



**PHYSICIAN ASSISTANT BOARD**

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**MEETING NOTICE**

**August 3, 2015**

**PHYSICIAN ASSISTANT BOARD**

**2005 Evergreen Street – Hearing Room #1150**

**Sacramento, CA 95815**

**9:00 A.M. – 5:00 P.M.**

**AGENDA**

**(Please see below for Webcast information)**

**EXCEPT “TIME CERTAIN”\* ITEMS, ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE**

1. Call to Order by President (Sachs)
2. Roll Call, Establishment of a Quorum (Winslow)
3. Approval of May 4, 2015 Meeting Minutes (Sachs)
4. Approval of July 13, 2015 Teleconference Meeting Minutes (Sachs)
5. Public Comment on items not on the Agenda (Sachs) (Note: The Board may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide whether to place the matter on the agenda for a future meeting. [Government Code Sections 11125, 11125.7(a).])
6. Reports
  - a. President’s Report (Sachs)
    - 1) 2015-2016 Sunset Oversight Review by the Legislature: Update
    - 2) California Academy of Physician Assistants Conference: PAB Exhibit Space
    - 3) Requirements for an approved controlled substance education course: Responsibility of Providers
  - b. Executive Officer’s Report (Mitchell)
    - 1) Update on BreEZe Implementation
    - 2) Controlled Substance Utilization Review and Evaluation System (CURES) Update
    - 3) Implementation of Business and Professions Code Section 3518.1 – Mandated Personal Data Collection from Physician Assistants: Update
  - c. Licensing Program Activity Report (Forsyth)
  - d. Diversion Program Activity Report (Mitchell)
  - e. Enforcement Program Activity Report (Forsyth)
7. Department of Consumer Affairs
  - a. Director’s Update (Christine Lally)
8. Regulations
  - a. Proposed Amendments to Guidelines for Imposing Discipline/Uniform Standards Regarding Substance-Abusing Healing Arts Licensees, Section 1399.523 of Division 13.8 of Title 16 of the California Code of Regulations: Update (Mitchell)

9. Lunch break will be taken at some point during the meeting.

10. CLOSED SESSION

- a. Pursuant to Section 11126(c)(3) of the Government Code, the Board will move into closed session to deliberate on disciplinary matters.
- b. The Board will move into closed session to Receive Advice from Legal Counsel Pursuant to California Government Code Section 11126(e): *Tommie L. Williams, Jr., v. Medical Board of California Physician Assistant Board*, Cal. Court of Appeals (2<sup>nd</sup> dist.), Case No. B254437.

11. The Legislative Committee (Hazelton/Earley)

Legislation of Interest to the Physician Assistant Board AB 12, AB 85, AB 611, AB 637, AB 728, AB 1060, AB 1351, AB 1352, SB 323, SB 337, SB 464, SB 800 and other bills impacting the Board identified by staff after publication of the agenda

12. The Education/Workforce Development Advisory Committee: Update on activities (Grant/Alexander)

13. Medical Board of California Activities Summary and Update (Bishop)

14. Budget Update (Forsyth/Rumbaoa)

15. Discussion of compliance with Title 16 of the California Code of Regulations Section 1399.546 Reporting of Physician Assistant Supervision; electronic records and signatures: (Sachs)

- a. Other state reporting requirements

16. Possible re-scheduling of November Board Meeting

17. Agenda Items for Next Meeting (Sachs)

18. Adjournment (Sachs)

Note: Discussion and action may be taken on any item on the agenda. All times when stated are approximate and subject to change without prior notice at the discretion of the Board unless listed as "time certain". 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 or unforeseen circumstances. The webcast can be located at [www.dca.ca.gov](http://www.dca.ca.gov). If you would like to ensure participation, please plan to attend at the physical location. Adjournment, if it is the only item that occurs after a closed session, may not be webcast.

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 Anita Winslow at (916) 561-8782 or email [Anita.Winslow@mbc.ca.gov](mailto:Anita.Winslow@mbc.ca.gov) 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.

