioner or nurse-midwife, the delegation of supervision from the physician, surgeon or podiatrist to the PA, nurse practitioner or nurse-midwife, must be documented in a written standard protocol.

Community and free clinics. In response to California's growing population and ensuing need to provide health care services, SB 111 (Alpert, Chapter 358, Statutes of 2000) permitted MAs to perform technical supportive services in community and free clinics under the direct supervision of a PA, nurse practitioner or nurse-midwife.

There are four types of licensed community clinics in California: (1) Federally Qualified Health Center sites (FQHC); (2) FQHC look-alike sites; (3) free clinic sites; and (4) other independent, non-profit clinic sites.

A key distinction among these different designations is the type of public funding support each clinic receives. FQHC sites and FQHC look-alike sites both meet eligibility requirements for two critical sources of funding support: (1) enhanced Medi-Cal reimbursement rates and (2) a federal operating grant made available by Section 330 of the Public Health Service Act (PHSA). Only FQHC clinics receive PHSA Section 330 operating grants, which are nationally competitive. Conversely, FQHC look-alike clinics have a non-competitive grant process.

Free clinics are statutorily required to not directly charge patients for receipt of treatment. Further, free clinics are not supported by enhanced Medi-Cal reimbursements or a PHSA Section 330 operating grant and are supported largely by private donations.

Since the passage of SB 111, neither the Physician Assistant Committee nor the Board of Registered Nursing of the Department of Consumer Affairs have received any patient safety complaints or enacted any disciplinary action related to PAs, nurse practitioners or nurse-midwives supervising MAs in community and free clinics.

Comments

According to the author's office, current laws require that a physician must be present at the practice site to supervise an MA. However, MAs can work under the

performing administrative and clerical duties and therefore may not perform or assist with even the simplest technical supportive services if the physician is not on the premises.

FISCAL EFFECT: Appropriation: No Fiscal Com.: No Local: No

SUPPORT: (Verified 4/9/13)

California Academy of Physician Assistants (co-source)
California Association of Physician Groups (co-source)
California Academy of Family Physicians
California Association for Nurse Practitioners
California Optometric Association
United Nurses Associations of California/Union of Health Care Professionals

OPPOSITION: (Verified 4/16/13)

California Nurses Association

ARGUMENTS IN SUPPORT: According to this bill's sponsor, the California Academy of Physician Assistants (CAPA), PAs have been delegated the task of supervising MAs when the physician is not physically present in specified licensed community clinics for over a decade. As such, CAPA proposes to eliminate legal restrictions and barriers to efficient coordinated care by allowing physicians to delegate the task of MA supervision to a PA across all outpatient medical settings. This change is necessary if California hopes to accommodate the dramatic increase in patients expected to result from the Patient Protection and Affordable Care Act (ACA).

The California Association for Nurse Practitioners indicates that this bill will expand the current practice that occurs in community clinics of allowing nurse practitioners and PAs to supervise MAs to all settings. This model has been in place for over 10 years with no complications. Allowing nurse practitioners to supervise MAs in this way has enabled them to focus their time and services on patient care, delegating some very basic functions to an MA. Expanding this practice to all settings will allow nurse practitioners to increase the number of patients they will be able to see, providing much needed increased access to health care. This bill makes no changes to the scope of practice of either an MA or a nurse practitioner but instead removes the limitations in current law that do not

The California Optometric Association believes this bill will expand access and allow more patients to receive care. They state, "...deploying these professionals in a team-based delivery model where they work collaboratively with physician assistants, nurse practitioners or midwives will allow California to meet the demands placed on its health care systems created by a rapidly aging physician population and expansion of health insurance coverage."

The United Nurses Associations of California/Union of Health Care Professionals indicates that with the implementation of the ACA, change is necessary in California in order to accommodate the dramatic increase in patients expected to result from health care reform.

The California Academy of Family Physicians indicates with the large influx of newly insured individuals in California nearing, it is necessary to continue to find more efficient ways of ensuring adequacy in the delivery of primary care. The Academy applauds efforts that streamline delivery of quality care while preserving the team based approach that is best for patients.

ARGUMENTS IN OPPOSITION: According to the California Nurses Association (CNA), "this bill will contribute to the fragmentation of primary care services, and, by consequently expanding the use of MAs, will undermine the delivery of safe health care services at a critical time in the expansion of access to primary care under the Affordable Care Act.... This bill is premature since there is no indication that the impact of the Affordable Care Act will necessitate a deskilling of healthcare services in order to provide primary care provider access to California consumers. CNA believes this bill will shift licensed nursing functions onto far less qualified employees in order to shuttle patients through offices and clinics more rapidly. Quantity care is not quality care and CNA maintains its position that the expansion of access to primary healthcare services does not require existing providers to work more quickly, it simply requires a greater number of those appropriately educated providers."

MW:k 4/16/13 Senate Floor Analyses

SUPPORT/OPPOSITION: SEE ABOVE

**** END ****





California.
LEGISLATIVE INFORMATION

SB-491 Nurse practitioners. (2013-2014)

AMENDED IN SENATE MAY 01, 2013

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 01, 2013

CALIFORNIA LEGISLATURE— 2013-2014 REGULAR SESSION

SENATE BILL

No. 491

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 2835.5, 2835.7, 2836.1, 2836.2, and 2836.3 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 491, as amended, Hernandez. Nurse practitioners.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing. Existing law requires an applicant for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including, among others, ordering durable medical equipment, and, in consultation with a physician and surgeon, approving, signing, modifying, or adding to a plan of treatment or plan for an individual receiving home health services or personal care services.

This bill would revise these provisions by deleting the requirement that those acts be performed pursuant to a standardized procedure or in consultation with a physician and surgeon. The bill would also authorize a nurse practitioner to perform specified additional acts, including, among others, examining patients and establishing a medical diagnosis and prescribing drugs and devices. The bill would require that, on and after July 1, 2016, an applicant for initial qualification or certification as a nurse practitioner hold a national certification as a nurse practitioner from a national certifying body recognized by the board.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

(a) Nurse practitioners are a longstanding, vital, safe, effective, and important part of the state's health care delivery system. They are especially important given California's shortage of physicians, with just 16 of 58 counties having the federally recommended ratio of physicians to residents.

(b) Nurse practitioners will play an especially important part in the implementation of the federal Patient Protection and Affordable Care Act, which will bring an estimated five million more Californians into the health care delivery system, because they will provide for greater access to primary care services in all areas of the state. This is particularly true for patients in medically underserved urban and rural communities.

(c) Due to the excellent safety and efficacy record that nurse practitioners have earned, the Institute of Medicine of the National Academy of Sciences has recommended full independent practice for nurse practitioners. Currently, 17 states allow nurse practitioners to practice to the full extent of their training and education with independent practice.

(d) Furthermore, nurse practitioners will assist in addressing the primary care provider shortage by removing delays in the provision of care that are created when dated regulations require a physician's signature or protocol before a patient can initiate treatment or obtain diagnostic tests that are ordered by a nurse practitioner.

SEC. 2. Section 2835.5 of the Business and Professions Code is amended to read:

2835.5. (a) A registered nurse who is holding himself or herself out as a nurse practitioner or who desires to hold himself or herself out as a nurse practitioner shall, within the time prescribed by the board and prior to his or her next license renewal or the issuance of an initial license, submit educational, experience, and other credentials and information as the board may require for it to determine that the person qualifies to use the title "nurse practitioner," pursuant to the standards and qualifications established by the board.

(b) Upon finding that a person is qualified to hold himself or herself out as a nurse practitioner, the board shall appropriately indicate on the license issued or renewed, that the person is qualified to use the title "nurse practitioner." The board shall also issue to each qualified person a certificate evidencing that the person is qualified to use the title "nurse practitioner."

(c) A person who has been found to be qualified by the board to use the title "nurse practitioner" prior to January 1, 2005, shall not be required to submit any further qualifications or information to the board and shall be deemed to have met the requirements of this section.

(d) On and after January 1, 2008, an applicant for initial qualification or certification as a nurse practitioner under this article who has not been qualified or certified as a nurse practitioner in California or any other state shall meet the following requirements:

- (1) Hold a valid and active registered nursing license issued under this chapter.
- (2) Possess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing.
- (3) Satisfactorily complete a nurse practitioner program approved by the board.

(e) On and after July 1, 2016, an applicant for initial qualification or certification as a nurse practitioner shall, in addition, hold a national certification as a nurse practitioner from a national certifying body recognized by the board.

SEC. 3. Section 2835.7 of the Business and Professions Code is amended to read:

2835.7. (a) Notwithstanding any other law, in addition to any other practices authorized in statute or regulation, a nurse practitioner may do any of the following:

(1) Order durable medical equipment. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) After performance of a physical examination by the nurse practitioner, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(3) For individuals receiving home health services or personal care services, approve, sign, modify, or add to a plan of treatment or plan of care.

- (4) Assess patients, synthesize and analyze data, and apply principles of health care.
 - (5) Manage the physical and psychosocial health status of patients.
 - (6) Analyze multiple sources of data, identify alternative possibilities as to the nature of a health care problem, and select, implement, and evaluate appropriate treatment.
 - (7) Examine patients and establish a medical diagnosis by client history, physical examination, and other criteria.
 - (8) Order, furnish, or prescribe drugs or devices pursuant to Section 2836.1.
 - (9) Refer patients to other health care providers as provided in subdivision (b).
 - (10) Delegate *tasks* to a medical assistant *pursuant to standardized procedures and protocols developed by the nurse practitioner and medical assistant, that are within the medical assistant's scope of practice.*
 - (11) Perform additional acts that require education and training and that are recognized by the nursing profession as proper to be performed by a nurse practitioner.
 - (12) Order hospice care as appropriate.
 - (13) Perform procedures that are necessary and consistent with the nurse practitioner's ~~training and education~~ *scope of practice.*
- (b) A nurse practitioner shall refer a patient to a physician or another licensed health care provider if the referral will protect the health and welfare of the patient, and shall consult with a physician or other licensed health care provider if a situation or condition occurs in a patient that is beyond the nurse practitioner's knowledge and experience.
- (c) A nurse practitioner shall maintain medical malpractice insurance.

SEC. 4. Section 2836.1 of the Business and Professions Code is amended to read:

2836.1. (a) Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing, ordering, or prescribing drugs or devices when both of the following apply:

- (1) The drugs or devices that are furnished, ordered, or prescribed are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.
- (2) (A) The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished, ordered, or prescribed under this section.

(B) Nurse practitioners who are certified by the board and hold an active furnishing number and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

(b) A nurse practitioner shall not furnish, order, or prescribe a dangerous drug, as defined in Section 4022, without an appropriate prior examination and a medical indication, unless one of the following applies:

- (1) The nurse practitioner was a designated practitioner serving in the absence of the patient's physician and surgeon, podiatrist, or nurse practitioner, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.
- (2) The nurse practitioner transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:
 - (A) The nurse practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.
 - (B) The nurse practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon, podiatrist, or nurse practitioner, as the case may be.

(3) The nurse practitioner was a designated practitioner serving in the absence of the patient's physician and surgeon, podiatrist, or nurse practitioner, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with subdivision (b) of Section 120582 of the Health and Safety Code.

(c) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include the ordering of a drug or device.

(d) "Drug order" or "order" for purposes of this section means an order for medication which is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (2) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 5. Section 2836.2 of the Business and Professions Code is amended to read:

2836.2. All nurse practitioners who are authorized pursuant to Section 2836.1 to prescribe, furnish, or issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.

SEC. 6. Section 2836.3 of the Business and Professions Code is amended to read:

2836.3. (a) The furnishing of drugs or devices by nurse practitioners is conditional on issuance by the board of a number to the nurse applicant who has successfully completed the requirements of paragraph (2) of subdivision (b) of Section 2836.1. The number shall be included on all transmittals of orders for drugs or devices by the nurse practitioner. The board shall make the list of numbers issued available to the Board of Pharmacy. The board may charge the applicant a fee to cover all necessary costs to implement this section.

(b) The number shall be renewable at the time of the applicant's registered nurse license renewal.

(c) The board may revoke, suspend, or deny issuance of the numbers for incompetence or gross negligence in the performance of functions specified in Sections 2836.1 and 2836.2.

**SENATE COMMITTEE ON BUSINESS, PROFESSIONS
AND ECONOMIC DEVELOPMENT
Senator Curren D. Price, Jr., Chair**

Bill No: SB 491 Author: Hernandez
As Amended: April 16, 2013 Fiscal: Yes

SUBJECT: Nurse practitioners.

SUMMARY: Deletes the requirement that nurse practitioners perform certain tasks pursuant to standardized procedures and/or consultation with a physician or surgeon and authorizes a nurse practitioner to perform those tasks independently. Also requires, after July 1, 2016, that nurse practitioners possess a certificate from a national certifying body in order to practice.

Existing law:

- 1) Establishes the Board of Registered Nursing (BRN), within the Department of Consumer Affairs (DCA), and authorizes the BRN to license, certify and regulate nurses. (Business and Professions Code (BPC) §§ 2701; 2708.1)
- 2) Clarifies that there are various and conflicting definitions of "nurse practitioner" (NP) and "registered nurse" (RN) that are used within California and finds the public interest is served by determining the legitimate and consistent use of the title "nurse practitioner" established by the BRN. (BPC § 2834)
- 3) Requires applicants for licensure as a NP to meet specified educational requirements including: (BPC § 2835.5)
 - a) Possessing a Master's degree in nursing, and/or a Master's degree in a clinical field related to nursing;
 - b) A graduate degree in nursing; and
 - c) Completion of a RN program authorized by the BRN.
- 4) Recognizes the existence of overlapping functions between physicians and NPs and permits additional sharing of functions within organized health care systems that provide for collaboration between physician and NPs. (BPC § 2725; Health and Safety Code (HSC) § 1250)
- 5) Defines "health facility" as any facility, place, or building that is organized, maintained and

or more of these purposes, for which one or more persons are admitted for a 24-hour stay or longer. (HSC § 1250)

- 6) Authorizes a NP to do the following, pursuant to standardized procedures created by a physician or surgeon, or in consultation with a physician or surgeon: (BPC § 2835.7)
 - a) Order durable medical equipment;
 - b) Certify disability claims; and
 - c) Approve, sign, modify or add information to a plan of treatment for individuals receiving home health services.
- 7) Defines "furnishing" as the ordering of a drug or device in accordance with standardized procedures or protocols (SPP) or transmitting an order of a supervising physician and surgeon. (BPC § 2836.1(h))
- 8) Defines "drug order" or "order" as an order for medication which is dispensed to or for an ultimate user and issued by a NP. (BPC § 2836.1(i))
- 9) Establishes that the furnishing and ordering of drugs or devices by NPs is done in accordance with the SPP developed by the supervising physician and surgeon, NP and the facility administrator or designee and shall be consistent with the NPs educational preparation and/or established and maintained clinical competency. (BPC § 2836.1)
- 10) Indicates a physician and surgeon may determine the extent of supervision necessary in the furnishing or ordering of drugs and devices. (BPC § 2836.1(g)(2))
- 11) Permits a NP to furnish or order Schedule II through Schedule V controlled substances and specifies that a copy of the SPP shall be provided upon request to any licensed pharmacist when there is uncertainty about the NP furnishing the order. (BPC § 2836.1(f)(1)(2); HSC §§ 11000; 11055; 11056).
- 12) Indicates that for Schedule II controlled substances, the SPP must address the diagnosis of the illness, injury or condition for which the controlled substance is to be furnished. (BPC § 2836.1(2))
- 13) Requires that a NP has completed a course in pharmacology covering the drugs or devices to be furnished or ordered. (BPC § 2836.1(g)(1))
- 14) States that a NP must hold an active furnishing number, register with the United States Drug Enforcement Administration and take a continuing education course in Schedule II controlled substances. (BPC § 2836.1(3))
- 15) Specifies the SPP must list which nurse practitioners may furnish or order drugs or devices. (BPC § 2836.1(c)(1))

approval of the SPP and availability of the physician and surgeon to be contacted via telephone at the time of the patient examination by the NP. (BPC § 2836.1(d))

- 17) Limits the physician and surgeon to supervise no more than four NPs at one time.
(BPC § 2836.1(e))
- 18) Authorizes the BRN to issue a number to NPs who dispense drugs or devices and revoke, suspend or deny issuance of the number for incompetence or gross negligence.
(BPC § 2836.2)

This bill:

- 1) Makes findings and declarations of the Legislature regarding the vital, safe and effective role of NPs and notes the important role of NPs addressing the primary care shortage anticipated as a result of the implementation of the federal Patient Protection and Affordable Care Act (ACA).
- 2) Indicates that a person who has been found to be qualified by the BRN to use the title "nurse practitioner" prior to January 1, 2005, is not required to submit additional information to the BRN.
- 3) Requires after July 1, 2016, an applicant for certification as a NP must hold a national certification from a national certifying body recognized by the BRN.
- 4) Removes the requirement that NPs must do the following tasks only if there are SPP authorized by a physician:
 - a) Order durable medical equipment;
 - b) Certify disability claims; and
 - c) Approve, sign, modify or add information to a plan of treatment for individuals receiving home health services.
- 5) Adds the following to the list of tasks NPs can perform independently and without SPP authorized by a physician:
 - a) Assess patients, synthesize and analyze data, and apply principles of health care;
 - b) Manage patients' physical and psychosocial health status;
 - c) Analyze data to identify the nature of a health care problem and select, implement and evaluate appropriate treatment;
 - d) Examine a patient and establish a medical diagnosis;
 - e) Order, furnish or prescribe drugs or devices;

f) Refer a patient to another health care provider and consult with the other health care provider if the situation or condition is beyond the NPs knowledge and experience;

g) Delegate duties to a medical assistant;

h) Order hospice care; or

i) Maintain medical malpractice insurance.

6) Specifies that drugs or devices furnished, ordered or prescribed independently by a NP shall be consistent with the NPs educational preparation or level of competency.

7) Indicates that a NP shall not furnish, order or prescribe a dangerous drug without an appropriate examination and a medical indication except in certain circumstances.

8) Permits NPs to prescribe controlled substances and register with the United States Drug Enforcement Administration.

FISCAL EFFECT: Unknown. This bill has been keyed "fiscal" by Legislative Counsel.

COMMENTS:

1. **Purpose.** The bill is sponsored by the Author. The Author indicates SB 491 will establish full practice authority for NPs enabling them to perform all tasks and functions consistent with their education and training, and in collaboration with physicians and other health care providers. The Author believes SB 491 is an answer to the anticipated health workforce shortages due to the implementation of the Patient Protections and Affordable Care Act in 2014. The Author notes, "...many newly insured Californians will cause additional pressure on the already strained health care system, particularly in medically underserved areas."

2. **Background.**

a) **The Patient Protections and Affordable Care Act.** On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into federal statute. The ACA, which states will begin implementing in 2014, represents one of the most significant government expansions and regulatory overhauls of the United States health care system since the passage of Medicare and Medicaid in 1965. The ACA is aimed at increasing the rate of health insurance coverage for Americans and reducing the overall costs of health care. It provides a number of mechanisms including mandates, subsidies and tax credits to employers and individuals in order to increase the coverage rate. Additional reforms aim to improve health care outcomes and streamline the delivery of health care. One salient provision is the requirement for insurance companies to cover all applicants and offer the same rates regardless of pre-existing medical conditions.

Opponents of the ACA turned to the federal courts to challenge its constitutionality. On June 28, 2012, the United States Supreme Court upheld the constitutionality of most of ACA in the case of *National Federation of Independent Business versus Sebelius*

protection under the Commerce Clause. However, the Supreme Court determined that states could not be forced to participate in the expansion of Medicaid. As such, all provisions of the ACA will continue in effect or will take effect as scheduled subject to states determination on Medicaid expansion. In California, efforts are well underway to implement the ACA including Medicaid expansion, also referred to as "Medi-Cal" in California, by 2014.

- b) **Primary Care Workforce Shortage.** As a result of implementation of the ACA, about 4.7 million additional Californians will be eligible for health insurance beginning in 2014. It is anticipated that the newly insured will increase demand for health care on an already strained system. For example, according to estimates obtained from the Council on Graduate Medical Education (CGME), the number of primary care physicians actively practicing in California is far below the state's need. The distribution of these primary care physicians is also poor. In 2008, there were 69,460 actively practicing primary care physicians in California, of which only 35 percent reported they actually practiced primary care. This equates to 63 active primary care physicians per 100,000 persons. However, according to the CGME, 60 to 80 primary care physicians are needed per 100,000 persons in order to adequately meet the needs of the population. When the same metric is applied regionally, only 16 of California's 58 counties fall within the needed supply range for primary care physicians. In other words, less than one third of Californians live in a community where they have access to adequate health care services.
- c) **Nurse Practitioner Education, Training and Scope.**

Education and Training. The BRN sets the educational standards for NP certification. A NP is a registered nurse (RN) who has earned a bachelors and postgraduate nursing degree such as a Master's or Doctorate degree. NPs possess advanced skill in physical diagnosis, psycho-social assessment and management of health-illness needs in primary health care, which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease (CCR §§ 1480(b); 1484). Examples of primary health care include: physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, withdrawal of blood and authority to initiate emergency procedures.

Scope/Standardized Procedures (SPPs). A NP does not have an additional scope of practice beyond the RNs scope and must rely on SPPs for authorization to perform medical functions which overlap with those conducted by a physician (CCR § 1485). Examples of these functions include: diagnosing mental and physical conditions, using drugs in or upon human beings, severing or penetrating the tissue of human beings and using other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions. Standardized procedures and protocols must be developed collaboratively with NPs, physicians and administration of the organized health care system where they will be utilized. Because of this interdisciplinary collaboration, there is accountability on several levels for the activities to be performed by the NP. Importantly, a NP must provide the organized health system with satisfactory evidence that the nurse meets the experience, training and/or education requirements to perform the functions. If

The BRN and the Medical Board of California (MBC) jointly promulgated the following guidelines for SPPs: (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474; Medical Board of California, Title 16, CCR Section 1379.)

Standardized procedures and protocols shall include a written description of the method used in developing and approving them and any revision thereof. Each SPP shall:

- 1) Be in writing, dated and signed by the organized health care system personnel authorized to approve it.
- 2) Specify which SPP functions registered nurses may perform and under what circumstances.
- 3) State any specific requirements which are to be followed by NPs in performing particular SPP functions.
- 4) Specify any experience, training, and/or education requirements for performance of SPP functions.
- 5) Establish a method for initial and continuing evaluation of the competence of those NPs authorized to perform SPP functions;
- 6) Provide for a method of maintaining a written record of those persons authorized to perform SPP functions.
- 7) Specify the scope of supervision required for performance of SPP functions, for example, telephone contact with the physician.
- 8) Set forth any specialized circumstances under which the NP is to immediately communicate with a patient's physician concerning the patient's condition.
- 9) State the limitations on settings, if any, in which SPP functions may be performed.
- 10) Specify patient record-keeping requirements.
- 11) Provide for a method of periodic review of the SPP.

d) Nurse Practitioners in Medically Underserved Areas.

Supervision of Medical Assistants. In response to California's growing population and ensuing need to provide health care services, SB 111 was passed in 2001. SB 111 permits NPs and other specified allied health professionals to supervise medical assistants (MAs) without a physician present and according to SPPs established by the physician. This supervision model is currently only permitted in free and community clinics such as Federally Qualified Health Centers (FQHC) and independent non-profit clinics. These clinics are typically in medically underserved areas and are statutorily prohibited from

the BRN within the DCA has not received any patient safety complaints or enacted any disciplinary action related to NPs supervising MAs in free and community clinics.

(<http://www.chcf.org/topics/almanac/inde.cfm?itemId=133890>; HSC Division 2, Chapter 1, Article 1 § 1204)

Nurse-Managed Health Clinics. Nurse-managed health clinics, of which many are FQHCs and independent non-profit clinics, are safety net clinics that provide primary care, health promotion and disease prevention services to patients who are least likely to receive ongoing health care. This population includes people of all ages who are uninsured, underinsured, living in poverty and minority groups. Unlike other FQHC and independent non-profits, these clinics are solely operated by NPs.

According to the National Nursing Centers Consortium, there are at least 250 nurse-managed clinics already operating in the United States; most are located in the East Coast. Of these, 10 have been chosen for funding through a federal expansion initiative. One such clinic, GLIDE Health Services, is a FQHC located in San Francisco, California and provides primary and urgent care, preventative services and psychiatric treatment to an urban population.

Physician Supervision. In many of the nurse-managed clinics, the physician to NP supervision relationship is quite flexible. A supervising physician may be present for a very limited amount of time to perform perfunctory tasks such as signing off on equipment orders, and reviewing and signing medical records. The physician may also elect to make himself/herself available for telephonic consult. For example, at GLIDE the supervising physician is physically on site 1-2 days a week to sign off on orders such as wheel chairs, walkers and commodes and to review medications that have been prescribed and furnished by NPs. According to Patricia Dennehy, a NP and director of GLIDE, "Though we value our MD colleagues and consult with them for complex care issues, currently there are administrative barriers to care delivery and access that are not practical."

Clinical Training Sites. In addition to providing care to patients, nurse-managed health clinics also play an important role in health professions education. More than 85 of the nation's leading nursing schools operate nurse-managed health clinics that serve as clinical education and practice sites for nursing students and faculty. Many, like GLIDE, also have partnerships with other academic programs and provide learning opportunities for medical, pharmacy, social work, public health and other students.

- e) **Full Practice Authority.** The American Association of Nurse Practitioners defines full practice authority as, "The collection of state practice and licensure laws that allow for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments, including prescribe medications, under the exclusive licensure authority of the state board of nursing." Like the changes to statute proposed in this legislation, under full practice authority, NPs are still required to meet educational and practice requirements for licensure, maintain national certification and remain accountable to the public and the state board of nursing. Under this model, NPs would continue to consult and refer patients to other health care providers according to the patient's needs.

Academies of Science released a 2010 report titled, *The Future of Nursing: Leading Change, Advancing Health*, in which the IOM wrote, "Remove scope of practice barriers. [NPs] should be able to practice to the full extent of their education and training...the current conflicts between what [NPs] can do based on their education and training and what they may do according to state federal regulations must be resolved so that they are better able to provide seamless, affordable and quality care." A report by the National Governor's Association, *The Role of Nurse Practitioners in Meeting Increased Demand for Primary Care* noted, "In light of research evidence, states might consider changing scope of practice restrictions and assuring adequate reimbursement for their services as a way of encouraging and incentivizing greater NP involvement in the provision of primary health care."

Despite these arguments, some physician groups, including the American Medical Association (AMA) assert that encouraging full practice authority may put patients' health at risk. They cite the difference in educational attainment noting that physicians are required to complete four years of medical school plus three years of residency compared to the four years of nursing school and two years of graduate school required for NPs.

Other States. Many other states have recognized the ability for NPs to play a more efficient role in the delivery of health care services and have updated their practice acts to align with NPs training and education. For example, about one third of the nation has adopted full practice authority including: Alaska, Arizona, Colorado, District of Columbia, Hawaii, Idaho, Iowa, Maine, Montana, Oregon, New Hampshire, New Mexico, North Dakota, Rhode Island, Vermont, Washington and Wyoming. The AMA contends that many of the NPs that practice independently in these states do not deliver care to underserved areas.

Financial Implications. Over the past 40 years, there have been a number of studies on the cost-effectiveness of NP practice (Office of Technology Assessment, 1986; Chenowith, Martin, Pankowski & Raymond, 2008; Bakerjian, 2008; Chen, McNeese-Smith, Cowan, Upenieks & Afifi, 2009). Results overwhelmingly show NPs provide equivalent or improved medical care at a lower cost than their physician counterparts. Though the ACA encourages the creation of nurse-managed practices, by requiring insurers to pay NPs the same rates paid to physicians for identical services rendered, Medicare will not provide equal reimbursement. Presently, Medicare pays NPs 85% of the physician rate for the same services. The Medicare Payment Advisory Commission, the federal agency that advises Congress on Medicare issues, found that there was no analytical foundation for this difference. Despite this fact, revising payment methodology would require Congress to change the Medicare law. Additionally, health insurance plans have significant discretion to determine what services they cover and which providers they recognize. Not all plans cover NPs. Further, many managed care plans require enrollees to designate a primary care provider but do not always recognize NPs. In fact, a 2009 survey conducted by the National Nursing Centers Consortium found that nearly half of the major managed care organizations did not credential NPs as primary care providers (www.healthaffairs.org/healthpolicybriefs/brief.php). If NPs were granted full practice authority, state efforts would need to be undertaken to ensure NPs would be recognized as primary care providers by insurance companies.

3. **Arguments in Support.** The United Nurses Associations of California/ Union of Health Care Professionals supports the bill. In their letter they indicate, "Independent practice would allow NPs to choose to see Medi-Cal patients, a decision that is now left up to the physician they work for. Due to the excellent safety and efficacy record NPs have earned historically, the Institutes of Medicine and the National Council of State Boards of Nursing have recommended full practice for NPs. Currently, 17 states allow NPs to practice at the full extent of their training and education with independent practice."

The California Association for Nurse Practitioners supports the bill. They point out in their letter, "Next year's addition of up to seven million new health care consumers affected by implementation of the Affordable Care Act is sure to exacerbate California's current shortage and uneven distribution of primary care physicians. SB 491 provides a partial solution to this dilemma by allowing NPs to play a boarder role in the health care system. Adoption of the policy changes proposed in this bill would add California to the growing number of states that already allow 'independent practice' for NPs in a wide range of health care settings."

The American Association of Retired Persons supports the bill. In their letter they note, "Decades of evidence demonstrate that [nurse practitioners] have been providing high quality health care with positive outcomes equal to the care provided by their physician counterparts. Consumers will have improved access to medications, diagnoses and treatments, and referrals to specialists and therapists with the modernization of California's scope of practice laws."

The Association of California Healthcare Districts states, "As health care districts are located in rural areas and have a difficult time recruiting physicians to their areas, expanding the scope of practice of Nurse Practitioners would allow patients to receive continuous preventative and acute care should there be no access to a physician."

The California Association for Nurse Anesthetists supports the bill. In their letter they note, "[Nurse Anesthetists] work independently of anesthesiologists in 80% of California counties in a wide variety of practice settings; currently seven rural counties depend solely on nurse anesthetists... In 2009, Governor Arnold Schwarzenegger allowed California to "opt-out" of a requirement that [nurse anesthetists] be supervised by physicians to receive federal reimbursement. This has allowed our members to provide safe, high quality care to Californians at affordable rates, while increasing access to care."

The California Optometric Association believes that this legislation is necessary to make the promise of the ACA a reality.

Blue Shield of California indicates that the bill will expand the range of services that these practitioners are able to provide will improve access and quality of care as they are well trained and highly educated professionals that are already providing integral health services.

The California Pharmacists Association wrote a joint letter with the California Society of Health-System Pharmacists. In it they write, "CSHP and CPhA believe that it is vital to better utilize all health care providers consistent with their training and education to address current workforce shortages. By empowering nurse practitioners to provide additional services with

Californians for Patient Care also supports the bill. In their letter they note, "It is widely noted that there are not enough trained medical professionals to appropriately care for the influx of new patients. We believe it is important that qualified, educated and trained nurse practitioners be allowed to practice to the extent of their licenses to best serve California's patient population throughout the state."

The National Association of Pediatric Nurse Practitioners state their support when they write, "With the exception of Nevada, California is surrounded by states that allow nurse practitioners full practice authority. We are not asking to expand on what we are trained to do; we are requesting that required supervision by a physician be removed since we already operate under professional standards. This is an unnecessary regulation and time spent supervising and being supervised limits the amount of time the nurse practitioner and physician can spend providing direct patient care."

4. **Support if Amended.** The California Association of Physician Groups supports the bill if amended. They state, "Our concern over full autonomous practice, as currently stated in this measure, is that it will lead to increased practice silos in California, competition with primary care physicians, and increased fragmented delivery of care."

The California Hospital Association supports the bill if amended. In their letter they write, "CHA applauds the author's bold initiative to proactively address California's health care access needs. While CHA supports the conceptual premises outlined in the SB 491 provisions, we would like to work with the author and offer amendments...to assure NP practice is firmly based within the boundaries of their education, training and certification and that quality and patient safety measures are firmly embedded in the provisions."

5. **Arguments in Opposition.** The California Medical Association (CMA) opposes the bill and raises several concerns in their letter. They indicate, "There is no evidence that states that have expanded scope of practice have experienced improved access to care or lower levels of underserved patient populations. For example, of the states that allow independent practice of nurse practitioners, 12 states have a larger underserved population than California." The CMA also notes, "Current requirements for standardized procedures are not mere formalities or bureaucratic barriers to care. These requirements are in place to ensure that patient care includes the involvement and oversight of a physician who is substantially more qualified and experienced to oversee patient care." They add, "Contrary to claims that allowing full independent practice is consistent with a national trend of state scope of practice expansions...33 states including Texas, Florida, New York and Illinois require physician involvement with nurse practitioners. Of these, 24 require physician involvement...to diagnose, treat and prescribe." The CMA is also concerned that complaints about care provided by NPs would be referred to the BRN which would be responsible for investigation and discipline. They write, "...the BRN is structured very differently from the MBC and does not have access to expert physician reviewers who can assess if the care provided was below or within the community standard of care."

The California Academy of Eye Physicians & Surgeons state their opposition when they note, "The bills are being promoted such that they would in some way provide additional access to medical services for those who will gain coverage under the Affordable Care Act. With

work under physician supervision. If they were independent, they would likely see exactly the same number of patients. The only change would be that they would see them on their own.”

The Union of American Physicians and Dentists also opposes the bill. They note in their letter, “UAPD/AFSCME embraces the concept of expanding health care access to residents of the State of California. However, SB 491 is not the solution. The bill does nothing to expand the delivery of quality health care to residents. Rather, SB 491 stakes out an untested and uncertain health care delivery system full of potential pitfalls for the patient. The removal of medical supervision over nurse practitioners has many shortcomings, including disrupting an effective health care treatment team.”

The Lighthouse for Christ Mission opposes the bill. They believe physicians, who have many years more training, are far less likely to miss more rare causes of some diseases, helping to ensure patients will get the right treatment.

Canvasback Missions indicated similar opposition in their letter when they note, “As an organization that is keenly interested in health care and works to serve populations who need access to high quality health care, we have concerns...NPs who have less training than physicians...are far less likely to miss rare causes of some diseases.”

The California Society of Anesthesiologists opposes the bill. They indicate, “Patient safety could be at risk by allowing NP prescription of drugs, including controlled substances, without the collaboration of physicians having far more training in diagnosing underlying diseases and conditions. Further, since excessive prescribing of controlled substances is seen as a major health problem, authorizing a new category of direct prescribers is contrary to the need for stronger oversight and controls.”

The California Right to Life Committee, Inc. is also opposes the bill. They are concerned that the bill “would be used as a vehicle for nurses to perform abortions and administer abortifacient drugs.”

The California Psychiatric Association opposes the bill. In their letter they write, “SB 491 does nothing to assure that in this independent practice that there is any notification whatsoever to a patient’s physician of additions, deletions or other changes to psychotropic medications that may have been prescribed by the physician. SB 491 also opens up the door to a nurse practitioner diagnosing mental illnesses and then prescribing powerful anti-psychotics or other psychotropic medications to new patients, and/or patients without a personal physician.”

The California Chapter of the American College of Emergency Physicians also opposes the bill. They have concerns that nurse practitioners “do not have sufficient education and training to examine and diagnose completely independent of physicians and such a practice puts patients at risk.”

- 6. Oppose Unless Amended.** The California Academy of Family Physicians opposes the bill unless it is amended. They believe legislation that changes the scope of [NPs] profession as “independent” or “autonomous” is contrary to what California consumers have come to expect

The Osteopathic Physicians and Surgeons of California also opposes the bill unless it is amended. They indicate, "SB 491 is...a premature response to a genuine problem. OPSC would be happy to continue a dialogue with Dr. Hernandez, the NPs and other stakeholders on a more appropriate solution. It is recommended that SB 491 be held in committee until that dialogue is completed and consensus is reached on responsible amendments on the measure."

7. **Current Related Legislation.** SB 352 (Pavley, 2013) would authorize a NP, physician assistant or certified nurse-midwife to supervise medical assistants without a physician present and according to standardized procedures and protocols created by the physician. *(Note: This bill passed out of Senate Business Professions and Economic Development (BPED) Committee on April 8, 2013, and is currently on the Senate floor.)*

SB 492 (Hernandez of 2013) Permits an optometrist to diagnose treat and manage additional conditions with ocular manifestations, directs the California Board of Optometry to establish educational and examination requirements and permits optometrists to perform vaccinations and surgical and non-surgical primary care procedures. The bill is also up for consideration before the Committee today. *(Note: The bill is up for consideration before the BP&ED Committee today.)*

SB 493 (Hernandez, 2013) authorizes a pharmacist to administer drugs and biological products that have been ordered by a prescriber. Expands other functions pharmacists are authorized to perform, and authorizes pharmacists to order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies and to independently initiate and administer routine vaccinations. Also establishes board recognition for an advanced practice pharmacist. *(Note: The bill is up for consideration before the BP&ED Committee today.)*

8. **Prior Related Legislation.** AB 2348 (Mitchell, Chapter 460, Statutes of 2012) authorized a registered nurse to dispense specified drugs or devices upon an order issued by a certified nurse-midwife, nurse practitioner, or physician assistant within specified clinics. The bill also authorized a registered nurse to dispense or administer hormonal contraceptives in strict adherence to specified standardized procedures.

SB 1524 (Hernandez, Chapter 796, Statutes of 2012) deleted the requirement for at least 6 months duration of supervised experience by a physician before a nurse-midwife could furnish or order drugs. The bill authorized a physician and surgeon to determine the extent of the supervision in connection with the furnishing or ordering of drugs and devices by a nurse practitioner or certified nurse-midwife.

AB 867 (Nava, Chapter 416, Statutes of 2010) authorized, until July 1, 2018, the California State University to establish a Doctor of Nursing Practice degree pilot program at 3 campuses chosen by the Board of Trustees to award the Doctor of Nursing Practice degree. The bill required the Doctor of Nursing Practice degree pilot program to be designed to enable professionals to earn the degree while working full time, train nurses for advanced practice, and prepare clinical faculty to teach in postsecondary nursing programs.

revised the educational requirements for certification as a nurse practitioner and would have required a nurse practitioner to be certified by a nationally recognized certifying body approved by the board. The bill would have allowed a nurse practitioner to prescribe drugs and devices if he or she has been certified by the board to have satisfactorily completed at least 6 months of supervised experience in the prescribing of drugs and devices and if such prescribing is consistent with his or her education or established clinical competency, would have deleted the requirement of standardized procedures and protocols, and would have deleted the requirement of physician supervision. (Note: *This bill died in Senate BPED Committee.*)

AB 1436 (Hernandez, 2007) would have allowed a nurse practitioner to perform comprehensive health care services according to his or her educational preparation. The bill would have authorized a nurse practitioner to admit and discharge patients from health facilities, change a treatment regimen, or initiate an emergency procedure, in collaboration with specified health practitioners. (Note: *This bill was never taken up on the Senate floor.*)

AB 1711 (Strickland, Chapter 58, Statutes of 2005) authorized a registered nurse or licensed pharmacist to administer influenza and pneumococcal immunizations without patient-specific orders to patients age 50 years or older in a skilled nursing facility under standing orders when they meet federal recommendations and are approved by the medical director of the skilled nursing facility.

AB 1821 (Cohn, 2004) would have established the Nursing Workforce Education Investment Act. The act would establish in OSHPD a state nursing contract program with accredited schools and programs that educate and train licensed vocational nurses and registered nurses to increase the supply of nurses in California. (Note: *This bill was vetoed by the Governor.*)

AB 2226 (Spitzer, Chapter 344, Statutes of 2004) would have required, after January 1, 2008, an applicant for initial qualification or certification as a nurse practitioner to meet specified requirements, including possessing a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board.

AB 2560 (Montanez, Chapter 205, Statutes of 2004) authorized a nurse practitioner to furnish drugs or devices under standardized procedures or protocols when the drugs and devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

SB 111 (Alpert, Chapter 358, Statutes of 2001) amended the Medical Practice Act to authorize a medical assistant to perform specified services in community and free clinics under the supervision of a physician assistant, nurse practitioner or nurse-midwife. The bill authorized a physician and surgeon in these specified clinics to provide written instructions for medical assistants, regarding the performance of tasks or duties, while under the supervision of a physician assistant, nurse practitioner or nurse midwife when the supervising physician and surgeon was not on site.

not direct a pharmacist to dispense a trade name or generic drug; use a dispensing device; or hand drugs or dangerous devices to patients in his or her office or place of practice.

9. **Suggested Author's Amendments.**

- a) In order to clarify the authority NPs have to delegate tasks to a medical assistant and specify that the tasks must be within the scope of practice of a medical assistant, the following amendment should be made:

Amendment. On page 4, line 31, after the word "assistant" add the following:

"pursuant to standardized procedures and protocols as developed between the nurse practitioner and medical assistant and as permitted within the medical assistant scope of practice."

- b) In order to clarify the NPs scope of practice should guide any procedures they perform, the following amendment should be made:

Amendment. On page 4, line 40, make the following changes:

Strike out the following: ~~"the nurse practitioner's training and education."~~
Replace with: **"the nurse practitioners scope of practice."**

10. **Policy Issue: Should the BRN and MBC collaborate to discuss NPs proposed independent prescribing authority?** There has been recent attention paid to the issue of deaths caused by prescription drug overdose and the connection to physicians who over-prescribe these drugs to patients. A Los Angeles Times series titled *Dying for Relief* highlighted the role of prescription drugs in overdose deaths. Reporters conducted an analysis of coroners' reports for over 3000 deaths occurring in four counties in Southern California where toxicology tests found a prescription drug in the deceased's system. The analysis found that in nearly half of the cases where prescription drug toxicity was listed as the cause of death, there was a direct connection to a prescribing physician. Similarly, a study conducted by the Centers for Disease Control (CDC) found that in 2010, there were 38,329 deaths resulting from drug overdose, 37,004 deaths in 2009 and 16,849 deaths in 1999. Additionally, the CDC found that nearly 60 percent of the overdose deaths in 2010 involved pharmaceutical drugs. The attention focused on this issue has led to questions regarding the role that licensing boards and other state entities should play when regulating health professionals who have prescribing authority.

This bill would allow NPs to have independent prescribing authority. As such, and in the wake of the current scrutiny of physicians and surgeons who are over-prescribing medications, it is suggested that the BRN and the MBC collaborate to discuss the implications of providing NPs with independent prescribing privileges and the plan for the two boards to work together to address this issue as it relates to regulating NPs' prescribing authority.

SUPPORT AND OPPOSITION:

Support:

California Association of Nurse Practitioners
California Association of Nurse Anesthetists
California Optometric Association
Californians for Patient Care
United Nurses Associations of California/ Union of Health Care Professionals
American Association for Retired Persons
Association of California Healthcare Districts
Blue Shield of California
California Pharmacists Association/ California Society for Health System Pharmacists
National Association of Pediatric Nurse Practitioners
Western University of Health Sciences
1 nurse practitioner
57 individuals

Support if Amended:

California Association of Physician Groups
California Hospital Association

Oppose unless amended:

California Academy of Family Physicians
Osteopathic Physicians and Surgeons of California

Opposition:

California Academy of Eye Physicians & Surgeons
California Medical Association
California Right to Life Committee, Inc.
California Society of Anesthesiologists
Canvasback Missions Inc.
Lighthouse for Christ Mission Eye Center
Union of American Physicians and Dentists
California Psychiatric Association
American College of Emergency Physicians- California Chapter
Hundreds of individuals

Consultant: Le Ondra Clark, Ph.D.





California
LEGISLATIVE INFORMATION

SB-492 Optometrist: practice: licensure. (2013-2014)

AMENDED IN SENATE MAY 08, 2013

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 01, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL

No. 492

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 3041 and 3041.1 of the Business and Professions Code, relating to optometry.

LEGISLATIVE COUNSEL'S DIGEST

SB 492, as amended, Hernandez. Optometrist: practice: licensure.

The Optometry Practice Act creates the State Board of Optometry, which licenses optometrists and regulates their practice. Existing law defines the practice of optometry to include, among other things, the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and doing certain things, including, but not limited to, the examination of the human eyes, the determination of the powers or range of human vision, and the prescribing of contact and spectacle lenses. Existing law authorizes an optometrist certified to use therapeutic pharmaceutical agents to diagnose and treat specified conditions, use specified pharmaceutical agents, and order specified diagnostic tests. Any violation of the act is a crime.