Agenda

Item

3

## MEETING MINUTES

May 4, 2015

**PHYSICIAN ASSISTANT BOARD**  
2005 Evergreen Street – Hearing Room #1150  
Sacramento, CA 95815  
9:00 A.M. – 5:00 P.M.

### 1. Call to Order by President

President Sachs called the meeting to order at 9:00 a.m.

### 2. Roll Call

Staff called the roll. A quorum was present.

Board Members Present: Robert Sachs, PA-C  
Charles Alexander, Ph.D.  
Michael Bishop, M.D.  
Jed Grant, PA-C  
Rosalee Shorter, PA-C  
Sonya Earley, PA-C  
Xavier Martinez  
Catherine Hazelton  
Cristina Gomez-Vidal Diaz

Staff Present: Glenn L. Mitchell, Jr., Executive Officer  
Kristy Schieldge, Senior Staff Counsel,  
Department of Consumer Affairs (DCA)  
Lynn Forsyth, Licensing Analyst  
Anita Winslow, Administration Analyst

### 3. Approval of February 9, 2015 Meeting Minutes

M/ Jed Grant S/ Michael Bishop C/ to:

Approve the February 9, 2015 meeting minutes.

Member	Yes	No	Abstain	Absent	Recusal
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz				X	
Sonya Earley	X				
Jed Grant	X				
Catherine Hazelton			X		
Xavier Martinez	X				
Robert Sachs	X				
Rosalee Shorter				X	

Motion approved.

#### **4. Public Comment on items not on the Agenda**

There was no public comment at this time.

#### **5. Reports**

##### **a. President's Report**

- 1) Mr. Mitchell administered the Oath of Office for Mr. Sachs' appointment as Board Chair.

Mr. Sachs thanked Governor Brown, and his staff Mona Pasquil and Sonia Huestis. He also thanked Christine Lally Deputy Director, Board and Bureau Relations, Department of Consumer Affairs for appointing him.

- 2) Mr. Sachs recognized the many years of service of Board member Cristina Gomez-Vidal Diaz. Ms. Gomez-Vidal Diaz was appointed to the Board 10 years ago. She has set the bench mark as a public member and faithfully served California consumers in the role. Ms. Gomez-Vidal Diaz is an outstanding enforcement individual who is always there for the consumer. Mr. Sachs on behalf of the Board presented Ms. Gomez-Vidal Diaz with a plaque and wished her well in her future endeavors.

##### **b. Executive Officer's Report**

- 1) Update on BreEZe Implementation

Mr. Mitchell reported that Board staff continues to work with the BreEZe team on the implementation of BreEZe. He reported that there continues to be issues with the enforcement reports and we are still not yet able to rely on them for the reporting of accurate data. However, many of these issues are being resolved and the data collected in the reports is becoming more reflective of our actual statistics. We look forward to the eventual use of the reports.

The BreEZe licensing program continues to function with no issues.

We are in the process of implementing our online license renewal system for a late May 2015 roll out. The design work has been completed by the BreEZe programmers and Board staff is in the process of testing the system to detect any issues that may need to be addressed prior to implementation. Mr. Mitchell reported that implementation of the online renewal system will benefit our licensees and will add to efficiencies in the office in that licensees will be able to renew and pay online and not be required to submit paperwork to the Board. Once the license renewal is approved, the licensee's record will be updated immediately. The online renewal system will also be helpful to licensees who renew prior to expiration or late.

We also continue to receive support from the Medical Board of California Information Systems Branch (MBC ISB) regarding our implementation of

BreEZe. We have greatly benefited from their expertise and guidance in helping us to understand and implement the system. Mr. Mitchell would like to thank the MBC and the MBC ISB for their continued support.

Other BreEZe developments:

Earlier this year the California State Auditor concluded an audit of the BreEZe system. In summary, the audit identified inadequate planning, staffing, management, and oversight of the project which led to implementation of far fewer Department of Consumer Affairs (DCA) boards and at a significantly higher cost.

DCA has agreed with the recommendations of the audit and is taking steps to address the concerns raised in the audit. Many of the concerns raised were already being addressed by DCA prior to the release of the audit.

Also, Mr. Mitchell indicated that DCA has received notification from the Joint Legislative Budget Committee to allow DCA to enter into a contract amendment for the BreEZe project would:

- Terminate the contract with the current vendor after Release 2 boards; and
- Increase project costs by \$17.5 million. (Pursuant to Control Section 11.00 of the 2014-2015 Budget Act.)

DCA believes that these amendments are necessary to complete R2 and provide critical maintenance and enhancements for Release 1 Boards, which includes this Board.

2) CURES update

According to the Department of Justice (DOJ), the Project is scheduled to “go live” on June 30, 2015 and is currently within budget.

User Acceptance Testing (UAT) which will take place in late May until mid-June.

The other major step DCA and DOJ taking place includes outreach to licensees and the public. The goal is to provide a clear and consistent message from the boards, DCA and DOJ on the CURES 2.0 Project. We are looking at the various methods of outreach.

3) Implementation of Business and Professions Code Section 3518.1 – Mandated Personal Data Collection from Physician Assistants

SB 2101 (Ting) (Effective January 1, 2015) requires the:

Physician Assistant Board (PAB), Board of Registered Nursing, Board of Vocational Nursing and Psychiatric Technicians, and Respiratory Board to collect data for the Office of Statewide Health Planning and Development (OSHPD).

The PAB is required to collect the data biennially at the time of initial licensure and renewal obtaining the following data:

- Location of practice (including city, county, and Zip code)
- Race or ethnicity (licensees may, but are not required to report race and ethnicity)
- Gender
- Languages spoken
- Education background
- Classification of primary practice site (such as a clinic, hospital, managed care organization, or private practice)

The PAB is working with legal counsel, DCA, and other boards to implement the provisions of SB 2102.

PAB staff are currently working with other DCA Boards and DCA staff on the development of the survey questions. Initially, the plan is to include a link to the electronic online survey. Our initial license letter inserted with the wall certificate and pocket ID card will be updated with a link to the survey. The renewal notice will also be updated. Staff will also update the Board's website with information and links for SB 2102. Roll out of the survey is scheduled for July 2015.

Mr. Mitchell would like to encourage licensees to complete the survey as the data will provide helpful and useful information to assist the state in determining health care shortages, such as the need for additional PA training programs. This data will also provide useful information to improve access to patient care. The data will also be useful to the Board with regard to its public and policy goals of consumer protection.

Mr. Mitchell also would like to encourage professional associations, such as the California Academy of Physician Assistants (CAPA), to encourage their members to complete the survey.

c. Licensing Program Activity Report

Between February 1, 2015 and April 30, 2015, 179 physician assistant licenses were issued. As of April 30, 2015, 10,093 physician assistant licenses are renewed and current.

d. Diversion Program Activity Report

As of April 1, 2015, the Board's Diversion Program has 14 participants, which includes 3 self-referral participants and 11 board-referral participants.

A total of 131 participants have participated in the program since implementation in 1990.

e. Enforcement Program Activity Report

Between February 1, 2015 and April 30, 2015, there were no accusations filed; there were no Statement of Issues filed; 8 probationary licenses were issued, and there are currently 53 probationers.

## **6. Department of Consumer Affairs**

Marcus McCarther, representative of the Deputy Director, Board and Bureau Relations, thanked Board members for their compliance in completing the annual Statement of Economic Interests form (Form 700) that were due April 1, 2015.

Mr. Marcus clarified questions about Board member training. He stated that all reappointed Board members would have to complete the Board Orientation Training. He added that the next orientations were on June 18, 2015 in Van Nuys and September 23, 2015 in Sacramento.

Mr. Marcus also reminded everyone that 2015 is a mandatory compliance year for all DCA employees, including Board members, to take the Sexual Harassment Training course.