This bill would add the provision of habilitative optometric services to the definition of the practice of optometry. The bill would expand the practice parameters of optometrists who are certified to use therapeutic pharmaceutical agents by removing certain limitations on their practice and adding certain responsibilities, including, but not limited to, the ability to immunize and treat certain diseases, and deleting the specified drugs the optometrist would be authorized to use, and authorizing the optometrist to use all therapeutic pharmaceutical agents approved by the United States Food and Drug Administration, as provided. The bill would also delete limitations on ~~what certain~~ kinds of diagnostic tests an optometrist ~~could~~ *can* order and ~~instead~~ would authorize an optometrist to order appropriate laboratory and diagnostic imaging tests, *as provided*.

Existing law requires optometrists in diagnosing or treating eye disease to be held to the same standard of care

This bill would expand this requirement to include *diagnosing* other diseases, and would require an optometrist to consult with and, if necessary, refer to a physician and surgeon or other appropriate health care provider if a situation or condition was beyond the optometrist's ~~education and training~~ *scope of practice*.

Because this bill would change the definition of a crime, it would create a state-mandated local program.

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

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

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 3041 of the Business and Professions Code is amended to read:

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

- (1) The examination of the human eye or eyes, or its or their appendages, and the analysis of the human vision system, either subjectively or objectively.
- (2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eye or eyes, including the scope of its or their functions and general condition.
- (3) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.
- (4) The prescribing of contact and spectacle lenses for, or the fitting or adaptation of contact and spectacle lenses to, the human eye, including lenses that may be classified as drugs or devices by any law of the United States or of this state.
- (5) The use of topical pharmaceutical agents for the purpose of the examination of the human eye or eyes for any disease or pathological condition.

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

- (A) Through medical treatment, infections of the anterior segment and adnexa.
- (B) Ocular allergies of the anterior segment and adnexa.
- (C) Ocular inflammation, *nonsurgical in cause except when comanaged with the treating physician and surgeon*.
- (D) Traumatic or recurrent conjunctival or corneal abrasions and erosions.
- (E) Corneal surface disease and dry eyes.
- (F) Ocular pain, *nonsurgical in cause except when comanaged with the treating physician and surgeon*.
- (G) Pursuant to subdivision ~~(e)~~ (f), glaucoma in patients over 18 years of age, as described in subdivision ~~(i)~~ (j).
- (H) Eyelid disorders, *including hypotrichosis and blepharitis*.

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

(c) In diagnosing and treating the conditions listed in subdivision (b), an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may use all therapeutic pharmaceutical agents approved by the United States Food and Drug Administration for use in treating eye conditions set forth in this chapter,

Section 11000) of the Health and Safety Code) and the United States Controlled Substances Act (21 U.S.C. Sec. 801 et seq.). The use of these agents shall be limited to three days.

(d) In any case that an optometrist consults with a physician and surgeon, the optometrist and the physician and surgeon shall both maintain a written record in the patient's file of the information provided to the physician and surgeon, the physician and surgeon's response, and any other relevant information. Upon the request of the optometrist or physician and surgeon and with the patient's consent, a copy of the record shall be furnished to the requesting party.

~~(d)~~

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

(1) Corneal scraping with cultures.

(2) Debridement of corneal epithelia.

(3) Mechanical epilation.

(4) Venipuncture for testing patients suspected of having diabetes.

(5) Suture removal, *upon notification of the treating physician and surgeon .*

(6) Treatment or removal of sebaceous cysts by expression.

(7) Administration of oral fluorescein .

(8) Use of an auto-injector to counter anaphylaxis.

(9) Ordering of appropriate laboratory and diagnostic imaging tests *for conditions authorized to be treated pursuant to this section.*

(10) A clinical laboratory test or examination classified as waived under CLIA and designated as waived in paragraph (9) necessary for the diagnosis of conditions and diseases of the eye or adnexa, or if otherwise specifically authorized by this chapter.

~~(10)~~

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

~~(11)~~

(12) The prescription of therapeutic contact lenses, including lenses or devices that incorporate a medication or therapy the optometrist is certified to prescribe or provide.

~~(12)~~

(13) Removal of foreign bodies from the cornea, eyelid, and conjunctiva with any appropriate instrument other than a scalpel . Corneal foreign bodies shall be nonperforating, be no deeper than the midstroma, and require no surgical repair upon removal.

~~(13)~~

(14) For patients over 12 years of age, lacrimal irrigation and dilation, excluding probing of the nasal lacrimal tract. The board shall certify any optometrist who graduated from an accredited school of optometry before May 1, 2000, to perform this procedure after submitting proof of satisfactory completion of 10 procedures under the supervision of an ophthalmologist as confirmed by the ophthalmologist. Any optometrist who graduated from an accredited school of optometry on or after May 1, 2000, shall be exempt from the certification requirement contained in this paragraph.

~~(14)~~

~~(15) Immunizations—Administration of immunizations for influenza and shingles, Herpes Zoster Virus, and additional immunizations that may be necessary to protect public health during a declared disaster or public health emergency.~~

~~(15)~~

~~(16)~~ In addition to diagnosing and treating conditions of the visual system pursuant to subdivision ~~(a)~~ *this section, testing for and, diagnoses of diabetes mellitus, hypertension, and hyperlipidemia hypercholesterolemia.*

~~(e)~~

~~(f)~~ The board shall grant a certificate to an optometrist certified pursuant to Section 3041.3 for the treatment of glaucoma, as described in subdivision ~~(i)~~ *(j)*, in patients over 18 years of age after the optometrist meets the following applicable requirements:

(1) For licensees who graduated from an accredited school of optometry on or after May 1, 2008, submission of proof of graduation from that institution.

(2) For licensees who were certified to treat glaucoma under this section prior to January 1, 2009, submission of proof of completion of that certification program.

(3) For licensees who have substantially completed the certification requirements pursuant to this section in effect between January 1, 2001, and December 31, 2008, submission of proof of completion of those requirements on or before December 31, 2009. "Substantially completed" means both of the following:

(A) Satisfactory completion of a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma.

(B) Treatment of 50 glaucoma patients with a collaborating ophthalmologist for a period of two years for each patient that will conclude on or before December 31, 2009.

(4) For licensees who completed a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, submission of proof of satisfactory completion of the case management requirements for certification established by the board pursuant to Section 3041.10.

(5) For licensees who graduated from an accredited school of optometry on or before May 1, 2008, and not described in paragraph (2), (3), or (4), submission of proof of satisfactory completion of the requirements for certification established by the board pursuant to Section 3041.10.

~~(f)~~

~~(g)~~ Other than for prescription ophthalmic devices described in subdivision (b) of Section 2541, any dispensing of a therapeutic pharmaceutical agent by an optometrist shall be without charge.

~~(g)~~

~~(h)~~ The practice of optometry does not include performing surgery. "Surgery" means any procedure in which human tissue is cut, altered, or otherwise infiltrated by mechanical or laser means. "Surgery" does not include those procedures specified in subdivision ~~(d)~~ *(e)*. Nothing in this section shall limit an optometrist's authority to utilize diagnostic laser and ultrasound technology within his or her scope of practice.

~~(h)~~

~~(i)~~ An optometrist licensed under this chapter is subject to the provisions of Section 2290.5 for purposes of practicing telehealth.

~~(i)~~

~~(j)~~ For purposes of this chapter, "glaucoma" means either of the following:

(1) All primary open-angle glaucoma.

(2) Exfoliation and pigmentary glaucoma.

~~(i)~~

~~(k)~~ For purposes of this chapter, "adnexa" means ocular adnexa.

~~(k)~~

~~(l)~~ In an emergency, an optometrist shall stabilize, if possible, and immediately refer any patient who has an

SEC. 2. Section 3041.1 of the Business and Professions Code is amended to read:

3041.1. With respect to the practices set forth in Section 3041, optometrists diagnosing or treating eye *disease* or *diagnosing* other diseases shall be held to the same standard of care to which physicians and surgeons and osteopathic physicians and surgeons are held. An optometrist shall consult with and, if necessary, refer to a physician and surgeon or other appropriate health care provider if a situation or condition occurs that is beyond the optometrist's ~~education and training~~ *scope of practice*.

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

**SENATE COMMITTEE ON BUSINESS, PROFESSIONS
AND ECONOMIC DEVELOPMENT
Senator Curren D. Price, Jr., Chair**

Bill No: SB 492 Author: Hernandez
As Amended: April 24, 2013 Fiscal: Yes

SUBJECT: Optometrist: practice: licensure.

SUMMARY: Permits an optometrist to diagnose, treat and manage additional conditions with ocular manifestations; directs the California Board of Optometry to establish educational and examination requirements and permits optometrists to perform vaccinations and surgical and non-surgical primary care procedures.

Existing law:

- 1) Establishes the California Board of Optometry (Board), within the Department of consumer Affairs, which licenses optometrists and regulates the practice of optometry. (BPC § 3010.5)
- 2) Authorizes the Board to establish educational and examination requirements for licensure. (BPC § 3041.2)
- 3) Defines the practice of optometry as follows: (BPC § 3041)
 - a) The prevention and diagnosis of disorders and dysfunctions of the visual system;
 - b) Treatment and management of certain disorders and dysfunctions of the visual systems;
 - c) Provision of rehabilitative optometric services;
 - d) Examination of the human eyes;
 - e) Determination of the powers or range of human vision;
 - f) The prescribing or directing the use of any optical device in connection with ocular exercises, visual training, vision training or orthoptics;
 - g) Prescribing of contact lenses and glasses; and
 - h) The use of topical pharmaceutical agents for the purpose of the examination of the human eye or eyes for any disease or pathological condition.
- 4) Specifies that an optometrist who is certified to use therapeutic pharmaceutical agents may also diagnose and treat the human eye or eyes or any of its appendages for the following conditions: (BPC § 3041(b)(1))
 - a) Infections;
 - b) Ocular allergies;

- e) Corneal surface disease and dry eyes;
 - f) Ocular pain, non-surgical in cause except when co-managed with the treating physician and surgeon; and
 - g) Glaucoma in patients over the age of 18.
- 5) Permits optometrists to use the following therapeutic pharmaceutical agents: (BPC § 3041(c))
- a) Topical miotics;
 - b) Topical lubricants;
 - c) Anti-allergy agents;
 - d) Topical and oral anti-inflammatories;
 - e) Topical antibiotic agents;
 - f) Topical hyperosmotics;
 - g) Topical and oral anti-glaucoma agents;
 - h) Non-prescription medications;
 - i) Oral antihistamines;
 - j) Prescription oral non-steroidal anti-inflammatory agents;
 - k) Oral antibiotics for treatment of ocular disease;
 - l) Topical and oral antiviral medication for treatment of:
 - i) Herpes.
 - ii) Viral Keratitis.
 - iii) Herpes Simplex Viral conjunctivitis.
 - iv) Periocular herpes simplex viral dermatitis.
 - v) Varicella zoster viral keratitis.
 - vi) Varicella zoster viral conjunctivitis.
 - vii) Periocular varicella zoster viral dermatitis.
 - m) Oral analgesics that are not controlled substances; and
 - n) Codeine with compounds and hydrocodone with compounds with specific restrictions regarding usage timeframe.
- 6) Specifies that an optometrist who is certified to use therapeutic pharmaceutical agents may also perform the following:
- a) Corneal scraping with cultures;
 - b) Debridement of corneal epithelia;
 - c) Mechanical epilation;
 - d) Venipuncture for testing patients suspected of having diabetes;
 - e) Suture removal, with prior consultation with the treating physician and surgeon;
 - f) Treatment or removal of sebaceous cysts by expression;
 - g) Administration of oral fluorescein to patients suspected as having diabetic retinopathy;
 - h) Use of an auto-injector to counter anaphylaxis;
 - i) Ordering of smears, cultures, sensitivities, complete blood count, mycobacterial culture, acid fast stain, urinalysis, tear fluid analysis and X-rays necessary for the diagnosis of conditions or diseases of the eye or adnexa;
 - j) A clinical laboratory test or examination classified as waived under CLIA necessary for the diagnosis of conditions and diseases of the eye or adnexa;
 - k) Punctal occlusion by plugs, excluding laser diathermy, cryotherapy, or other means

- l) The prescription of therapeutic contact lenses, including lenses or devices that incorporate a medication or therapy the optometrist is certified to prescribe or provide;
- m) Removal of foreign bodies from the cornea, eyelid and conjunctiva with any appropriate instrument other than a scalpel or needle; and
- n) Lacrimal irrigation and dilation, excluding probing of the nasal lacrimal tract for patients over 12 years of age.

This bill:

- 1) Adds the provision of habilitative optometric services to the definition of the practice of optometry.
- 2) Allows an optometrist who is TPA certified to treat the lacrimal gland, lacrimal drainage system and the sclera in patients under 12 years of age.
- 3) Allows an optometrist to treat ocular inflammation via surgical or non-surgical means and deletes the requirement to co-manage the treatment with the patient's treating physician and surgeon .
- 4) Allows an optometrist to treat ocular pain via surgical or non-surgical means and deletes the requirement to co-manage the treatment with the patient's treating physician and surgeon.
- 5) Permits optometrists to treat eye lid disorders.
- 6) Allows an optometrist to use all therapeutic pharmaceutical agents approved by the FDA for use in treating eye conditions including narcotic substances other than Schedule I drugs.
- 7) Removes the requirement for optometrists to only utilize specific TPAs.
- 8) Allows TPA certified optometrists to remove sutures without prior consultation with the treating physician and surgeon.
- 9) Removes the restriction that optometrists can only administer oral fluorescein to patients suspected as having diabetic retinopathy.
- 10)Deletes the list of specific tests optometrists are permitted to order and permits optometrists to order any laboratory and diagnostic imaging tests.
- 11)Adds the provision that optometrists can administer immunizations for influenza and shingles and additional immunizations that may be necessary to protect public health during a declared disaster or public health emergency.
- 12)Permits optometrists to diagnose diabetes, hypertension and hyperlipidemia.
- 13)Specifies that an optometrist diagnosing or treating eye or other disease shall be held to the same standard of care to which physicians and surgeons and osteopathic physicians and surgeons are held

- 14) Allows an optometrist to consult with and refer to a physician and surgeon or appropriate health care provider if a situation or condition occurs that is beyond the optometrist's education and training.

FISCAL EFFECT: Unknown. This bill has been keyed "fiscal" by Legislative Counsel.

COMMENTS:

1. **Purpose.** This bill is sponsored by the Author. According to the Author, SB 492 is intended to allow optometrists to practice to the full extent of their education and training in order to expand access to the health care delivery system for the millions of Californians who will have new access to coverage through the implementation of the federal Patient Protection and Affordable Care Act (ACA). The bill will allow optometrists to diagnose, treat and manage specific eye disorders and common diseases such as diabetes, hypertension and hyperlipidemia. The bill will also expand the drugs optometrists can prescribe and it will permit optometrists to administer immunizations and to perform surgical and non-surgical procedures.

2. **Background.**

- a) **The Patient Protections and Affordable Care Act.** On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into federal statute. The ACA, which states will begin implementing in 2014, represents one of the most significant government expansions and regulatory overhauls of the United States health care system since the passage of Medicare and Medicaid in 1965. The ACA is aimed at increasing the rate of health insurance coverage for Americans and reducing the overall costs of health care. It provides a number of mechanisms including mandates, subsidies and tax credits to employers and individuals in order to increase the coverage rate. Additional reforms aim to improve health care outcomes and streamline the delivery of health care. One salient provision is the requirement for insurance companies to cover all applicants and offer the same rates regardless of pre-existing medical conditions.

Opponents of the ACA turned to the federal courts to challenge its constitutionality. On June 28, 2012, the United States Supreme Court upheld the constitutionality of most of ACA in the case of *National Federation of Independent Business vs. Sebelius*. Specifically, the Supreme Court upheld the mandate for individuals to purchase health insurance if not covered by their employers on the basis that it is a tax rather than protection under the Commerce Clause. However, the Supreme Court determined that states could not be forced to participate in the expansion of Medicaid. As such, all provisions of the ACA will continue in effect or will take effect as scheduled subject to states determination on Medicaid expansion. In California, efforts are well underway to implement the ACA including Medicaid expansion, also referred to as "Medi-Cal" in California, by 2014.

- b) **Primary Care Workforce Shortage.** As a result of implementation of the ACA, about 4.7 million additional Californians will be eligible for health insurance beginning in 2014. It is anticipated that the newly insured will increase demand for health care on an already

practicing in California is far below the state's need. The distribution of these primary care physicians is also poor. In 2008, there were 69,460 actively practicing primary care physicians in California, of which only 35 percent reported they actually practiced primary care. This equates to 63 active primary care physicians per 100,000 persons. However, according to the CGME, 60 to 80 primary care physicians are needed per 100,000 persons in order to adequately meet the needs of the population. When the same metric is applied regionally, only 16 of California's 58 counties fall within the needed supply range for primary care physicians. In other words, less than one third of Californians live in a community where they have access to adequate health care services.

- c) **Shortage of Optometrists.** According to a report prepared by the Center for the Health Professions at the University of California San Francisco, the number of optometrist licenses in California has declined, but the number of licensees with a secondary practice location has increased. According to the California Board of Optometry, there are approximately 9000 optometrists in California, the largest population of optometrists in the United States. These optometrists are generally concentrated in coastal counties, the Bay Area and counties in the Sacramento region. Several counties have no licensed optometrists with an address of record in those counties, and a number of other counties have ratios that indicate there is approximately one optometrist for every 10,000 people.
- d) **Optometry and Ophthalmology.** This bill would expand the types of procedures an optometrist is authorized to execute. This would include some tasks that have been traditionally performed by ophthalmologists. This bill would also require optometrists to consult with ophthalmologists as needed. As such, the current education, training and scope of each profession is outlined below.
- i) Optometrist Education, Training and Scope. After completion of an undergraduate degree, optometrists complete four years of an accredited optometry college after which they are awarded the Doctor of Optometry degree. Some optometrists also undertake an optional one year non-surgical residency program to enhance their experience in a particular area. Students graduate with 2500-3000 patient encounters; these include a mix of post-surgical, medical and routine visits.

Optometrists are trained to diagnose mild to severe eye problems such as serious eye infections, inflammations of the eye, trauma, foreign bodies and glaucoma. They also examine the eye for vision prescription and corrective lenses. Optometrists may apply for certification to administer therapeutic pharmaceutical agents (TPA); to perform lacrimal irrigation and dilation (TPL); and to diagnose and treat primary open angle glaucoma (TLG).

- ii) Ophthalmologist Education, Training and Scope. After obtaining an undergraduate degree, ophthalmologists complete four years at an accredited medical school and earn a Medical Degree. This is followed by a one year internship and a three or four year surgical residency. Many ophthalmologists pursue additional fellowship training in specialized areas such as retina, glaucoma or cornea. Ophthalmologists may become certified by the American Board of Ophthalmology, which requires, serving as primary surgeon or first assistant to the primary surgeon on a minimum of 364 eye surgeries

The central focus of ophthalmology is surgery and management of complex eye diseases. An ophthalmologist specializes in the refractive, medical and surgical care of the eyes and visual system and in the prevention of disease and injury.

- e) **Current and Proposed Scope of Practice for Optometrists.** This bill would expand the scope of practice for optometrists. The following chart illustrates some of the salient changes that would be made to the current scope of practice for optometrists.

Current Scope	Proposed Scope
Defines the practice of optometry to include, among other things, the prevention and diagnosis of disorders and dysfunctions of the visual system, examination of the eyes, determination of the powers or range of human vision and prescribing of contact and spectacle lenses.	Adds the provision of habilitative optometric services to the definition of the practice of optometry.
Limits the conditions of the eye and visual system that can be diagnosed and treated and requires consultation with a physician and surgeon.	Adds eye lid disorders to the list of conditions that can be treated and permits optometrists to treat ocular inflammation and ocular pain that is the result of surgery. Deletes the requirement to consult with a physician and surgeon for treatment of specified conditions.
Limits the pharmaceutical authority of TPA Certified Optometrists.	Allows optometrists to prescribe appropriate drugs including narcotic substances other than Schedule I drugs.
Limits prescriptions to Schedule III drugs, codeine with compounds and hydrocodone and limits the use of these to 3 days with a referral to an ophthalmologist if the pain persists.	Would allow a TPA certified optometrist to prescribe all TPAs approved by the FDA.
Specifies the tests optometrists may order which are necessary for the diagnosis of conditions or diseases of the eye or adnexa.	Permits an optometrist to order any appropriate test including laboratory or diagnostic imaging tests.
Specifies that an optometrist cannot treat the lacrimal gland, the lacrimal drainage system and the sclera in patients under 12 years of age.	Permits an optometrist to treat the lacrimal gland, the lacrimal drainage system and the sclera in patients under 12 years of age.
Does not allow the treatment of systemic disease.	Allows an optometrist to diagnose and treat conditions of the visual system and diagnose diabetes mellitus, hypertension and hyperlipidemia.
Allows optometrists to perform venipuncture for testing patients suspected of having diabetes.	Allows for the administration of immunizations without specific training.
Allows optometrists to remove sutures with prior consultation with the treating physician and surgeon.	Deletes the requirement to have prior consultation with the treating physician and surgeon for this procedure.
Clarifies that the dispensing of TPAs by an optometrist shall be without charge.	Deletes this requirement.
Specifies record keeping requirements for consultations with a physician and surgeon.	Deletes these requirements.

- f) **Other States.** Since 1997, there have been over 45 attempts in over 20 states by optometry associations to expand the scope of practice for optometrists including legislating surgery privileges. However, with the exception of Oklahoma and West Virginia, most states continue to prohibit optometrists from performing surgery, and their statutes specify that the license to practice optometry does not include the right to practice medicine. States such as Colorado and North Carolina specifically exclude surgery from their definition of the practice of optometry.

3. **Arguments in Support.** Blue Shield of California supports the bill. In their letter they state, "Expanding the range of services that these practitioners are able to provide will improve access and quality of care as they are well trained and highly educated professionals that are already providing integral health services."

The Bay Area Council also supports the bill. They note that the bill would expand the range of services optometrists can perform to help ensure that the citizens of our state have access to high-quality primary care.

Californians for Patient Care also supports the bill. In their letter they note, "It is widely noted that there are not enough trained medical professionals to appropriately care for the influx of new patients. We believe it is important that qualified, educated and trained optometrists be allowed to practice to the extent of their licenses to best serve California's patient population throughout the state."

The California Pharmacists Association wrote a joint letter with the California Society of Health-System Pharmacists. They write, "CSHP and CPhA believe that it is vital to better utilize all health care providers consistent with their training and education to address current workforce shortages. By empowering nurse practitioners to provide additional services with greater flexibility, SB 492 is an important part of the equation to meet health system demand."

The California Optometric Association believes that this legislation, "...addresses the health care provider gap by expanding the scope of practice of optometry. Optometrists are positioned and prepared to be part of the solution to meeting the additional health care needs upon enactment of the ACA in 2014."

The United Nurses Associations of California/ Union of Health Care Professionals supports the bill. In their letter they indicate, "SB 492 would allow optometrists to practice to the full extent of their education and training in order to expand access to the health care delivery system for the millions of Californians who will have new access to coverage through implementation of the federal ACA."

1. **Support if Amended.** The California Hospital Association has taken a support if amended position. They indicate, "Doctors of optometry are extensively trained and educated according to national standards. Optometrists provide valuable services in the community and have an opportunity to be an integral component in the new clinical delivery systems of the future. For this reason, CHA supports these provisions and sees value in offering amendments to promote safe and effective care delivery by and optometrist. Our proposed amendments would address issues specifically related to the medical acts performed by an optometrist in the new provisions, and assurance that appropriate safeguards and quality mechanisms are embedded in the SB 492 provisions to protect the public safety."

The California Association of Physician Groups supports the bill if it is amended. They propose the following amendments:

- Section 3041(a)(2) is overbroad and should be amended to state: "drugs for the treatment of ocular problems including narcotic pain medications for the treatment of

- Section 3041(a)(3) is problematic because most eye surgery is performed with topical or local anesthetic. Cataract surgery, for instance, is done with topical/local anesthesia. Perhaps this section can be better defined, such as, "...primary care procedures on the lids, and conjunctiva and cornea that only require topical or local anesthesia."
- Section (5)(b). Because there can be complications from the administration of certain vaccines, notably live vaccines, we suggest that this scope expansion requires an optometrist to have more knowledge of the patient than is reasonable given the limited access to patient records under independent practice, when outside of an integrated, coordinated care system. We recommend against this section under independent practice.
- Section (5)(c)(a). As written, this would allow for the treatment of diabetes; not the ocular manifestations of diabetes, but the illness itself. Temporal Arteritis is another very serious illness, for example, with ocular manifestations. We suggest a similar limitation as outlined in the preceding section.

Arguments in Opposition. The California Medical Association opposes the bill. They outline several concerns in their letter. Included is the provision of primary care services that optometrists would be permitted to do if the bill passed. CMA believes that this is "...beyond the existing scope of practice related to visual disorders and could result in serious harm to patients." They also note that optometrists "...do not have the training and experience necessary to provide comprehensive primary care. In addition, "SB 492 would allow optometrists to practice medicine without being subject to the Medical Practice Act. Currently, optometrists are licensed by the Board of Optometry. Under SB 492, the scope of practice for optometrists would be expanded to the point where they would be practicing as ophthalmologists, who are required to have a medical license, without being subject to the controls and oversight of the Medical Practice Act."

The California Association for Medical Laboratory Technology also opposes the bill. They note in their letter, "While we recognize the ability of optometrists to perform certain waived tests limited to their scope of practice, we have concerns about the broad range of testing contained in this bill. Of greater concern is whether or not optometrists receive the proper education and training to perform as a laboratory director."

The California Academy of Eye Physicians & Surgeons is concerned about the expanded scope of practice for optometrists permitted by SB 492. Specifically, they are concerned about the provisions that would allow optometrists to conduct eye surgeries and prescribe medications by all routes with no additional training."

The Union of American Physicians and Dentists shares the Author's concerns regarding expanding health care access to residents of the State of California. However, SB 492 is a questionable solution. SB 492 rolls out an uncertain health care delivery system with patients subject to unintended consequences of the bill. Medical supervision over optometrists is critical to safe patient outcomes. SB 492 raises serious patient safety concerns in allowing optometrists to prescribe medication and perform surgical procedures without and medical supervision "

The Blind Children's Center notes, "While we support some increased role for optometrists in helping to provide health care, we question whether optometrists, with only a 4-year optometry school education, have the training, education and experience to perform the procedures authorized by the bill. Many of these procedures should only be performed by experts with many more years of training and experience."

The Lighthouse for Christ Mission Eye Center and the Canvasback Missions, Inc. oppose the bill and state in their letters, "The bill would give optometrists greatly increased privileges, including the ability to treat any disease that might have a "manifestation" in the eye without additional specific training requirements. The Board of Optometry, whose members have no experience doing surgery or treating the added diseases would be allowed to decide those training requirements."

Here4Them Inc., provides aid to children and adults who have been abandoned, orphaned, disadvantaged, threatened or are in high risk situations. They oppose the bill and note, "Since we have organized cataract surgery projects, we are well aware of the importance of skilled professionals for eye surgeries. When one is used to highly qualified medical ophthalmologists with 100% success rates in surgery, how could the possibility of less trained professionals even be a consideration? It is important to provide more access to health care, but not at the cost of the best possible care."

The California Society of Anesthesiologists also opposes SB 492. In their letter they argue, "SB 492 would allow the diagnosis and initiation of treatment of any condition with ocular manifestation. This is a broad and unclear authorization that has not attained scientific consensus. It is not a sufficient basis to authorize comprehensive primary care. Also, by granting full drug prescribing authority to optometrists, the bill would add a new category of authorized controlled substance prescribers at a time when more controls are being sought over excessive prescribing."

The California Chapter of the American College of Emergency Physicians writes, "While we share the legitimate concern about the lack of access to care, which currently exists and which may be exacerbated by the implementation of the affordable care act, we are adamantly opposed to any solution which would allow health care practitioners to treat patients well outside their areas of training and expertise."

The California Society of Plastic Surgeons believes that the practice of optometry does not include performing surgery. They state that optometrists do not have the training or education to be performing these types of medical procedures nor do they have training in the administration of local anesthesia.

- 6. Oppose Unless Amended.** The Osteopathic Physicians & Surgeons of California (OPSC) have taken an oppose unless amended position on SB 492. They state, "While optometrists play an important role in the provision of health care to patients in California, their current education and training requirements fall far short of the knowledge base necessary to safely and appropriately treat the complete health of patients. OPSC finds it unconscionable that a health care provider with education and training limited to a specific area of the body be given broad authority to provide treatment that has implications for health of the entire body"

The California Academy of Family Physicians also has an oppose unless amended position. They note, "Physicians see many benefits from working collaboratively with other health care professionals to meet patient care demand, but the framework of care delivery should be within the scope of practice that each health care professional is qualified to perform. Arbitrarily allowing allied health care professionals to independently practice medicine or to render services that are beyond a providers scope can lead to increased costs through over utilization of tests, over prescribing of medications and excess referrals to specialists."

7. **Current Related Legislation.** SB 491 (Hernandez, 2013) deletes the requirement that Nurse Practitioners perform certain tasks pursuant to standardized procedures and/or consultation with a physician or surgeon and authorizes a Nurse Practitioner to perform those tasks independently. Also requires, after July 1, 2016, that Nurse Practitioners possess a certificate from a national certifying body in order to practice. (Note: *The bill is up for consideration before the BP&ED Committee today*)

SB 493 (Hernandez, 2013) authorizes a pharmacist to administer drugs and biological products that have been ordered by a prescriber. Expands other functions pharmacists are authorized to perform, and authorizes pharmacists to order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies and to independently initiate and

administer routine vaccinations. Also establishes board recognition for an advanced practice pharmacist. (Note: *The bill is up for consideration before the BP&ED Committee today*)

8. **Prior Related Legislation.** SB 668 (Polanco, Chapter 13, Statutes of 1996) expanded the scope of practice of optometrists to provide for the diagnosis and treatment of specified conditions or diseases of the human eye or its appendages, and to use other therapeutic pharmaceutical agents.

SB 929 (Polanco, Chapter 676, Statutes of 2000) expanded the scope of lawful practice for optometrists by specifying additional diseases and conditions that optometrists may treat (in particular certain types of glaucoma) with specified medications, and by specifying the extent of physician involvement that is required under various circumstances.

SB 1406 (Correa, Chapter 352, Statutes of 2008) specified permissible procedures for certified optometrists, and created the Glaucoma Diagnosis and Treatment Advisory Committee to establish glaucoma certification requirements.

9. **Author's Amendments.** The following amendments reflect the Author's efforts to address many of the concerns of the opposition that are highlighted in the opposition's comments above. The amendments do the following: (See the mock-up of amendments attached.)

- Specifies the eyelid disorders that can be treated by an optometrist including: hypotrichosis and blepharitis.
- Removes the provision for optometrists to treat ocular inflammation and ocular pain that is the result of surgery and restores the requirement for optometrists to consult with a physician and surgeon for treatment of these conditions

- Specifies FDA approved drugs that TPA certified optometrist can prescribe including codeine with compounds and hydrocodone with compounds and limits the use of these agents to three days.
- Permits an optometrist to order appropriate laboratory or diagnostic imaging test for specified conditions.
- Removes the provision for an optometrist to treat the lacrimal gland, the lacrimal drainage system and the sclera in patients under 12 years of age.
- Only permits an optometrist to use a clinical laboratory test or examination classified as CLIA-waived for the diagnosis of conditions and diseases of the eye or adnexa.
- Allows an optometrist to diagnose and treat conditions of the visual system and test for and diagnose diabetes mellitus, hypertension and hypercholesterolemia.
- Requires an optometrist to notify the treating physician and surgeon if sutures are removed from a patient.
- Specifies record keeping requirements for consultations between optometrists and physicians and surgeons.

SUPPORT AND OPPOSITION:

Support:

Bay Area Council
Blue Shield of California
California Optometric Association
California Pharmacists Association/ California Society of Health-System Pharmacists
Californians for Patient Care
United Nurses Associations of California/Union of Health Care Professionals
Western University of Health Sciences
57 individuals

Support if Amended:

California Association of Physician Groups
California Hospital Association

Opposition:

California Medical Association
Blind Children's Center
California Academy of Eye Physicians & Surgeons
California Association for Medical Laboratory Technology

Here4Them

Lighthouse for Christ Mission Eye Center

Union of American Physicians and Dentists

American College of Emergency Physicians- California Chapter

California Society of Plastic Surgeons

Over 100 letters from employees and parents of children of the Blind Children's Center

Hundreds of individuals

Oppose Unless Amended:

California Academy of Family Physicians

Osteopathic Physicians & Surgeons of California

Consultant: Le Ondra Clark, Ph.D.



California
LEGISLATIVE INFORMATION

SB-493 Pharmacy practice. (2013-2014)

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 01, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL

No. 493

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 733, 4050, 4051, 4052, 4052.3, and 4060 of, and to add Sections 4016.5, 4052.6, 4052.8, 4052.9, 4210, and 4233 to, the Business and Professions Code, relating to pharmacy.

LEGISLATIVE COUNSEL'S DIGEST

SB 493, as amended, Hernandez. Pharmacy practice.

The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy in the Department of Consumer Affairs. The law specifies the functions pharmacists are authorized to perform, including to administer, orally or topically, drugs and biologicals pursuant to a prescriber's order, and to administer immunizations pursuant to a protocol with a prescriber. Pharmacists may also furnish emergency contraception drug therapy pursuant to standardized procedures if they have completed a training program. A violation of the Pharmacy Law is a crime.

This bill, instead, would authorize a pharmacist to administer drugs and biological products that have been ordered by a prescriber. The bill would expand other functions pharmacists are authorized to perform, including, among other things, to furnish self-administered hormonal contraceptives, prescription ~~smoking cessation~~ *smoking cessation* drugs, and prescription medications not requiring a diagnosis that are recommended for international travelers, as specified. Additionally, the bill would authorize pharmacists to order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies, and to independently initiate and administer routine vaccinations, as specified. This bill also would establish board recognition for an advanced practice pharmacist, as defined, would specify the criteria for that recognition, and would specify additional functions that may be performed by an advanced practice pharmacist, including, among other things, performing ~~physical~~ *patient* assessments, and certain other functions, as specified. Because a violation of these provisions would be a crime, the bill would impose a state-mandated local program.

The bill would make other conforming and technical changes.

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

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

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 733 of the Business and Professions Code is amended to read:

733. (a) A licentiate shall not obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. A violation of this section constitutes unprofessional conduct by the licentiate and shall subject the licentiate to disciplinary or administrative action by his or her licensing agency.

(b) Notwithstanding any other law, a licentiate shall dispense drugs and devices, as described in subdivision (a) of Section 4024, pursuant to a lawful order or prescription unless one of the following circumstances exists:

(1) Based solely on the licentiate's professional training and judgment, dispensing pursuant to the order or the prescription is contrary to law, or the licentiate determines that the prescribed drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

(2) The prescription drug or device is not in stock. If an order, other than an order described in Section 4019, or prescription cannot be dispensed because the drug or device is not in stock, the licentiate shall take one of the following actions:

(A) Immediately notify the patient and arrange for the drug or device to be delivered to the site or directly to the patient in a timely manner.

(B) Promptly transfer the prescription to another pharmacy known to stock the prescription drug or device that is near enough to the site from which the prescription or order is transferred, to ensure the patient has timely access to the drug or device.

(C) Return the prescription to the patient and refer the patient. The licentiate shall make a reasonable effort to refer the patient to a pharmacy that stocks the prescription drug or device that is near enough to the referring site to ensure that the patient has timely access to the drug or device.

(3) The licentiate refuses on ethical, moral, or religious grounds to dispense a drug or device pursuant to an order or prescription. A licentiate may decline to dispense a prescription drug or device on this basis only if the licentiate has previously notified his or her employer, in writing, of the drug or class of drugs to which he or she objects, and the licentiate's employer can, without creating undue hardship, provide a reasonable accommodation of the licentiate's objection. The licentiate's employer shall establish protocols that ensure that the patient has timely access to the prescribed drug or device despite the licentiate's refusal to dispense the prescription or order. For purposes of this section, "reasonable accommodation" and "undue hardship" shall have the same meaning as applied to those terms pursuant to subdivision (l) of Section 12940 of the Government Code.

(c) For the purposes of this section, "prescription drug or device" has the same meaning as the definition in Section 4022.

(d) This section applies to emergency contraception drug therapy and self-administered hormonal contraceptives described in Section 4052.3.

(e) This section imposes no duty on a licentiate to dispense a drug or device pursuant to a prescription or order without payment for the drug or device, including payment directly by the patient or through a third-party payer accepted by the licentiate or payment of any required copayment by the patient.

(f) The notice to consumers required by Section 4122 shall include a statement that describes patients' rights relative to the requirements of this section.

SEC. 2. Section 4016.5 is added to the Business and Professions Code, to read:

4016.5. "Advanced practice pharmacist" means a licensed pharmacist who has been recognized as an advanced

is entitled to practice advanced practice pharmacy, as described in Section 4052.6, within or outside of a licensed pharmacy as authorized by this chapter.

SEC. 3. Section 4050 of the Business and Professions Code is amended to read:

4050. (a) In recognition of and consistent with the decisions of the appellate courts of this state, the Legislature hereby declares the practice of pharmacy to be a profession.

(b) Pharmacy practice is a dynamic, patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use, drug-related therapy, and communication for clinical and consultative purposes. Pharmacy practice is continually evolving to include more sophisticated and comprehensive patient care activities.

(c) The Legislature further declares that pharmacists are health care providers who have the authority to provide health care services.

SEC. 4. Section 4051 of the Business and Professions Code is amended to read:

4051. (a) Except as otherwise provided in this chapter, it is unlawful for any person to manufacture, compound, furnish, sell, or dispense a dangerous drug or dangerous device, or to dispense or compound a prescription pursuant to Section 4040 of a prescriber unless he or she is a pharmacist under this chapter.

(b) Notwithstanding any other law, a pharmacist may authorize the initiation of a prescription, pursuant to Section 4052.1, 4052.2, 4052.3, or 4052.6, and otherwise provide clinical advice, services, information, or patient consultation, as set forth in this chapter, if all of the following conditions are met:

(1) The clinical advice, services, information, or patient consultation is provided to a health care professional or to a patient.

(2) The pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice.

(3) Access to the information described in paragraph (2) is secure from unauthorized access and use.

SEC. 5. Section 4052 of the Business and Professions Code is amended to read:

4052. (a) Notwithstanding any other law, a pharmacist may:

(1) Furnish a reasonable quantity of compounded drug product to a prescriber for office use by the prescriber.

(2) Transmit a valid prescription to another pharmacist.

(3) Administer drugs and biological products that have been ordered by a prescriber.

(4) Perform procedures or functions in a licensed health care facility as authorized by Section 4052.1.

(5) Perform procedures or functions as part of the care provided by a health care facility, a licensed home health agency, a licensed clinic in which there is a physician oversight, a provider who contracts with a licensed health care service plan with regard to the care or services provided to the enrollees of that health care service plan, or a physician, as authorized by Section 4052.2.

(6) Perform procedures or functions as authorized by Section 4052.6.

(7) Manufacture, measure, fit to the patient, or sell and repair dangerous devices, or furnish instructions to the patient or the patient's representative concerning the use of those devices.

(8) Provide consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

(9) Provide professional information, including clinical or pharmacological information, advice, or consultation to other health care professionals, and participate in multidisciplinary review of patient progress, including appropriate access to medical records.

(10) Furnish the following medications:

(A) Emergency contraception drug therapy and self-administered hormonal contraceptives, as authorized by Section 4052.3.

(B) Prescription ~~smoking cessation~~ *smoking cessation* drugs and devices, as authorized by Section 4052.9.

(C) Prescription medications not requiring a diagnosis that are recommended by the federal Centers for Disease Control and Prevention for individuals traveling outside of the United States.

(11) Administer immunizations pursuant to a protocol with a prescriber.

(12) Order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies.

(b) A pharmacist who is authorized to issue an order to initiate or adjust a controlled substance therapy pursuant to this section shall personally register with the federal Drug Enforcement Administration.

(c) This section does not affect the applicable requirements of law relating to either of the following:

(1) Maintaining the confidentiality of medical records.

(2) The licensing of a health care facility.

SEC. 6. Section 4052.3 of the Business and Professions Code is amended to read:

4052.3. (a) (1) Notwithstanding any other law, a pharmacist may furnish self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. The standardized procedure or protocol shall require that the patient use a self-screening tool, based on the United States Medical Eligibility Criteria (USMEC) for Contraceptive Use developed by the federal Centers for Disease Control and Prevention, and that the pharmacist refer the patient to the patient's primary care provider or, if the patient does not have a primary care provider, to nearby clinics.

(2) The board and the Medical Board of California are both authorized to ensure compliance with this subdivision, and each board is specifically charged with the enforcement of this subdivision with respect to its respective licensees. This subdivision does not expand the authority of a pharmacist to prescribe any prescription medication.

(b) (1) Notwithstanding any other law, a pharmacist may furnish emergency contraception drug therapy in accordance with either of the following:

(A) Standardized procedures or protocols developed by the pharmacist and an authorized prescriber who is acting within his or her scope of practice.

(B) Standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. The board and the Medical Board of California are both authorized to ensure compliance with this clause, and each board is specifically charged with the enforcement of this provision with respect to its respective licensees. This subdivision does not expand the authority of a pharmacist to prescribe any prescription medication.

(2) Prior to performing a procedure authorized under this subdivision, a pharmacist shall complete a training program on emergency contraception that consists of at least one hour of approved continuing education on emergency contraception drug therapy.

(3) A pharmacist, pharmacist's employer, or pharmacist's agent shall not directly charge a patient a separate consultation fee for emergency contraception drug therapy services initiated pursuant to this subdivision, but may charge an administrative fee not to exceed ten dollars (\$10) above the retail cost of the drug. Upon an oral, telephonic, electronic, or written request from a patient or customer, a pharmacist or pharmacist's employee shall disclose the total retail price that a consumer would pay for emergency contraception drug therapy. As used in this paragraph, total retail price includes providing the consumer with specific information regarding the price of the emergency contraception drugs and the price of the administrative fee charged. This limitation is not intended to interfere with other contractually agreed-upon terms between a pharmacist, a

required to pay an administrative fee. These patients shall be required to pay copayments pursuant to the terms and conditions of their coverage. This paragraph shall become inoperative for dedicated emergency contraception drugs if these drugs are reclassified as over-the-counter products by the federal Food and Drug Administration.

(4) A pharmacist shall not require a patient to provide individually identifiable medical information that is not specified in Section 1707.1 of Title 16 of the California Code of Regulations before initiating emergency contraception drug therapy pursuant to this subdivision.

(c) For each emergency contraception drug therapy or self-administered hormonal contraception initiated pursuant to this section, the pharmacist shall provide the recipient of the drug with a standardized factsheet that includes, but is not limited to, the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. The board shall develop this form in consultation with the State Department of Public Health, the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other health care organizations. This section does not preclude the use of existing publications developed by nationally recognized medical organizations.

SEC. 7. Section 4052.6 is added to the Business and Professions Code, to read:

4052.6. (a) A pharmacist recognized by the board as an advanced practice pharmacist may do all of the following:

- (1) Perform ~~physical~~ *patient* assessments.
- (2) Order and interpret drug therapy-related tests.
- (3) Refer patients to other health care providers.

~~(b) In addition to the authority provided in subdivision (a), a pharmacist recognized as an advanced practice pharmacist who is acting in collaboration with a patient's health care providers, operating under a protocol with a physician, health care facility, or health plan or disability insurer, or participating in a medical home, accountable care organization, or other system of care, may do both of the following:~~

~~(1) Initiate, adjust, or discontinue drug therapy. As used in this section, "adjust" means changing the dosage, duration, frequency, or potency of a drug.~~

~~(2)~~

(4) Participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers.

(5) *Initiate, adjust, or discontinue drug therapy in the manner specified in paragraph (4) of subdivision (a) of Section 4052.2.*

~~(e)~~

(b) A pharmacist who adjusts or discontinues drug therapy shall promptly transmit written notification to the patient's diagnosing prescriber or enter the appropriate information in a patient record system shared with the prescriber. A pharmacist who initiates drug therapy shall promptly transmit written notification to, or enter the appropriate information into, a patient record system shared with the patient's primary care provider or diagnosing provider, as appropriate.

~~(d)~~

(c) This section shall not interfere with a physician's order to dispense a prescription drug as written, or other order of similar meaning.

~~(e)~~

(d) Prior to initiating or adjusting a controlled substance therapy pursuant to this section, a pharmacist shall personally register with the federal Drug Enforcement Administration.

SEC. 8. Section 4052.8 is added to the Business and Professions Code, to read:

4052.8. (a) In addition to the authority provided in paragraph (9) of subdivision (a) of Section 4052, a pharmacist may independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC) for persons three years of age and older.

(b) In order to initiate and administer an immunization described in subdivision (a), a pharmacist shall do all of the following:

(1) Complete an immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and shall maintain that training.

(2) Be certified in basic life support.

(3) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.

(c) A pharmacist administering immunizations pursuant to this section, or paragraph (9) of subdivision (a) of Section 4052, may also initiate and administer epinephrine or diphenhydramine by injection for the treatment of a severe allergic reaction.

SEC. 9. Section 4052.9 is added to the Business and Professions Code, to read:

4052.9. A pharmacist may furnish prescription ~~smoking-cessation~~ *smoking cessation* drugs and devices, and provide ~~smoking-cessation~~ *smoking cessation* services if all of the following conditions are met:

(a) The pharmacist maintains records of all prescription drugs and devices furnished for a period of at least three years for purposes of notifying other health care providers and monitoring the patient.

(b) The pharmacist notifies the patient's primary care provider of any drugs or devices furnished to the patient. If the patient does not have a primary care provider, the pharmacist provides the patient with a written record of the drugs or devices furnished and advises the patient to consult a physician of the patient's choice.

(c) The pharmacist is certified in ~~smoking-cessation~~ *smoking cessation* therapy by an organization recognized by the board.

(d) The pharmacist completes one hour of continuing education focused on ~~smoking-cessation~~ *smoking cessation* therapy biennially.

SEC. 10. Section 4060 of the Business and Professions Code is amended to read:

4060. A person shall not possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to Section 4052.1, 4052.2, or 4052.6. This section does not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, if in stock in containers correctly labeled with the name and address of the supplier or producer.

This section does not authorize a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

SEC. 11. Section 4210 is added to the Business and Professions Code, to read:

4210. (a) A person who seeks recognition as an advanced practice pharmacist shall meet all of the following requirements:

(1) Hold an active license to practice pharmacy issued pursuant to this chapter that is in good standing

(2) Satisfy any ~~one~~ two of the following criteria:

(A) Earn certification in a relevant area of practice, *including, but not limited to, ambulatory care, critical care, nuclear pharmacy, nutrition support pharmacy, oncology pharmacy, pediatric pharmacy, pharmacotherapy, or psychiatric pharmacy*, from an organization ~~approved by a board-recognized accrediting agency~~ *recognized by the Accreditation Council for Pharmacy Education* or another entity recognized by the board.

(B) Complete a one-year postgraduate residency *through an accredited postgraduate institution* where at least 50 percent of the experience includes the provision of direct patient care services with interdisciplinary teams.

(C) Have actively managed patients for at least one year under a collaborative practice agreement or protocol with a physician, advanced practice pharmacist, pharmacist practicing collaborative drug therapy management, or health system.

(3) File an application with the board for recognition as an advanced practice pharmacist.

(4) Pay the applicable fee to the board.

(b) An advanced practice pharmacist recognition issued pursuant to this section shall be valid for two years, coterminous with the certificate holder's license to practice pharmacy.

(c) *The board shall adopt regulations establishing the means of documenting completion of the requirements in this section.*

SEC. 12. Section 4233 is added to the Business and Professions Code, to read:

4233. A pharmacist who is recognized as an advanced practice pharmacist shall complete 10 hours of continuing education each renewal cycle in addition to the requirements of Section 4231. The subject matter shall be in one or more areas of practice relevant to the pharmacist's clinical practice.

SEC. 13. 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.

**SENATE COMMITTEE ON BUSINESS, PROFESSIONS
AND ECONOMIC DEVELOPMENT
Senator Curren D. Price, Jr., Chair**

Bill No: SB 493 Author: Hernandez
As Amended: April 24, 2013 Fiscal: Yes

SUBJECT: Pharmacy practice.

SUMMARY: Updates Pharmacy Law to authorize pharmacists to perform certain functions according to specified requirements, including: administer physician prescribed injectable medications; furnish immunizations for people ages three and up if the pharmacist has completed training and follows specified procedures; furnish self-administered hormonal contraceptives, based on a statewide protocol, similar to the existing authority for pharmacists to furnish emergency contraceptive drug therapy; furnish smoking cessation drugs and devices if the pharmacist has completed training and follows specified procedures; furnish travel medications approved by the U.S. State Department; and, order and interpret tests to monitor drug safety. Establishes "advanced practice pharmacist" recognition, allowing such pharmacists to perform physical assessments; order and interpret medication-related tests; refer patients to other providers; initiate, adjust and discontinue medications under physician protocol or as part of an integrated system and; participate in the evaluation and management of health conditions in collaboration with other providers.

Existing law, the Business and Professions Code (BPC):

- 1) Establishes the Pharmacy Law which provides for the licensure and regulation of pharmacies, pharmacists and wholesalers of dangerous drugs or devices by the Board of Pharmacy (Board) within the Department of Consumer Affairs (DCA) and establishes a scope of practice for pharmacy as a profession.
- 2) Defines "furnish" as supply by any means, by sale or otherwise. (BPC § 4026)
- 3) Defines "dispense" as the furnishing of drugs or devices upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor or upon an order to furnish drugs or transmit a prescription from a certified nurse-midwife, nurse practitioner, physician assistant, naturopathic doctor, or pharmacist acting within the scope of his or her practice. Dispense also means and refers to the furnishing of drugs or devices directly to a patient by a physician, dentist, optometrist, podiatrist, or veterinarian, or by a certified nurse-midwife, nurse practitioner, naturopathic doctor, or physician assistant acting within the scope of his or her practice. (BPC § 4024)

consultative purposes. Provides that pharmacy practice is continually evolving to include more sophisticated and comprehensive patient care activities. (BPC § 4050)

- 5) Permits a pharmacist to initiate a prescription according to certain requirements. Permits a pharmacist to provide clinical advice, information or patient consultation if as follows: (BPC § 4051 (b))
 - a) The advice, information or consultation is provided to a health care professional or patient.
 - b) The pharmacist has access to prescription, patient profile or other relevant medical information for purposes of patient and clinical consultation and advice.
 - c) Access to the information is secure from unauthorized use.

- 6) Permits a pharmacist to: (BPC § 4052)
 - a) Furnish a reasonable quantity of compounded drug product to a prescriber for use in his or her office.
 - b) Transmit a valid prescription to another pharmacist.
 - c) Administer, orally or topically, drugs and biologicals pursuant to a prescriber's order.
 - d) Perform certain procedures or functions in a licensed health care facility.
 - e) Perform certain procedures or functions as part of the care provided by a health care facility, licensed home health agency, licensed clinic in which there is a physician oversight, provider who contracts with a licensed health care service plan with regard to the care or services provided to the enrollees of that plan or a physician.
 - f) Manufacture, measure, fit to the patient or sell and repair dangerous devices or furnish instructions to a patient or patient's representative concerning the use of those devices.
 - g) Provide consultation to patients and professional information, including clinical or pharmacological information, advice or consultation to other health professionals.
 - h) Furnish emergency contraception drug therapy.
 - i) Administer immunizations pursuant to a protocol with a prescriber.

- 7) Provides that a pharmacist authorized to issue an order to initiate or adjust a controlled substance therapy shall register with the federal Drug Enforcement Administration (DEA). (BPC § 4052 (b))

- 8) Permits pharmacists to perform the following procedures under physician protocols in licensed health care facilities: (BPC §4052.1)
 - a) Order and perform routine drug therapy-related patient assessment procedures.
 - b) Order drug therapy-related laboratory tests.
 - c) Administer drugs and biologicals by injection pursuant to a prescriber's order.
 - d) Initiate or adjust a patient's drug regimen pursuant to authorization or order by the patient's prescriber.

- 9) Permits pharmacists in a number of specified settings to do the following: (BPC § 4052.2)

- a) Order and perform routine drug therapy-related patient assessment procedures

- d) Initiate or adjust a patient's drug regimen pursuant to authorization or order by the patient's treating prescriber. Prohibits the substitution or selection of a different drug unless authorized by protocol and requires prescriber notification of initiated drug regimens to be transmitted within 24 hours.
 - e) Specifies that a patient's treating prescriber may prohibit pharmacists from making any changes or adjustments to patients' drug regimens.
 - f) Requires the governing policies, procedures and protocols to be developed by specified health professionals and established minimum requirements for those policies, procedures and protocols.
 - g) Requires pharmacists performing procedures authorized by this section to have successfully completed clinical residency training or demonstrated clinical experience in direct patient care delivery.
- 10) Permits a pharmacist to furnish emergency contraception drug therapy (ECDT) in accordance with either standardized procedures or protocols developed by the pharmacist and an authorized provider or standardized procedures developed and approved by the Board and Medical Board of California (MBC) in consultation with the American College of Obstetricians and Gynecologists (ACOG), California Pharmacists Association (CPhA) and other entities. Provides that the Board and MBC have authority to ensure compliance and charges both boards with enforcing this provision for its licensees. Requires a pharmacist to complete a training program on emergency contraception that consists of at least one hour of approved continuing education on ECDT prior to furnishing emergency contraception drug therapy. Provides that a pharmacist, pharmacist's employer or pharmacist's agent may charge a patient an administrative fee of up to \$10 above the retail cost of the drug but may not charge a patient a separate consultation fee for ECDT services. Prohibits a pharmacist from requiring a patient to provide individually identifiable medical information unless otherwise specified before initiating ECDT. Requires a pharmacist to provide ECDT recipients standardized factsheets developed in consultation with the State Department of Public Health (DPH), ACOG, CPhA and other health care organizations that include indications for use of the drug, appropriate method for use, need for medical followup and other appropriate information. Makes this inoperative if ECDT are reclassified as over-the-counter products by the FDA. (BPC § 4052.3)
- 11) Specifies certain requirements regarding the dispensing and furnishing of dangerous drugs and devices, and prohibits a person from furnishing any dangerous drug or device except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian or naturopathic doctor. (BPC § 4059)
- 12) Authorizes pharmacists filling prescription orders for drug products prescribed by their trade or brand names to substitute a drug product with a different form of medication with the same active chemical ingredients of equivalent strength and duration of therapy as the prescribed drug product when the change will improve the ability of the patient to comply with the prescribed drug therapy, subject to a patient notification and bottle labeling requirement, unless the prescriber specifies that a pharmacist may not substitute another drug product by either indicating on the form submitted for the filling of the prescription drug orders "Do not substitute" or words of similar meaning or selecting a box on the form marked "Do not substitute" (BPC § 4052.5)

- 13) Authorizes pharmacists filling prescription orders for drug products prescribed by their trade or brand names to substitute generic drugs for orders if the generic contains the same active chemical ingredients of equivalent strength and duration of therapy, subject to a patient notification and bottle labeling requirement, unless the prescriber specifies that a pharmacist may not substitute another drug product by either indicating on the form submitted for the filling of the prescription drug orders "Do not substitute" or words of similar meaning or selecting a box on the form marked "Do not substitute." (BPC § 4073)
- 14) Specifies that dispensing of drugs in a non-profit community clinic or primary care clinic, as defined, shall be performed only by a physician, a pharmacist, or other person lawfully authorized to dispense drugs, and only in compliance with all applicable laws and regulations. (BPC § 4181)
- 15) Requires pharmacists to submit proof of completion of 30 hours of approved continuing pharmacy education (CE) prior to license renewal. (BPC § 4231)

This bill:

- 1) Makes various technical and clarifying changes.
- 2) Defines "advanced practice pharmacist" (APP) as a licensed pharmacist who has been recognized as an advanced practice pharmacist by the Board. Specifies that a Board-recognized APP is entitled to practice advanced practice pharmacy as described in Section 4052.6, within or outside of a licensed pharmacy as authorized by this chapter.
- 3) Declares that pharmacists are health care providers who have the authority to provide health care services.
- 4) Deletes the requirement that pharmacists only administer drugs and biological products orally or topically and instead permits pharmacists to administer drugs and biological products by other means including injection that have been ordered by a prescriber.
- 5) Permits an APP to perform specified procedures or functions.
- 6) Permits a pharmacist to provide consultation, training and education about drug therapy, disease management and disease prevention.
- 7) Permits a pharmacist to participate in multidisciplinary review of patient progress, including appropriate access to medical records.
- 8) Permits a pharmacist to furnish self-administered hormonal contraceptives, smoking cessation drugs and devices and prescription medications not requiring a diagnosis that are recommended by the CDC for individuals traveling outside of the U.S., in addition to ECdT.
- 9) Permits a pharmacist to administer immunizations pursuant to a protocol with a prescriber.
- 10) Permits a pharmacist to order and interpret tests for the purpose of monitoring and managing

- 11) Permits a pharmacist to furnish self-administered hormonal contraceptives in accordance with procedures and protocols developed and approved by the Board and the MBC in consultation with ACOG, CPhA and other appropriate entities. Specifies that procedures or protocols shall require the patient to use a self-screening tool based on the United States Medical Eligibility Criteria for Contraceptive Use developed by the federal Centers for Disease Control and Prevention (CDC) and that the pharmacist refer the patient to their primary care provider or to nearby clinics. Provides that the Board and the MBC have authority to ensure compliance and charges both boards with enforcing this provision for its licensees. Clarifies that this does not expand the authority of a pharmacist to prescribe any prescription medication.
- 12) Expands the requirements in current law for providing ECDT recipients standardized factsheets to include patients receiving self-administered hormonal contraception and requires contraindications of the drugs to be included on fact sheets.
- 13) Provides that a pharmacist recognized by the Board as an APP is permitted to do all of the following:
 - a) Perform patient assessments.
 - b) Order and interpret drug-therapy related tests.
 - c) Refer patients to other health care providers.
 - d) Participate in the evaluation or management of diseases and health conditions in collaboration with other health care providers.
 - e) Initiate, adjust or discontinue drug therapy pursuant to the authority established in current law for pharmacists to perform certain procedures in a licensed health care facility.
- 14) Provides that a pharmacist who adjusts or discontinues drug therapy shall promptly transmit written notification to the patient's diagnosing prescriber or enter the appropriate information into a patient record system shared with the prescriber. Provides that a pharmacist who initiates drug therapy shall promptly transmit written notification to the patient's diagnosing prescriber or enter the appropriate information into a patient record system shared with the prescriber.
- 15) Requires a pharmacist to register with the DEA prior to initiating or adjusting a controlled substance.
- 16) Permits a pharmacist to independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices for persons ages three and older.
- 17) Requires a pharmacist, in order to initiate and administer vaccines, to do all of the following:
 - a) Complete an immunization training program endorsed by the CDC or Accreditation Council for Pharmacy Education that includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines and recognizing and treating emergency reactions to vaccines

- c) Comply with all federal and state recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the CDC.

18) Permits a pharmacist who has met the requirements for initiating and administering vaccines to also initiate and administer epinephrine or diphenhydramine by injection for the treatment of a severe allergic reaction.

19) Permits a pharmacist to furnish prescription smoking cessation drugs and devices, and provide smoking cessation services if all of the following conditions are met:

- a) The pharmacist maintains records of all prescription drugs and devices furnished for a period of at least three years for purposes of notifying other health care providers and monitoring the patient.
- b) The pharmacist notifies the patient's primary care provider of any drugs or devices furnished to the patient, or provides the patient with a written record of the drugs or devices if the patient does not have a primary care provider and advises the patient to consult a physician of the patient's choice.
- c) The pharmacist is certified in smoking-cessation therapy by an organization recognized by the Board.
- d) The pharmacist completes one hour of continuing education focused on smoking-cessation biennially.

21) Provides that in order to be recognized as an APP, a person must meet all of the following requirements:

- a) Hold an active license with the Board and be in good standing.
- b) File an application with the Board for recognition as an APP.
- c) Pay the applicable fee to the Board.

22) Provides that in order to be recognized as an APP, a person must satisfy two of the following criteria:

- a) Possess certification in a relevant area of practice, including but not limited to, ambulatory care, nuclear pharmacy, nutrition support pharmacy, oncology pharmacy, pediatric pharmacy, pharmacotherapy or psychiatric pharmacy from an organization recognized by the Accreditation Council for Pharmacy Education or other entity recognized by the Board.
- b) Complete a one year postgraduate residency through an accredited postgraduate institution where at least 50 percent of the experience includes a provision of direct patient care services with interdisciplinary teams.
- c) Have actively managed patients for at least one year under a collaborative practice agreement or protocol with a physician, APP, pharmacist practicing collaborative drug therapy management or health system.

23) Provides that APP recognition is valid for two years

- 24) Requires the Board to adopt regulations establishing the means of documenting completion of the requirements for an APP.
- 25) Requires an APP to complete 10 hours of continuing education (CE) each license renewal cycle for a subject matter in one or more areas relevant to a pharmacist's clinical practice, in addition to current CE requirements.

FISCAL EFFECT: Unknown. This bill has been keyed "fiscal" by Legislative Counsel.

COMMENTS:

1. **Purpose.** This measure is sponsored by the Author. According to the Author, pharmacists provide patient care that optimizes medication therapy and promotes health, wellness, and disease prevention. The Author states that pharmacists complete a four year post-graduate doctoral training program that includes extensive training in human anatomy and physiology, recognition and treatment of diseases and conditions, pharmacology, optimal medication use, as well as experience in direct patient care in multiple health care settings through clinical rotations. The Author further acknowledges that many pharmacists complete a residency program and obtain board certification in a specialized area of practice. According to the Author, this bill will align California law more consistently with federal programs such as the Department of Defense, the Veterans Administration, and Indian Health Service, where pharmacists have been practicing in this collaborative way for over 40 years.

The Author believes that "Californians deserve access to high quality primary care offered by a range of safe, efficient, and regulated providers. Physician assistants, nurse practitioners, pharmacists and optometrists have all significantly advanced their educational, testing, and certification programs over the past decade. They've enhanced clinical training, moved to graduate or advanced degrees, and upgraded program accreditation processes."

2. **Background.**

- a) **The Patient Protection and Affordable Care Act.** On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into federal statute. The ACA, which states will begin implementing in 2014, represents one of the most significant expansions and overhauls of the United States health care system since the passage of Medicare and Medicaid in 1965. The ACA is aimed at increasing the rate of health insurance coverage for Americans and reducing the overall costs of health care. It provides a number of mechanisms including mandates, subsidies and tax credits to employers and individuals in order to increase the rate of people with coverage. As a result of implementation of the ACA, anywhere from 4-7 million additional Californians will be eligible for health insurance beginning in 2014. It is anticipated that the newly insured will increase demand for health care on an already strained system.

- b) **Primary Care Workforce Shortage.** The Author provided a number of studies and reports highlighting a shortage in California of primary care physicians. According to a report commissioned by the California Health Care Foundation, *Fewer and More Specialized: A New Assessment of Physician Supply in California* the number of primary

that rural counties in particular suffer from low physician practice rates and a shortage of primary care physicians. According to the report, in 2008, there were 69,460 actively practicing physicians in California (a figure which includes Doctors of Medicine and Doctors of Osteopathic Medicine), but only 35 percent of these physicians reported practicing primary care. This equates to 63 active primary care physicians in patient care per 100,000 persons. According to the Council on Graduate Medical Education, which provides an ongoing assessment of physician workforce trends, training issues and financing policies, and recommends appropriate federal and private sector efforts on these issues, a range of 60 to 80 primary care physicians are needed per 100,000 in order to adequately meet the needs of the population. When the same metric is applied regionally, only 16 of California's 58 counties fall within the needed supply range for primary care physicians. Less than one third of Californians live in a community where they have access to the health care services they need.

- c) **Pharmacists.** According to a recent report by the Center for the Health Professions at the University of California, San Francisco, *California's Health Care Workforce: Readiness for the ACA Era.*, as of February 2011, there were 29,245 individuals with a California address in possession of a current and valid license to practice as a registered pharmacist in the state. The report found that pharmacists are generally concentrated in the belt of counties stretching from the Bay Area eastward across the state and that several counties have very low license per 100,000 population rates, including Imperial, Kings, San Benito, Merced, Mariposa, Yuba, and Tehama counties. Based on the report findings, the range of 18 - 30 licenses per 100,000 population ratio would mean there are between .9 - 1.5 pharmacists for every 5,000 people.

The number of pharmacists in California is only likely to grow. For a number of years, California had only three schools of pharmacy. Since the early 1990s, that number has increased to eight schools today, with plans underway for eight additional entities to open new schools of pharmacy in California in the next few years. This change alone would double the current number of schools, and presumably the number of California graduates which would in turn result in growing numbers of pharmacists eligible for licensure and ready to work. Pharmacists are already well placed in every community throughout the state to provide medication therapy management services; including in rural and inner city communities where primary care access is particularly impacted.

Pharmacists provide patient care with a goal of optimizing medication therapy and promoting health, wellness, and disease prevention. Pharmacists complete a four year post-graduate doctoral training program that includes extensive training in human anatomy and physiology, recognition and treatment of diseases and conditions, pharmacology, optimal medication use, as well as experience in direct patient care in multiple health care settings through clinical rotations. Many pharmacists complete a residency program and obtain board certification in a specialized area of practice. Throughout the U.S., since 2003, all schools of pharmacy now only offer a doctorate in pharmacy (Pharm D) which includes course study on: Basic Life Support, Diagnosing & Disease State Management of Diabetes, Infectious Diseases, Hypertension, Heart Disease, Oncology; Immunization Training, Medication Management, Pharmacy Law/Administration, Pharmacy Practice, Therapeutic Drug Monitoring, Therapeutics. The Pharm D, which has been the sole

rotations, one or more retail rotations and one or more elective rotations in either geriatrics, long-term care or medication therapy management. Pharmacists may also choose to complete certificate programs focused on the management of specific disease or other certification to demonstrate competency and expertise in a certain area. In addition to meeting educational and experience requirements, an applicant for licensure as a pharmacist must take and pass both the North American Pharmacist Licensure Examination (NAPLEX) and the California Practice Standards and Jurisprudence Examination for Pharmacists (CPJE).

A December 2012 *New York Times* editorial, part of a continuing examination by the paper of ways to cut medical costs while improving quality, highlighted using pharmacists to provide medical care as a sensible solution to the primary care shortage crisis and as a means of ensuring health care delivery to millions of new patients under ACA. Specifically, the editorial noted a report by the chief pharmacist of the U.S. Public Health Service who argued that pharmacists are underutilized given their education, training and closeness to their communities except for in the Department of Veterans Affairs (VA), Department of Defense (DOD) and Indian Health Service (IHS) where they deliver health care with minimal supervision. These federal pharmacists manage the care of patients when medications are the primary treatment and can start, stop or adjust medications, order and interpret laboratory tests and coordinate follow-up care.

- d) **Scope of Practice and Access.** Numerous entities have explored amending scope of practice laws at the state level as a means of meeting the overall goal of providing quality care and controlling long-term health care costs. A report from the Brookings Institution recommended creating incentives for states to amend scope of practice laws to allow for greater use of certain professions like nurse practitioners, pharmacists, physician assistants and community health workers. A 2010 white paper by the Citizen Advocacy Center in Washington D.C. addressed the role of states like California in addressing scope of practice, writing that scope of practice laws restrict health care professionals from “performing the full range of skills for which they have been trained” which in turns limits access to care and inflates health care costs. The paper also cited data from the National Practitioner Data Bank and Health Integrity and Protection Data Bank where no trends or observations suggesting increased liability for offices employing physician assistants or advanced practice nurses and that the inclusion of these professionals has been a safe and beneficial undertaking.

3. **Specific Practices Authorized by SB 493.**

- a) *Permits pharmacists to administer physician prescribed injectable medications.*

Biological products are generally derived from living material, human, animal, or microorganism and FDA regulations specify that biological products include blood-derived products, vaccines, in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products. These treatments are not widespread but rather used as specialty drugs to treat serious conditions and diseases. In some instances, patients undergoing treatments for serious diseases receive biological injections. in addition to other infusion therapies and could access those drugs

- b) *Permits pharmacists to furnish immunizations for people ages three and up if the pharmacist has completed specified training and follow specified procedures.*

Immunizations stand as a useful, cost-effective measure in promoting public health and preventing the spread of disease. According to the Institute of Medicine, more than 50,000 adults and 300 children die annually in the United States from diseases or complications arising from diseases that are considered vaccine-preventable. Studies show that immunizations assist in preventing an estimated 14 million cases of vaccine-preventable diseases and 33,000 cases of death.

Vaccines against influenza have been especially useful in preventing the spread of that virus and have recently been at the center of a larger national and international vaccination conversation. While CDC recommends vaccination against influenza for over 70% of the population, actual rates of immunization are much lower. CDC estimates that 36,000 people die each year from influenza or its complications. The H1N1 outbreak of 2009 resulted in a CDC recommendation that everyone receive the vaccine. Yet access to immunizations can be compounded by a growing uninsured population in the state who may lack the ability to be seen in a physician's office.

Pharmacies and pharmacists are able to play a unique role in contributing to higher access to immunizations. CDC's ACIP recommendations for 2008 call for vaccinations to be provided in alternative settings like pharmacies to help make progress toward achieving national health objectives. According to an article in the *Journal of the American Pharmaceutical Association*, "Pharmacists and Immunizations," Gallup Polls have consistently named the pharmacist among the most trusted professionals. People in many communities, especially rural areas, look to their community pharmacist for medical advice. This respect can be pivotal in helping educate parents and other adults about the importance of timely immunization. When parents and elderly patients pick up prescriptions, pharmacists can take advantage of their accessibility and reputation to ask them about their immunization status and counsel them on the importance of immunization. Pharmacies are located in many neighborhoods throughout the state, have extended hours of operation and have existing infrastructure to properly store vaccines.

- c) *Permits a pharmacist to furnish self-administered hormonal contraceptives like the pill, the patch and the ring, based on a statewide protocol, similar to the existing authority for pharmacists to furnish ECCT.*

Hormonal contraceptives are made up of female sex hormones: estrogen or progestin (a synthetic form of progesterone). Organizations like the World Health Organization (WHO), ACOG and Planned Parenthood Federation of America have developed evidence-based guidelines for hormonal contraceptive use based on a self-reported medical history and measurement of blood pressure. All of these guidelines acknowledge that hormonal contraception can be safely provided and utilized without requiring a pelvic examination.

The Institute of Medicine Committee (IOM) on Women's Health Research recently reported a universal need for making contraceptives more available, accessible, and acceptable (IOM, 2010b). They indicate the several barriers that women often face that keep them

these are expensive co-pays, insurance coverage limitations on prescriptions, and the difficulty or delay when scheduling an office visit.

Under the Department of Health and Human Services, and with guidance from the WHO, the CDC created the U.S. Medical Eligibility Criteria for Contraceptive Use 2010 (USMEC) and finalized the recommendations after consultation with a group of health professionals who met in Atlanta, Georgia, in February of 2009. The WHO's guidance includes recommendations for the use of specific contraceptive methods by women and men who have certain characteristics or medical conditions. The majority of the U.S. guidance does not differ from the WHO guidance and covers more than 60 characteristics or medical conditions. However, some WHO recommendations were modified for use in the United States, including recommendations about contraceptive use for women with venous thromboembolism, valvular heart disease, ovarian cancer, and uterine fibroids and for women who experience postpartum depression or are breastfeeding. Recommendations were added to the U.S. guidance for women with rheumatoid arthritis, history of bariatric surgery, peripartum cardiomyopathy, endometrial hyperplasia, inflammatory bowel disease, and solid organ transplantation. The recommendations are intended to assist health-care providers when they counsel women, men, and couples about contraceptive method choice. Although the recommendations are meant to serve as a source of clinical guidance, the CDC cautioned that health-care providers should always consider the individual clinical circumstances of each person seeking family planning services.

- d) *Permits a pharmacist to furnish smoking cessation drugs and devices if they have completed specified training and follow specified procedures.*

According to the CDC, tobacco use can lead to nicotine dependence and serious health problems. CDC states that cessation, a process of evaluation, education and support to aid patients who desire to stop smoking can provide many health benefits like: lowering the risk for lung and other types of cancer; reducing the risk for coronary heart disease, stroke, and peripheral vascular disease; reducing respiratory symptoms, such as coughing, wheezing, and shortness of breath; reducing the risk of developing chronic obstructive pulmonary disease (COPD), one of the leading causes of death in the United States; decreasing women's risk for infertility or having a low birth weight baby.

According to CDC, cessation treatment options currently include brief clinical interventions (i.e., when a doctor takes 10 minutes or less to deliver advice and assistance about quitting), counseling (e.g., individual, group, or telephone counseling), behavioral cessation therapies (e.g., training in problem solving) as well as over-the-counter medications like a nicotine patch, gum, lozenge and prescription medications like a nicotine inhaler, nasal spray and drugs like bupropion SR (Zyban®) and varenicline tartrate (Chantix®).

Safeway Inc. recently partnered with the UCSF School of Pharmacy whereby Safeway's pharmacists will be trained in smoking-cessation counseling techniques using a program developed by UCSF pharmacy faculty. The project will allow smoking cessation intervention to be applied systematically across a network of pharmacies.

- e) *Permits a pharmacist to furnish travel medications approved by the CDC*

Recommendations for the use of vaccines and other biologic products (such as immune globulin products) in the U.S. are developed by the CDC Advisory Committee on Immunization Practices (ACIP) and other groups, such as the American Academy of Pediatrics. These recommendations are based on scientific evidence of benefits (immunity to the disease) and risks (vaccine adverse reactions) and, where few or no data are available, on expert opinion. The recommendations include information on general immunization issues and the use of specific vaccines. Recommendations for travelers are not always the same as routine recommendations. CDC advises that individuals might benefit from shots or medications before traveling outside of the U.S. Recommended vaccines are those the CDC determines may protect travelers from illnesses present in other parts of the world and prevent the importation of infectious diseases across international borders. Many pharmacies are already providing services to travelers to determine which vaccines they should receive and when they should receive them; the authority in this bill will allow those patients to receive those vaccines at the pharmacy.

- f) *Permits a pharmacist to order and interpret tests to monitor drug safety. Permits APPs to perform physical assessments, order and interpret medication-related tests, refer patients to other providers, initiate, adjust and discontinue medications under physician protocol or as part of an integrated system and participate in the evaluation and management of health conditions in collaboration with other providers.*

A 2012 CDC program guide for public health, "*Partnering with Pharmacists in the Prevention and Control of Chronic Diseases*" outlines how the role of the pharmacist has expanded beyond just dispensing medications and is evolving into active participation in chronic disease management as a part of team-based care. At the federal agency level, the IHS has been engaged in an advanced practice pharmacy model whereby pharmacists deliver direct patient care services with physician collaboration since the early 1970s. Similarly, the VA implemented a similar program in 1995 that updated prescribing authority for clinical pharmacy specialists. These models have become a part of day-to-day care within hospitals, clinics and educational facilities with pharmacists performing many of the functions authorized in this bill.

4. **Related Legislation.** SB 352 (Pavley) of 2013 would authorize a nurse practitioner, physician assistant or certified nurse-midwife to supervise medical assistants without a physician present and according to standardized procedures and protocols created by the physician. This bill is currently pending on the Senate Floor.

SB 491 (Hernandez) of 2013 Deletes the requirement that Nurse Practitioners perform certain tasks pursuant to standardized procedures and/or consultation with a physician or surgeon and authorizes a Nurse Practitioner to perform those tasks independently. Also requires, after July 1, 2016, that Nurse Practitioners possess a certificate from a national certifying body in order to practice. The bill is also up for consideration before the Committee today.

SB 492 (Hernandez of 2013) Permits an optometrist to diagnose treat and manage additional conditions with ocular manifestations, directs the California Board of Optometry to establish educational and examination requirements, and permits optometrists to perform vaccinations

AB 2348 (Mitchell, Chapter 460, Statutes of 2012) authorized a registered nurse to dispense specified drugs or devices upon an order issued by a certified nurse-midwife, nurse practitioner, or physician assistant within specified clinics. The bill also authorized a registered nurse to dispense or administer hormonal contraceptives in strict adherence to specified standardized procedures.

SB 1524 (Hernandez, Chapter 796, Statutes of 2012) deleted the requirement for at least 6 months duration of supervised experience by a physician before a nurse-midwife could furnish or order drugs. The bill authorized a physician and surgeon to determine the extent of the supervision in connection with the furnishing or ordering of drugs and devices by a nurse practitioner or certified nurse-midwife.

AB 977 (Skinner) of 2010 would have authorized pharmacists to administer influenza immunizations, pursuant to standardized protocols developed and approved by the Medical Board of California (MBC), to any person 18 years or older, until January 1, 2015. The bill was never heard by a Senate policy committee.

SB 993 (Aanestad and Calderon) of 2007 would have revised the Psychology Licensing Law to authorize a "prescribing psychologist," as defined, to prescribe and administer drugs, and requires the Board of Psychology to establish and administer a certification process to grant licensed psychologists the authority to write prescriptions. The measure failed passage in this committee. SB 1427 (Calderon) of 2008 was substantially similar to SB 993 and failed passage in the Senate Committee on Health.

AB 1436 (Hernandez, 2007) would have allowed a nurse practitioner to perform comprehensive health care services according to his or her educational preparation. The bill would have authorized a nurse practitioner to admit and discharge patients from health facilities, change a treatment regimen, or initiate an emergency procedure, in collaboration with specified health practitioners. The bill failed passage on the Senate Floor.

AB 2408 (Negrete McLeod, Chapter 777, Statutes of 2006) recasts various provisions of the Pharmacy Law for purposes of clarifying and updating the duties a pharmacist can perform, and makes other technical changes. At one point the bill authorized a pharmacist to adjust a prescription and provide cognitive services under specified conditions; however, those provisions were removed from the bill in the Senate.

AB 1711 (Strickland, Chapter 58, Statutes of 2005) authorized a registered nurse or licensed pharmacist to administer influenza and pneumococcal immunizations without patient-specific orders to patients age 50 years or older in a skilled nursing facility under standing orders when they meet federal recommendations and are approved by the medical director of the skilled nursing facility.

AB 2660 (Leno, Chapter 191, Statutes of 2004) reinstated pharmacists authority to register with the DEA and therefore initiate or adjust controlled substance drug therapy under specified conditions.

furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

SB 490 (Alpert, Chapter 651, Statutes of 2003) authorized a licensed pharmacist to initiate ECDT in accordance with a standardized procedure approved by the Board and MBC.

SB 111 (Alpert, Chapter 358, Statutes of 2001) amended the Medical Practice Act to authorize a medical assistant to perform specified services in community and free clinics under the supervision of a physician assistant, nurse practitioner or nurse-midwife. The bill authorized a physician and surgeon in these specified clinics to provide written instructions for medical assistants, regarding the performance of tasks or duties, while under the supervision of a physician assistant, nurse practitioner or nurse midwife when the supervising physician and surgeon was not on site.

SB 1169 (Alpert, Chapter 900, Statutes of 2001) authorized a pharmacist to initiate ECDT in accordance with standardized procedures or protocols developed by the pharmacist and an authorized prescriber acting within their scope of practice.

AB 261 (Lempert, Chapter 375, Statutes of 1999) authorized pharmacists to dispense emergency contraception pills for patients who have a written authorization by the patient's physician.

5. **Arguments in Support.** Supporters write that the concept of team-based care which is currently being utilized in hospital and other health care settings should be expanded to community settings in order to meet the demands of millions of Californians.

The American Society of Health-System Pharmacies notes that this bill will allow pharmacists to use the full range of their education and training to meet the demands of a growing patient population in California.

According to the Bay Area Council, the business community recognizes the importance of allowing highly-educated, well-trained professionals like pharmacists to perform primary care services that will improve efficiency, help control costs and create additional capacity in our state's increasingly overburdened health care system.

Blue Shield of California writes that this bill will help alleviate the access challenge and the continued contribution of pharmacists will help control costs and reduce the strain in our overburdened health care system.

Californians for Patient Care also supports this bill, stating that they are especially pleased with the language designed to ensure patients receive safe and high quality care when needed.

California Northstate University, College of Pharmacy writes in support of this bill, stating that PharmD education consists of close to 6,000 hours of post graduate clinical education and training which extensively covers patient care, disease prevention and management and clinical rotations in a variety of health care settings.

According to the California Optometric Association, this legislation is necessary to make the promise of ACA a reality.

The California Pharmacists Association (CPhA) and California Society of Health-System Pharmacists (CSHP) state that California must look at improving efficiencies in how care is delivered and how the health care workforce is utilized. The organizations believe that pharmacists are trained and qualified to provide more services, pharmacists are one of the most accessible providers in the health care system and pharmacists provide safe care that will improve patient outcomes. CPhA and CSHP note that pharmacists will be working in close collaboration with physicians whenever modifying medication regimes and this bill will more fully integrate the pharmacy profession into the health care team, “an outcome that will strengthen interprofessional collaboration and boost patient outcomes.”

The California Retailers Association supports this bill, noting that the bill proposes a number of novel concepts that will fill in health care gaps and will not only better incorporate pharmacists into the health care system but will do so appropriately, resulting in significant cost savings for patients and the system as well as improved patient outcomes.

According to the Indian Pharmacists Association of California, representing over 400 pharmacists, including 103 independent pharmacy owners, pharmacists are widely recognized as being the most overqualified and underutilized professionals. The group writes that pharmacists’ formal education appropriately prepares them to successfully perform services related to the prevention and control of disease and that the passing of this bill would be an important milestone in health care reform signaling much needed empowerment of the pharmacy profession.

Pharmacy Choice and Access Now writes in support of this bill, noting that to alleviate the congestion caused by increasing numbers of patients and the current primary care physician shortages, California should focus on utilizing highly trained pharmacists.

According to the United Nurses Associations of California and Union of Health Care Professionals, this bill will allow for better utilization of our existing infrastructure of trainer medical providers to bridge the provider gap through expanded practice.

Western University of Health Sciences (WU) notes the extensive hours of training in a PharmD education and states that pharmacists have been acting as direct care providers for decades in federal and managed care systems. WU writes that this bill will enable pharmacists to make more significant contributions to the care team to improve care for patients.

- 6. Support if Amended.** The California of Physician Groups (CAPG) has adopted a support if amended position on this bill, writing that it can help to increase access to care but the group has concerns. Specifically, CAPG believes that APPs should be limited to current health system delivery models rather than have authority for independent, autonomous practice; that the training requirement in this bill is too low for the type of functions expected of an APP and unacceptable for independent practice; the CE requirements are too low and; including travel vaccines is very dangerous.

The California Hospital Association (CHA) also writes that it supports this bill if amended, noting that CHA is extremely supportive of efforts to include pharmacists in the health care clinical delivery teams of the future and is committed to working with the Author to provide amendments to address “practice safeguards and quality mechanisms to ensure of coordinated care across the state”.

Kaiser Permanente writes that it will be in full support of this bill if the Author clarifies that an APP would be allowed to perform “patient” assessments rather than “physical” assessments as the bill currently provides.

7. **Neutral.** The American Federation of State, County and Municipal Employees (AFSCME) has a neutral position on this bill due to differing positions taken by two of its impacted affiliates, the United Nurses Associations of California/Union of Health Care Professionals (AFSCME Local 1199) which supports the bill and the Union of American Physicians and Dentists (AFSCME Local 206) which opposes the bill.
8. **Arguments in Opposition.** Opponents of this bill support expanding access to health care but believe that its provisions put patients at risk.

According to BayBio and BIOCOM, the bill creates the ability of pharmacists to perform therapeutic substitution of an agent prescribed by a physician and that in contrast to generic substitution where the product is chemically identical to that ordered by a physician, this allows for substitution within a broad general class, creating a conflict of interest for pharmacists who could be motivated to switch to cheaper but also less appropriate drugs strictly for financial considerations.

The American College of Emergency Physicians, California Chapter (California ACEP) is concerned about the impact this bill will have on patient safety and the potential conflicts of interest it introduces. California ACEP believes that this bill undermines the corporate ban on the practice of medicine because pharmacists are not covered by the ban and it is foreseeable that a pharmacist working for a retail chain could be paid to prescribe a drug by the company profiting from the prescription.

The California Academy of Eye Physicians and Surgeons write that pharmacists have no experience doing any of the things they are requesting and the bill raises the specter of a “two-tiered system where those who are less well-off make do with less trained providers while those with greater resources (i.e. money) go wherever they want.”

According to the California Academy of Family Physicians (CAFP), California Medical Association and Osteopathic Physicians and Surgeons of California this bill puts patients at risk. The groups cite the expanded authority to administer immunizations as unsafe because safe administration requires extensive education, experience and training. The groups also believe that the bill’s expanded authority to prescribe smoking cessation drugs could result in increased likelihood of patient harm, particularly because some of these drugs are associated with a substantial risk of depression and should be used only under close medical supervision. The groups write that allowing APPs to adjust or discontinue drug therapy allows the pharmacist to interfere with the physician-patient relationship and make treatment

in the bill are unclear and inconsistent with expanded practice authority and that the bill allows pharmacists to practice medicine without being subject to the Medical Practice Act.

The California Psychiatric Association echoes the statements above about APP concerns, specifically stating problems with APPs having ability to initiate, adjust or discontinue drug treatments and the potential risks to the health and safety of patients who are taking powerful, sometimes dangerous psychotropic medications which often have serious side effects.

The California Right to Life Committee, Inc. is opposed to this bill on the basis that the health of women using self-administered hormonal contraceptive services could be at risk without an attending physician and these drugs can act as abortifacients and end the life of a pre-born child.

The California Society of Anesthesiologists believes that the provisions in this bill would diminish physician involvement essential for patient safety.

The California Society of Plastic Surgeons is concerned about the expansion in the scope of services and the negative impact on patient safety, as well as the lack of resources and expertise at the Board which could lead to pharmacists being held to a lower standard of care than physicians providing the same service.

Canvasback Missions, Inc. and Lighthouse for Christ Mission and Eye Center write that pharmacists play an important role in healthcare delivery but treating disease is not that role.

The Osteopathic Physicians and Surgeons of America states that there is clear patient danger that exists by authorizing pharmacists to independently furnish drugs and are also concerned that the bill references oversight by MBC but makes no mention of the Osteopathic Medical Board of California.

The Union of American Physicians and Dentists writes that this bill is not a step in the right direction and that it rolls out an uncertain and untested health care delivery system.

9. Recent Amendments.

- a) In response to concerns raised by organizations like PhRMA, BIOCOM, BayBio and others, the Author recently amended the bill to clarify that pharmacists cannot engage in therapeutic substitutions. PhRMA has taken a neutral position on this bill.
- b) In response to concerns raised by Kaiser, the Author recently amended the bill to clarify that an APP would be allowed to perform "patient" assessments rather than "physical" assessments.
- c) In response to concerns raised by multiple organizations about the qualification requirements for a pharmacist to be recognized as an APP by the Board, the Author recently strengthened the bill to specify the types of certification and specific areas of practice an APP must be certified in, and also added a requirement that an APP must

SUPPORT AND OPPOSITION:

Support:

American Society of Health-System Pharmacists
Bay Area Council
Blue Shield of California
Californians for Patient Care
California Northstate University, College of Pharmacy
California Optometric Association
California Pharmacists Association
California Society of Health-System Pharmacists
California Retailers Association
Indian Pharmacists Association of California
Pharmacy Choice and Access Now
Union of Health Care Professionals
United Nurses Association of California
Western University of Health Sciences
Hundreds of individuals, including Pharm D students and numerous deans of schools of pharmacy

Support if Amended:

California Association of Physician Groups
California Hospital Association
Kaiser Permanente

Neutral:

AFSCME
Pharmaceutical Research and Manufacturers of America (PhRMA)

Opposition:

American College of Emergency Physicians, California Chapter
Bay Bio
Biocom
California Academy of Eye Physicians and Surgeons
California Academy of Family Physicians
California Healthcare Institute
California Medical Association
California Psychiatric Association
California Right to Life Committee, Inc.
California Society of Anesthesiologists
California Society of Plastic Surgeons
Canvasback Missions, Inc.
Lighthouse for Christ Mission and Eye Center

Union of American Physicians and Dentists
Hundreds of individuals

Consultant: Sarah Mason



California
LEGISLATIVE INFORMATION

SB-494 Health care providers. (2013-2014)

AMENDED IN SENATE APRIL 03, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL

No. 494

**Introduced by Senator Monning
(Principal Coauthor(s): Senator Hernandez)**

February 21, 2013

An act to amend ~~Section 3500 of the Business and Professions Code~~ add Section 1375.9 to the Health and Safety Code, to add Section 10133.4 to the Insurance Code, and to amend Sections 14087.48, 14088, and 14254 of, and to add Section 14088.1 to, the Welfare and Institutions Code, relating to health care providers.

LEGISLATIVE COUNSEL'S DIGEST

SB 494, as amended, Monning. ~~Health care providers: California Health Benefit Exchange: providers.~~

Existing law, the federal Patient Protection and Affordable Care Act, requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and qualified employers, as specified, and meets certain other requirements. Existing law establishes the California Health Benefit Exchange (the Exchange) within state government for that purpose. Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

This bill would authorize, if the assignment of plan enrollees or insureds to a primary care physician is authorized by certain provisions of law or contract, the assignment of up to 2,000 enrollees or insureds to each full-time equivalent primary care physician and would authorize the assignment of an additional 1,750 enrollees or insureds, as specified, to a primary care physician if that physician supervises one or more nonphysician medical practitioners. By imposing new requirements on health care service plans, the willful violation of which would be a crime, this bill would impose a state-mandated local program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services. Prior to a Medi-Cal managed care plan commencing operations, existing law requires the department to evaluate, among other things, the extent to which the plan has an adequate provider network, including the location, office hours, and language capabilities of the plan's primary care physicians. Existing law defines primary care provider for these purposes as an internist, general practitioner, obstetrician/gynecologist, pediatrician, family practice physician, or, as specified, types of clinics and defines primary care physician as a

This bill would require that the department evaluate the location, office hours, and language capabilities of a plan's primary care practitioners instead of the plan's primary care physicians. The bill would add nonphysician medical practitioners to the definition of a primary care provider. The bill would define nonphysician medical practitioner as a physician assistant performing services under physician supervision, as specified, or as a nurse practitioner performing services in collaboration with a physician, as specified. The bill would authorize, if the assignment of beneficiaries enrolled in any type of Medi-Cal managed care plan to a primary care physician is authorized by specified provisions of law or contract, the assignment of up to 2,000 beneficiaries to each full-time equivalent primary care physician. The bill would authorize the assignment of an additional 1,750 beneficiaries, as specified, to a primary care physician when that physician supervises one or more nonphysician medical practitioners. The bill would make conforming changes.

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

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

~~This bill would state the intent of the Legislature to ensure that qualified health plans participating in the California Health Benefit Exchange provide an adequate network of primary care providers, including non-physician providers.~~

Vote: majority Appropriation: no Fiscal Committee: ~~no~~yes Local Program: ~~no~~yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. *Section 1375.9 is added to the Health and Safety Code, to read:*

1375.9. (a) If the assignment of plan enrollees to a primary care physician is authorized by this chapter, or any regulation or contract promulgated thereunder, each full-time equivalent primary care physician may be assigned up to 2,000 enrollees. Notwithstanding any other state law or regulation, if a primary care physician supervises one or more nonphysician medical practitioners, the physician may be assigned up to an additional 1,750 enrollees for each full-time equivalent nonphysician medical practitioner supervised by that physician.

(b) This section shall not require a primary care physician to accept an assignment of enrollees that would be contrary to paragraph (2) of subdivision (b) of Section 1375.7.

SEC. 2. *Section 10133.4 is added to the Insurance Code, to read:*

10133.4. (a) If the assignment of insureds to a primary care physician is authorized by this part, or any regulation, contract, or policy promulgated thereunder, each full-time equivalent primary care physician may be assigned up to 2,000 insureds. Notwithstanding any other state law or regulation, if a primary care physician supervises one or more nonphysician medical practitioners, the physician may be assigned up to an additional 1,750 insureds for each full-time equivalent nonphysician medical practitioner supervised by that physician.

(b) This section shall not require a primary care provider to accept the assignment of a number of insureds that would exceed standards of good health care as provided in Section 10133.5.

SEC. 3. *Section 14087.48 of the Welfare and Institutions Code is amended to read:*

14087.48. (a) For purposes of this section "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089), or pursuant to Article 1 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8.

(b) Before a Medi-Cal managed care plan commences operations based upon an action of the director that expands the geographic area of Medi-Cal managed care, the department shall perform an evaluation to determine the readiness of any affected Medi-Cal managed care plan to commence operations. The evaluation shall include, at a minimum, all of the following:

(1) The extent to which the Medi-Cal managed care plan demonstrates the ability to provide reliable service utilization and cost data, including, but not limited to, quarterly financial reports, audited annual reports,

(2) The extent to which the Medi-Cal managed care plan has an adequate provider network, including, but not limited to, the location, office hours, and language capabilities of primary care ~~physicians, practitioners,~~ specialists, pharmacies, and hospitals, that the types of specialists in the provider network are based on the population makeup and particular geographic needs, and that whether requirements will be met for availability of services and travel distance standards, as set forth in Sections 53852 and 53885, respectively, of Title 22 of the California Code of Regulations.

(3) The extent to which the Medi-Cal managed care plan has developed procedures for the monitoring and improvement of quality of care, including, but not limited to, procedures for retrospective reviews which include patterns of practice reviews and drug prescribing practice reviews, utilization management mechanisms to detect both under- and over-utilization of health care services, and procedures that specify timeframes for medical authorization.

(4) The extent to which the Medi-Cal managed care plan has demonstrated the ability to meet accessibility standards in accordance with Section 1300.67.2 of Title 28 of the California Code of Regulations, including, but not limited to, procedures for appointments, waiting times, telephone procedures, after hours calls, urgent care, and arrangement for the provision of unusual specialty services.

(5) The extent to which the Medi-Cal managed care plan has met all standards and guidelines established by the department that demonstrate readiness to provide services to enrollees.

(6) The extent to which the Medi-Cal managed care plan has submitted all required contract deliverables to the department, including, but not limited to, quality improvement systems, utilization management, access and availability, member services, member grievance systems, and enrollment and disenrollments.

(7) The extent to which the Medi-Cal managed care plan's Evidence of Coverage, Member Services Guide, or both, conforms to federal and state statutes and regulations, is accurate, and is easily understood.

(8) The extent to which the Medi-Cal managed care plan's primary care and facility sites have been reviewed and evaluated by the department.

SEC. 4. *Section 14088 of the Welfare and Institutions Code is amended to read:*

14088. (a) It is the purpose of this article to ensure that the Medi-Cal program shall be operated in the most cost-effective and efficient manner possible with the optimum number of Medi-Cal providers and shall assure quality of care and known access to services.

(b) For the purposes of this article, the following definitions shall apply:

(1) "Primary care provider" means either of the following:

(A) Any internist, general practitioner, obstetrician/gynecologist, ~~pediatrician or~~ *pediatrician*, family practice ~~physician~~ *physician, nonphysician medical practitioner,* or any primary care clinic, rural health clinic, community clinic or hospital outpatient clinic currently enrolled in the Medi-Cal program, which agrees to provide case management to Medi-Cal beneficiaries.

(B) A county or other political subdivision that employs, operates, or contracts with, any of the primary care providers listed in subparagraph (A), and that agrees to use that primary care provider for the purposes of contracting under this article.

(2) "Primary care case management" means responsibility for the provision of referral, consultation, ordering of therapy, admission to hospitals, follow up care, and prepayment approval of referred services.

(3) "Designation form" or "form" means a form supplied by the department to be executed by a Medi-Cal beneficiary and a primary care provider or other entity eligible pursuant to this article who has entered into a contract with the department pursuant to this article, setting forth the beneficiary's choice of contractor and an agreement to be limited by the case management decisions of that contractor and the contractor's agreement to be responsible for that beneficiary's case management and medical care, as specified in this article.

(4) "Emergency services" means health care services rendered by an eligible Medi-Cal provider to a Medi-Cal beneficiary for those health services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which if not immediately diagnosed and treated could lead to disability or death.

(5) "Modified primary care case management" means primary care case management wherein capitated services are limited to primary care physician *practitioner* office visits only.

(6) "Service area" means an area designated by either a single federal Postal ZIP Code or by two or more Postal ZIP Codes that are contiguous.

(c) For purposes of this part, "nonphysician medical practitioner" means a physician assistant performing services under physician supervision in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code or a nurse practitioner performing services in collaboration with a physician pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

SEC. 5. Section 14088.1 is added to the Welfare and Institutions Code, to read:

14088.1. If the assignment of beneficiaries enrolled in any type of Medi-Cal managed care plan to a primary care physician is authorized or required by a provision of Part 3 (commencing with Section 11000) of Division 9, or any regulation, contract, or policy promulgated thereunder, each full-time equivalent primary care physician may be assigned up to 2,000 beneficiaries. Notwithstanding any other state law or regulation, if a primary care physician in that plan supervises one or more nonphysician medical practitioners, the physician may be assigned up to an additional 1,750 beneficiaries for each full-time equivalent nonphysician medical practitioner supervised by that physician.

SEC. 6. Section 14254 of the Welfare and Institutions Code is amended to read:

14254. "Primary care ~~physician~~ *practitioner*" is a physician or nonphysician medical practitioner who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. A primary care physician shall be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. Section 3500 of the Business and Professions Code is amended to read: 3500.~~

~~In its concern with the growing shortage and geographic maldistribution of health care services in California, the Legislature intends to establish in this chapter a framework for development of a new category of health manpower—the physician assistant.~~

~~It is the intent of the legislature to ensure that qualified health plans participating in the California Health Benefit Exchange, created by Section 100500 of the Government Code, provide an adequate network of primary care providers, including non-physician providers.~~

~~The purpose of this chapter is to encourage the more effective utilization of the skills of physicians, and physicians and podiatrists practicing in the same medical group practice, by enabling them to delegate health care tasks to qualified physician assistants where this delegation is consistent with the patient's health and welfare and with the laws and regulations relating to physician assistants.~~

~~This chapter is established to encourage the utilization of physician assistants by physicians, and by physicians and podiatrists practicing in the same medical group, and to provide that existing legal constraints should not be an unnecessary hindrance to the more effective provision of health care services. It is also the purpose of this chapter to allow for innovative development of programs for the education, training, and utilization of physician assistants.~~

Senate Appropriations Committee Fiscal Summary
Senator Kevin de León, Chair

SB 494 (Monning) – Health care providers.

Amended: April 3, 2013

Urgency: No

Hearing Date: May 6, 2013

Policy Vote: Health 9-0

Mandate: Yes

Consultant: Brendan McCarthy

This bill meets the criteria for referral to the Suspense File.

Bill Summary: SB 494 would authorize a health plan or health insurance plan to assign up to 2,000 patients to a primary care physician. If a primary care physician supervises one or more non-physician medical practitioners, the primary care physician may be assigned an additional 1,750 patients per non-physician medical practitioner

Fiscal Impact:

- One-time costs of \$600,000 to review plan filings by the Department of Managed Health Care (Managed Care Fund).
- Potential ongoing enforcement cost in the tens of thousands per year by the Department of Managed Health Care (Managed Care Fund).
- One-time costs of \$80,000 to update regulations by the Department of Insurance (Insurance Fund).

Background: Under current law, health plans are licensed and regulated by the Department of Managed Health Care and insurance plans are licensed and regulated by the Department of insurance.

Under regulation, health plans that assign patients to a primary care physician can assign up to 2,000 patients per full time equivalent primary care physician (often referred to as a physician's "panel").

The state's Medi-Cal program provides health care coverage for low income children, their families, and certain disabled residents of the state. Of the roughly 8.2 million people enrolled in Medi-Cal, about 70% are served through by Medi-Cal managed care plans.

Proposed Law: SB 494 would authorize a health plan or health insurance plan to assign up to 2,000 patients to a primary care physician. If a primary care physician supervises one or more non-physician medical practitioners, the primary care physician may be assigned an additional 1,750 patients per non-physician medical practitioner

The bill specifies that these requirements do not require a physician to accept a number of patients that would exceed the standards of good health care.

These requirements would apply to both health plans and health insurers.

The bill specifically extends this authority to Medi-Cal managed care plans.

Staff Comments: The only costs that may be incurred by a local agency under the bill relate to crimes and infractions. Under the California Constitution, those costs are not reimbursable by the state.



California
LEGISLATIVE INFORMATION

SB-809 Controlled substances: reporting. (2013-2014)

AMENDED IN SENATE MAY 01, 2013

CALIFORNIA LEGISLATURE— 2013-2014 REGULAR SESSION

SENATE BILL

No. 809

**Introduced by Senator DeSaulnier, Steinberg
(Coauthor(s): Senator Hancock, Lieu, Pavley, Price)
(Coauthor(s): Assembly Member Blumenfield)**

February 22, 2013

An act to add Section 805.8 to the Business and Professions Code, to amend Sections 11165 and 11165.1 of the Health and Safety Code, and to add Part 21 (commencing with Section 42001) to Division 2 of the Revenue and Taxation Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 809, as amended, DeSaulnier. Controlled substances: reporting.

(1) Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

Existing law requires dispensing pharmacies and clinics to report, on a weekly basis, specified information for each prescription of Schedule II, Schedule III, or Schedule IV controlled substances, to the department, as specified.

This bill would establish the CURES Fund within the State Treasury to receive funds to be allocated, upon appropriation by the Legislature, to the Department of Justice for the purposes of funding CURES, and would make related findings and declarations.

This bill would require the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine to increase the licensure, certification, and renewal fees charged to practitioners under their supervision who are authorized to prescribe or dispense controlled substances, by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as

certification, and renewal fees charged to wholesalers, nonresident wholesalers, and veterinary food-animal drug retailers under their supervision by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified.

(2) Existing law permits a licensed health care practitioner, as specified, or a pharmacist to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care. Existing law also authorizes the Department of Justice to provide the history of controlled substances dispensed to an individual to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

This bill would require licensed health care practitioners, as specified, and pharmacists to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care, and, upon the happening of specified events, to access and consult that information prior to prescribing or dispensing Schedule II, Schedule III, or Schedule IV controlled substances.

(3) Existing law imposes various taxes, including taxes on the privilege of engaging in certain activities. The Fee Collection Procedures Law, the violation of which is a crime, provides procedures for the collection of certain fees and surcharges.

~~This bill would impose a tax upon qualified manufacturers, as defined, for the privilege of doing business in this state, as specified. This bill would also impose a tax upon specified insurers, as defined, for the privilege of doing business in this state, as specified. The tax would be administered by the State Board of Equalization and would be collected by the State Board of Equalization pursuant to the procedures set forth in the Fee Collection Procedures Law. The bill would require the board to deposit all taxes, penalties, and interest collected pursuant to these provisions in the CURES Fund, as provided. This bill would also allow specified insurers, as defined, to voluntarily contribute to the CURES Fund, as described.~~ Because this bill would expand application of the Fee Collection Procedures Law, the violation of which is a crime, it would impose a state-mandated local program.

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

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

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

Vote: 2/3 Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(a) The Controlled Substance Utilization Review and Evaluation System (CURES) is a valuable investigative, preventive, and educational tool for law enforcement, regulatory boards, educational researchers, and the health care community. Recent budget cuts to the Attorney General's Division of Law Enforcement have resulted in insufficient funding to support the CURES Prescription Drug Monitoring Program (PDMP). The PDMP is necessary to ensure health care professionals have the necessary data to make informed treatment decisions and to allow law enforcement to investigate diversion of prescription drugs. Without a dedicated funding source, the CURES PDMP is not sustainable.

(b) Each year CURES responds to more than 60,000 requests from practitioners and pharmacists regarding all of the following:

(1) Helping identify and deter drug abuse and diversion of prescription drugs through accurate and rapid tracking of Schedule II, Schedule III, and Schedule IV controlled substances.

(2) Helping practitioners make better prescribing decisions.

(3) Helping reduce misuse, abuse, and trafficking of those drugs.

(c) Schedule II, Schedule III, and Schedule IV controlled substances have had deleterious effects on private and public interests, including the misuse, abuse, and trafficking in dangerous prescription medications resulting in injury and death. It is the intent of the Legislature to work with stakeholders to fully fund the

SEC. 2. Section 805.8 is added to the Business and Professions Code, to read:

805.8. (a) (1) The Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine shall increase the licensure, certification, and renewal fees charged to practitioners under their supervision who are authorized pursuant to Section 11150 of the Health and Safety Code to prescribe or dispense Schedule II, Schedule III, or Schedule IV controlled substances by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating prescribers and dispensers of controlled substances licensed or certificated by these boards.

(2) The California State Board of Pharmacy shall increase the licensure, certification, and renewal fees charged to wholesalers and nonresident wholesalers of dangerous drugs, licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9, by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating wholesalers and nonresident wholesalers of dangerous drugs licensed or certificated by that board.

(3) The California State Board of Pharmacy shall increase the licensure, certification, and renewal fees charged to veterinary food-animal drug retailers, licensed pursuant to Article 15 (commencing with Section 4196) of Chapter 9, by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating veterinary food-animal drug retailers licensed or certificated by that board.

(b) The funds collected pursuant to subdivision (a) shall be deposited in the CURES accounts, which are hereby created, within the Contingent Fund of the Medical Board of California, the State Dentistry Fund, the Pharmacy Board Contingent Fund, the Veterinary Medical Board Contingent Fund, the Board of Registered Nursing Fund, the Osteopathic Medical Board of California Contingent Fund, the Optometry Fund, and the Board of Podiatric Medicine Fund. Moneys in the CURES accounts of each of those funds shall, upon appropriation by the Legislature, be available to the Department of Justice solely for maintaining CURES for the purposes of regulating prescribers and dispensers of controlled substances. All moneys received by the Department of Justice pursuant to this section shall be deposited in the CURES Fund described in Section 11165 of the Health and Safety Code.

SEC. 3. Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES accounts within the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, the Osteopathic Medical Board of California Contingent Fund, the Veterinary Medical Board Contingent Fund, the Optometry Fund, the Board of Podiatric Medicine Fund, and the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

(b) The reporting of Schedule III and Schedule IV controlled substance prescriptions to CURES shall be contingent upon the availability of adequate funds for the Department of Justice for the purpose of finding CURES. The department may seek and use grant funds to pay the costs incurred from the reporting of controlled substance prescriptions to CURES. The department shall make information about the amount and the source of all private grant funds it receives for support of CURES available to the public. Grant funds shall not be appropriated from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, the Naturopathic Doctor's Fund, or the Osteopathic Medical Board of California Contingent Fund to pay the costs of reporting Schedule III and Schedule IV controlled substance prescriptions to CURES.

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

for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency, as described in this subdivision, shall not be disclosed, sold, or transferred to any third party.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy or clinic shall provide the following information to the Department of Justice on a weekly basis and in a format specified by the Department of Justice:

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

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

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

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

(5) Quantity of the controlled substance dispensed.

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

(7) Number of refills ordered.

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

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(e) The CURES Fund is hereby established within the State Treasury. The CURES Fund shall consist of all funds made available to the Department of Justice for the purpose of funding CURES. Money in the CURES Fund shall, upon appropriation by the Legislature, be available for allocation to the Department of Justice for the purpose of funding CURES.

SEC. 4. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) A licensed health care practitioner eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances or a pharmacist shall provide a notarized application developed by the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner or pharmacist, the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

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

(i) Materially falsifying an application for a subscriber.

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

(iii) Suspended or revoked federal Drug Enforcement Administration (DEA) registration.

(iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Any subscriber accessing information for any other reason than caring for his or her patients.

(B) Any authorized subscriber shall notify the Department of Justice within 10 days of any changes to the subscriber account.

(2) To allow sufficient time for licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and a pharmacist to apply and receive access to PDMP, a written request may be made, until July 1, 2012, and the Department of Justice may release to that practitioner or pharmacist the history of controlled substances dispensed to an individual under his or her care based on data contained in CURES.

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

(c) (1) Until the Department of Justice has issued the notification described in paragraph (3), in order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(2) Upon the Department of Justice issuing the notification described in paragraph (3) and approval of the application required pursuant to subdivision (a), licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and pharmacists shall access and consult the electronic history of controlled substances dispensed to an individual under his or her care prior to prescribing or dispensing a Schedule II, Schedule III, or Schedule IV controlled substance.

(3) The Department of Justice shall notify licensed health care practitioners and pharmacists who have submitted the application required pursuant to subdivision (a) when the department determines that CURES is capable of accommodating the mandate contained in paragraph (2). The department shall provide a copy of the notification to the Secretary of the State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the notification on the department's Internet Web site.

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

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

SEC. 5. Part 21 (commencing with Section 42001) is added to Division 2 of the Revenue and Taxation Code, to read:

PART 21. Controlled Substance Utilization Review and Evaluation System (CURES) Tax Law

42001. For purposes of this part, the following definitions apply:

(a) "Controlled substance" means a drug, substance, or immediate precursor listed in any schedule in Section 11055, 11056, or 11057 of the Health and Safety Code.

(b) "Insurer" means ~~a health insurer licensed pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code, a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), and a workers' compensation insurer licensed pursuant to Part 3 (commencing with Section 11550) of Division 2~~ *an admitted insurer writing health insurance, as defined in Section 106 of the Insurance Code, and an admitted insurer writing workers' compensation insurance, as defined in Section 109 of the Insurance Code.*

(c) "Qualified manufacturer" means a manufacturer of a controlled substance ~~doing business in this state, as defined in Section 23101,~~ but does not mean a wholesaler or nonresident wholesaler of dangerous drugs, regulated pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2 of the Business and Professions Code, a veterinary food-animal drug retailer, regulated pursuant to Article 15 (commencing with Section 4196) of Chapter 9 of Division 2 of the Business and Professions Code, or an individual regulated by the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, or the California Board of Podiatric Medicine.

42003. (a) For the privilege of doing business in this state, an annual tax is hereby imposed on all qualified manufacturers in an amount of _____ dollars (\$ _____) determined pursuant to Section 42005, for the purpose of establishing and maintaining enforcement of the Controlled Substance Utilization Review and Evaluation System (CURES), established pursuant to Section 11165 of the Health and Safety Code.

~~(b) For the privilege of doing business in this state, a tax is hereby imposed on a one-time basis on all insurers in an amount of _____ dollars (\$ _____), for the purpose of upgrading CURES.~~

(b) The Department of Justice may seek grant moneys from insurers for the purpose of upgrading and modernizing the CURES. Insurers may contribute by submitting their payment to the Controller for deposit into the CURES Fund established pursuant to subdivision (e) of Section 11165 of the Health and Safety Code. The department shall make information about the amount and the source of all private grant funds it receives for support of CURES available to the public.

~~42005. Each qualified manufacturer and insurer shall prepare and file with the board a return, in the form prescribed by the board, containing information as the board deems necessary or appropriate for the proper administration of this part. The return shall be filed on or before the last day of the calendar month following the calendar quarter to which it relates, together with a remittance payable to the board for the amount of tax due for that period.~~

~~42007. The board shall administer and collect the tax imposed by this part pursuant to the Fee Collection Procedures Law (Part 30 (commencing with Section 55001)). For purposes of this part, the references in the Fee Collection Procedures Law (Part 30 (commencing with Section 55001)) to "fee" shall include the tax imposed by this part and references to "feepayer" shall include a person required to pay the tax imposed by this part.~~

42005. (a) *The board shall collect the annual tax imposed by this part pursuant to the Fee Collection Procedures Law (Part 30 (commencing with Section 55001)). For purposes of this part, a reference in the Fee Collection Procedures Law to a "fee" shall include this tax and a reference to a "feepayer" shall include a person liable for the payment for the taxes collected pursuant to that law.*

(b) (1) The board shall not accept or consider a petition for redetermination that is based on the assertion that a determination by the Department of Justice incorrectly determined that a qualified manufacturer is subject to the tax or that a determination by the Department of Justice improperly or erroneously calculated the amount of that tax. The board shall forward to the Department of Justice any appeal of a determination that asserts that a determination by the Department of Justice incorrectly determined that a qualified manufacturer is subject to the tax or that a determination by the Department of Justice improperly or erroneously calculated the amount of that tax.

(2) The board shall not accept or consider a claim for refund that is based on the assertion that a determination by the Department of Justice improperly or erroneously calculated the amount of a tax, or incorrectly determined that the qualified manufacturer is subject to the tax. The board shall forward to the Department of Justice any claim for refund that asserts that a determination by the Department of Justice incorrectly determined that a qualified manufacturer is subject to the tax or that a determination by the Department of Justice improperly or erroneously calculated the amount of that tax.

42007. (a) *The Department of Justice shall determine the annual tax by dividing the cost to establish and maintain enforcement of CURES by the number of qualified manufacturers. For calendar year 2014, the CURES cost shall be four million two hundred thousand dollars (\$4,200,000). Beginning with the 2015 calendar year, and for each calendar year thereafter, the Department of Justice shall adjust the rate annually to reflect increases or decreases in the cost of living during the prior fiscal year, as measured by the California Consumer Price Index for all items.*

(b) The Department of Justice shall provide to the board the name and address of each qualified manufacturer that is liable for the annual tax, the amount of tax, and the due date.

(c) All annual taxes referred to the board for collection pursuant to Section 42005 shall be paid to the board.

42009. All taxes, interest, penalties, and other amounts collected pursuant to this part, less refunds and costs of administration, shall be deposited into the CURES Fund.

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

SEC. 7. 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 Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the public from the continuing threat of prescription drug abuse at the earliest possible time, it is necessary this act take effect immediately.

SENATE GOVERNANCE & FINANCE COMMITTEE
Senator Lois Wolk, Chair

BILL NO: SB 809
AUTHOR: DeSaulnier
VERSION: 5/1/13
CONSULTANT: Miller

HEARING: 5/8/13
FISCAL: Yes
TAX LEVY: No

CONTROLLED SUBSTANCES: REPORTING (URGENCY)

Imposes an annual tax on Schedule II, III, and IV manufacturers, increases licensure fees on practitioners and providers, and allows grant and gift moneys for the purposes of upgrading, maintain and enforcing the CURES program.

Background and Existing Law

CURES

The California Uniform Controlled Substances Act (the Act) regulates controlled substances; it defines opiate as any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. The Act classifies controlled substances in five schedules according to their danger and potential for abuse. The Controlled Substances Utilization Review and Evaluation System (CURES) electronically monitors Schedule II, III and IV controlled substance prescriptions.

CURES provides for the electronic transmission of Schedule II, III and IV controlled substance prescription information to the Department of Justice (DOJ) at the time prescriptions are dispensed. CURES' purpose is to assist law enforcement and regulatory agencies in controlling diversion and abuse of Schedule II, III and IV controlled substances and for statistical analysis, education and research. DOJ maintain CURES, contingent upon the availability of adequate funds from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund and the Osteopathic Medical Board of California Contingent Fund.

Pharmacies and clinics that fill prescriptions for controlled substances must provide weekly information to DOJ including the patient's name, date of birth, the name, form, strength and quantity of the drug, and the pharmacy name, pharmacy number and the prescribing physician information.

In an optional program, licensed health care practitioners that are eligible to prescribe Schedule II, III or IV controlled substances, or a pharmacist, may apply to participate in the CURES Prescription Drug Monitoring Program (PDMP). DOJ may deny an application or suspend a subscriber for materially falsifying an application, failing to maintain effective controls for access to the patient activity report, suspended or revoked DEA registration, arrest for a controlled substance arrest or accessing information for any reason other than patient care. Under the PDMP, the participating (subscribing) practitioner or pharmacist may access the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in CURES.

Board of Equalization (BOE) Fee and Tax programs

BOE administers the property tax, the sales and use tax, the alcohol tax, the tobacco tax, and the fuel tax among others. In addition, the BOE acts as a collection agency and collects taxes and fees on three distinct groups but does not assess, enforce or administer the tax. Under these programs, BOE acts as the collection agency rather than the tax agency under the Fee Collection Procedures Law of the Revenue & Taxation Code; specifically:

1. **Water Rights**. The State Water Resources Control Board (SWRCB) sends BOE a notice of the name and address of each person or entity who is liable for a fee or expense, the amount of the fee or expense, and the due date and BOE collects it. SWRCB handles claims for refunds and other discrepancies.
2. **Fire Prevention Fee**: The State Board of Forestry and Fire Protection (Fire Board) provides BOE with the taxpayer name, address, and amount of the fee assessment, not to exceed \$150. All legal actions and discrepancies of the fee must be held pending CAL FIRE's decision on the petition.
3. **Childhood Lead**: The California Department of Public Health (CDPH) notifies the BOE of who to register and bill under this program. The fee is imposed on manufactures and other persons formerly, presently, or both engaged in the stream of commerce of lead or products containing lead, or who otherwise are responsible for identifiable sources of lead.

Proposed Law

Senate Bill 809 increases the license fees of practitioners in this state, provides that gifts may be made into the program, and imposes a tax on manufacturers of Schedule II, III, and IV drugs. The bill also delineates new requirements of the CURES program and participants and states findings and declarations to make

Practitioner and Provider Fees

SB 809 requires the following health practitioner boards to increase licensure, certification and renewal fees for licensees under their supervision authorized to prescribe controlled substances by up to 1.16 percent annually and clarifies that in no case shall the fee increase exceed the reasonable costs association with maintaining CURES:

1. Medical Board of California
2. Dental Board of California
3. California State Board of Pharmacy
4. Veterinary Medical Board
5. Board of Registered Nursing
6. Physician Assistant Committee of the Medical Board of California
7. Osteopathic Medical Board of California
8. State Board of Optometry
9. California Board of Podiatric Medicine

SB 809 also requires the Board of Pharmacy to increase licensure, certification and renewal fees for wholesalers, out-of-state wholesalers of dangerous drugs and veterinary food-animal drug retailers up to 1.16 percent annually. Clarifies that in no case shall the fee increase exceed the reasonable costs association with maintaining CURES.

Grants and gifts

SB 809 allows the DOJ to seek grant moneys from insurers for the purpose of upgrading and modernizing the CURES. Insurers may contribute by submitting their payment to the Controller which he or she deposits in the CURES fund. SB 809 requires that the DOJ make any information about the amount and source of private grant funds publicly available.

Manufacturers' tax

SB 809 requires DOJ to determine the annual tax on manufacturers of Schedule II, III, and IV drugs by dividing the cost to establish and maintain enforcement of CURES. For calendar year 2014, the CURES cost shall be \$4.2 million which is to be divided the number of "qualified manufacturers." SB 809 allows DOJ to adjust the cost of the program after January 1, 2015 by the cost of living during the prior year as measured by the Consumer Price Index. DOJ shall provide the BOE with the name and address of each qualified manufacturer that is liable for the annual tax, the amount of tax due and the due date.

SB 809 requires BOE to collect the annual tax prescribed by this bill under the Fee Collection Procedures Law. The bill explicitly states that BOE shall not consider a petition for redetermination or a claim for refund except for a math error. All other matters of discrepancy are to be taken to DOJ.

Miscellaneous

SB 809 requires various upgrades to the CURES system, new enforcement and reporting requirements, and new “real time” data sharing before Schedule II, III, and IV drugs may be dispensed.

SB 809 defines its terms, including “insurer” which is defined as a gross-premiums tax paying insurer administered by DOI.

SB 809 is an urgency measure and states that this is an urgency measure, necessary to take effect immediately so that the public is protected from the continuing threat of prescription drug abuse at the earliest possible time.

State Revenue Impact

According to DOJ, the intent of the bill is to pay for the system upgrade, the ongoing program and enforcement in the following amounts:

1. \$1.6 million from the providers’ licensure fee to pay for the ongoing program
2. \$3.8 million for a one-time upgrade to the CURES system.
3. \$4.2 million from the manufacturer’s tax for the enforcement of the program. The manufacturer’s tax is in SB 809.

Comments

1. Purpose of the bill. According to the author, “While the automated Prescription Drug Monitory Program (PDMP) within the Controlled Substances Utilization Review and Evaluation System (CURES) program is a valuable preventative, investigative, and educational tool for health care providers, law enforcement, and regulatory boards, recent budget cuts to the Attorney General’s Division of Law Enforcement have resulted in insufficient funding to support the CURES PDMP. The PDMP is necessary to ensure health care professionals have the necessary data to make informed treatment decisions and to allow law enforcement to investigate prescription drug diversion. Without a dedicated funding source, the CURES PDMP is not sustainable and will be suspended July 1, 2013.

SB 809 establishes CURES Fund to provide sufficient revenue to upgrade and ful-

pharmacists to enroll and consult the CURES PDMP once the program is capable of accommodating all users.

To provide dedicated funds, SB 809 increases fees, by 1.16 percent, per licensee, that is authorized to prescribe or dispense controlled substances and wholesalers licensed by the Board of Pharmacy; imposes annual taxes on drug manufacturers of schedule II, III, and IV controlled substances doing business in California to establish and support enforcement capability necessary to mitigate diversion and reduce the abuse of prescription narcotics; and directs the Department of Justice to seek grant funding from health insurance plans and workers compensation insurers to fund the CURES modernization upgrade.

2. General fund would be better. Pharmaceutical Research and Manufacturers of America (PhRMA) states that this bill creates an open-ended and permanent funding requirement on manufacturers to finance a "strike-team" to enforce California's anti-drug efforts. PhRMA supports the use of PDMPs and believes these and related enforcement programs should be funded with state General Fund dollars, federal grant monies, settlement programs at DOJ or other fiscal resources rather than a tax on the industry. The industry is additionally concerned that the new tax is not for the current administration of the program that may lose funding on July 1st of this year but instead for a new enforcement program.

3. Too little, too much, just right. SB 809 raises an interesting policy question: Who should bear the costs of maintain programs which everyone agrees contributes to the health and safety of all Californians? SB 809 answers that question with increased licensure fees, a tax on controlled substance manufacturing of Schedule II, III, IV manufacturers and attempts to encourage insurers to pay into the fund through a grant program. However, the cost of the bill, including a more robust enforcement program, falls disproportionately on the manufacturers. *The Committee may wish to consider amending the bill to provide that each group pay equitable amounts through the tax, grants or licensing fees in order to fund the program.*

4. Gross premiums tax. The bill permissively allows insurers to pay into a special fund voluntarily to assist with the startup costs of CURES funding. The previous version of the bill taxed insurers regulated by the Department of Insurance (DOI) that pay on the gross premiums tax (a type of sales tax on insurance premiums); a tax on gross premium paying insurers, however, is unconstitutional as the gross premiums tax is considered "in lieu" of any other tax. Therefore, the author allows insurers to contribute in this manner instead of compelling them to do so. Most managed care plans are regulated by the Department of Managed Healthcare (DMHC), and pay the corporate tax but the previous version of the bill did not assess these companies. In its definition of "insurer," the bill only applies to DOI plans. However, if corporate taxpaying companies or insurance

consider amending the bill to define insurers to include all health plans, even managed care plans and to disallow a state charitable deduction for this purpose since none of the other groups receive one.

5. Is there a better way? SB 809 grants DOJ a new quasi-taxing authority by allowing the department to tell the BOE how much to assess each manufacturer, and allows DOJ to enforce the tax. This is a significant departure from tax policy (with three exceptions at the BOE) whereby the tax agency has a direct relationship with the taxpayer and generally imposes taxes as a percent of a product (sales and use tax) or income (personal income tax). The bill requires taxpayers to register with DOJ as a manufacturer so that the tax may be enforced, and DOJ has to share the taxpayer, amount of tax, and address to the BOE in a second type of registration there. Since DOJ plans to divide the cost of enforcement by the number of manufactures that make Schedule II, III, and IV drugs, it may be simpler for the DOJ to levy a registration tax instead and not require the BOE to impose the tax at all. *The Committee may wish to direct staff to explore the feasibility of a registration tax.*

6. Timing is everything. SB 809 is an urgency measure because California could be one of only two states that do not have a program if CURES is not funded before July 1 of this year. However, the new requirements it imposes on practitioners and the new tax it imposes on manufacturers may not be imposed immediately for administrative reasons. *The Committee may wish to consider starting immediately the fee increases on licenses but delaying implementation on both the manufacturers tax to allow DOJ to gather the data and also on the data requirements of practitioners before the technology is fully functional.*

7. Attorney General. This bill is sponsored by California Attorney General Kamala Harris. According to the Author, the automated prescription drug management program (PDMP) within the CURES program is a valuable investigative, preventative, and educational tool for law enforcement, regulatory boards, and health care providers, but recent budget cuts to the Attorney General's Division of Law Enforcement have resulted in insufficient funding to support the CURES PDMP. The Author states that the PDMP is necessary to ensure health care professionals have the necessary data to make informed treatment decisions and to allow law enforcement to investigate prescription drug diversion. Without a dedicated funding source, the CURES PDMP is not sustainable and will be suspended July 1, 2013. To keep the program going and increase its effectiveness, SB 809 includes an urgency clause and establishes funds to upgrade the system to be fully modernized and provides dedicated ongoing funding to ensure the program is sustainable.

8. Double referral. SB 809 was heard in the Senate Business & Professions Committee on April 16th. That Committee discussed the issues related to the li-

9. Related legislation. Senator Burton made the CURES program permanent in 2004, since then there have been various attempts at tax and fee increases, some successful, to fund the program.

1. SB 62 (Price, 2013) requires coroners' reports to be transmitted to various health practitioner boards in the event that cause of death is determined to be prescription drug overdose. SB 62 is on the Senate Appropriations Committee suspense file.
2. SB 670 (Steinberg) provides the Medical Board of California with additional authority to inspect medical records and to limit the prescribing ability of physicians during a pending investigation if there is a reasonable suspicion the physician has engaged in overprescribing of controlled substances that resulted in a patient's death. SB 670 is on the Senate Floor.
3. SB 616 (DeSaulnier, 2012) increased fees, up to \$10 per licensee that is authorized to prescribe or dispense controlled substances, to fund CURES. The measure failed passage in the Assembly Committee on Business, Professions and Consumer Protection.
4. SB 360 (DeSaulnier, Chapter 418, Statutes of 2011) updated CURES to reflect the new PDMP and authorized DOJ to initiate administrative enforcement actions to prevent the misuse of confidential information collected through CURES.
5. SB 1071 (DeSaulnier, 2010) imposed a tax on manufacturers or importers of Schedule II, III and IV controlled substances to pay for ongoing costs of the CURES program. Fees would have been collected by the BOE, at the rate of \$0.0025 per pill included in Schedule II, III, and IV. The bill failed passage in the Senate Committee on Health.
6. SB 151 (Burton, Chapter 406, Statutes of 2004) made CURES permanent, among other provisions.

Support and Opposition (5/2/13)

Support: Attorney General Kamala Harris (Sponsor); California Department of Insurance; California Labor Federation; California Narcotic Officers Association; California Pharmacists Association; California Police Chiefs Association; California State Sheriffs' Association; City and County of San Francisco; County Alcohol and Drug Program Administrators Association of California; Deputy Sheriffs' Association of San Diego County; Healthcare Distribution Management Association; National Coalition Against Prescription Drug Abuse; Troy and Alana Pack

Opposition: Association of California Life and Health Insurance Companies; BayBio; California Healthcare Institute; Generic Pharmaceuticals Association; PhRMA; TEVA Pharmaceuticals.

Physician Assistant Committee

AGENDA ITEM # 17

Mission Statement

The mission of the Physician Assistant Committee is to protect and serve consumers through licensing, education and objective enforcement of the Physician Assistant laws and regulations.

Vision Statement:

As a result of our efforts the health care needs of California consumers are met by Physician Assistants in a compassionate, competent, ethical and culturally-sensitive manner.

Values:

- **Accountability:** We are accountable to the people of California and each other as stakeholders. We operate transparently and encourage public participation in our decision-making whenever possible.
- **Efficiency:** We diligently identify the best ways to deliver high-quality services with the most efficient use of our resources.
- **Effectiveness:** We make informed decisions that make a difference and have a positive, measurable impact.
- **Integrity:** We are honest, fair and respectful in our treatment of everyone, which is demonstrated through our decision-making process.
- **Customer Service:** We acknowledge all stakeholders as our customers, listen to them, and take their needs into account.
- **Employees:** We are an employer of choice and strategically recruit, train, and retain employees. We value and recognize employee contributions and talent.
- **Unity:** We draw strength from our organizational diversity as well as California's ever-changing cultural and economic diversity.

Physician Assistant Committee

Goals:

GOAL 1 - Licensing

Protect consumers by licensing qualified applicants using a timely, accurate and cost effective process.

GOAL 2 - Enforcement

To protect consumers through an enforcement process that is timely, fair, and consistent with the applicable laws and regulations.

GOAL 3 – Education & Outreach

Provide education and outreach to consumers, healthcare providers, physician assistant training programs and applicants in an accurate accessible manner, including presentations to diverse, underserved populations.

GOAL 4 – Administrative Efficiency

Utilizing the latest management tools and technology, provide cost-effective, quality administrative services to consumers, applicants and licensees.

GOAL 5 – Legislative & Regulatory

Support legislation; pursue laws and regulations that would better meet the needs of consumers in an ever-changing health care environment.

GOAL 6 - Workforce

Address Physician Assistant workforce needs.

Physician Assistant Committee

Objectives:

GOAL 1 - Licensing

Protect consumers by licensing qualified applicants using a timely, accurate and cost effective process.

Objectives (not prioritized):

- Streamline the regulatory language in regards to licensing schools.
- Improve the Committee's information technology system and support.
- Acquire and maintain adequate staff.
- Consider increasing the length of time between renewals.
- Review application, license, and renewal fees to ensure they are current.
- Develop and transition to an all-electronic processing method for licensing.

GOAL 2 - Enforcement

To protect consumers through an enforcement process that is timely, fair, and consistent with the applicable laws and regulations.

Objectives (not prioritized):

- Identify and use expert witnesses who understand the legal requirements for enforcement.
- Create an enforcement process tree and post it on the Committee's web site.
- Clarify enforcement regulations and statutes.
- Post disciplinary guidelines conspicuously on the web site.
- Reduce the time required to conduct investigations.
- Add requirement for licensees to report any convictions that occur prior to renewal of their license.
- Establish a faster Interim Suspension Order process and use it consistently.
- Increase the number of investigators on staff.

Physician Assistant Committee

Objectives (continued):

GOAL 3 – Education & Outreach

Provide education and outreach to consumers, healthcare providers, physician assistant training programs and applicants in an accurate accessible manner, including presentations to diverse, underserved populations.

Objectives (not prioritized):

- Arrange for a Twitter account for the Committee executive officer.
- Explore the creation of a blog or other form of “chat” site for Physician’s Assistants on the Committee’s web site.
- Ensure the views of the profession are represented on national health care issues.
- Create a calendar on the web site that allows PAs and the public to post outreach events.
- Create a newsletter and post it on the Committee's web site.
- Schedule and conduct seminars to increase community/public awareness of the profession.
- Promote the PA career path in high schools and junior colleges.
- Send representatives to present at 4-5 PA schools each year.
- Use electronic venues, such as the Web, Twitter and Facebook to educate stakeholders about new laws.

GOAL 4 – Administrative Efficiency

Utilizing the latest management tools and technology, provide cost-effective, quality administrative services to consumers, applicants and licensees.

Objectives (not prioritized):

- Explore setting up a VPN for the Committee.
- Increase the use of electronic, on-line communication to reduce the use of hard-copy.
- Provide electronic access to all electronic data.
- Provide internship opportunities for staff at the Committee.

Physician Assistant Committee

Objectives (continued):

GOAL 5 – Legislative & Regulatory

Support legislation; pursue laws and regulations that would better meet the needs of consumers in an ever-changing health care environment.

Objectives (not prioritized):

- Stay abreast of updated, changed, and newly enforced laws to make sure we stay compliant.
- Ensure that new legislation and regulations reflect the current needs of Physician Assistant practice.
- Keep regulations current.
- Develop and maintain relationships with legislators.
- Sponsor new legislation to speed up the enforcement process.
- Review the PA school accreditation process.
- Pursue mandatory reporting from hospitals and clinics of disciplinary actions taken against PAs.

GOAL 6 - Workforce

Address Physician Assistant workforce needs.

Objectives (not prioritized):

- Collect workforce data every three years and post it on the Committee's web site.
- Inform and educate legislators and the public about the need for more Physician Assistant schools.
- Provide information about the PA career to health sectors of the military branches.