Mr. Marcus reported that DCA's legal department is currently reviewing a Supreme Court decision on a case against the North Carolina State Board of Dental Examiners (NCBDE) by the Federal Trade Commission. The court decided that the NCBDE cannot be permitted to regulate their own markets for anti-trust accountability. DCA legal office is currently reviewing this decision and its potential impact on DCA Boards and Bureaus.

## **7. Regulations**

- a. Discussion and possible action regarding proposed amendments to Guidelines for Imposing Discipline/Uniform Standards Regarding Substance Abusing Health Arts Licensees. Section 1399.523 of Division 13.8 of Title 16 of the California Code of Regulations.

At the last Board meeting, Ms. Schieldge presented to the Board a summary of additional amendments to the *Manual of Disciplinary Guidelines and Model Disciplinary Orders* that she believed would further enhance the document.

The Board approved the amendments and voted to direct staff to take all steps necessary to complete the rulemaking process, including preparing modified text and an addendum to the Initial Statement of Reasons for an additional 15-day comment period, which includes amendments discussed at the February meeting.

The public comment period began on April 27, 2015 and will end May 13, 2015. As of today's meeting date there has been no public comment.

## **8. Closed Session:**

- a. Pursuant to Section 11126(c)(3) of the Government Code, the Board moved into closed session to deliberate on disciplinary matters.

## **Return to open session**

## **9. A lunch break was taken.**

## 10. Application for licensure as a Physician Assistant: Update

The application for licensure approved by the Board at the February 9, 2015 meeting is being updated by the Department of Consumer Affairs' Publications, Design, and Editing Office with a new look.

## 11. The Legislative Committee Report

Ms. Hazelton discussed specific bills that were of interest to the Board, including:

AB 12 (Cooley) This bill would require every state agency, department, board, bureau or other entity to review and revise regulations to eliminate inconsistent, overlapping, duplicative, and outdated provisions and adopt the revisions as emergency regulations by January 1, 2018. Additionally, this bill would require the Business, Consumer Services, and Housing Agency to submit a report to the Governor and Legislature affirming compliance with these provisions. These provisions would be repealed by January 1, 2019.

Ms. Hazelton stated that this bill would have a fiscal impact and be a resource drain on Board staff and resources.

M/ Michael Bishop S/ Xavier Martinez C/ to:

Take an opposed position on AB 12.

Member	Yes	No	Abstain	Absent	Recusal
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz			X		
Sonya Earley	X				
Jed Grant	X				
Catherine Hazelton	X				
Xavier Martinez	X				
Robert Sachs	X				
Rosalee Shorter	X				

Motion approved.

AB 85 (Wilk) This urgency bill would require two-member advisory committees or panels of a "state body" (as defined in the Bagley-Keene Open Meeting Act) to hold open, public meetings if at least one member of the advisory committee is a member of the larger state body and the advisory committee is supported, in whole or in part, by state funds.

M/ Michael Bishop S/ Xavier Martinez C/ to:

Take an opposed position on AB 85.

Member	Yes	No	Abstain	Absent	Recusal
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz	X				
Sonya Earley	X				
Jed Grant	X				
Catherine Hazelton	X				
Xavier Martinez	X				
Robert Sachs	X				
Rosalee Shorter	X				

Motion approved.

**AB 611 (Dahle)** This bill would provide that any individual within the Department of Consumer Affairs designated to investigate the holder of a professional license, may request the Department of Justice to release any data that may exist on that individual in the CURES database if there is probable cause that laws governing controlled substances have been violated by the licensee. It would also provide that an individual from a board licensing health care practitioners is not required to submit an application pursuant to this bill in order to access the CURES database.

M/ Michael Bishop S/ Xavier Martinez C/ to:

Take a support position on AB 611.

Member	Yes	No	Abstain	Absent	Recusal
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz	X				
Sonya Earley	X				
Jed Grant	X				
Catherine Hazelton	X				
Xavier Martinez	X				
Robert Sachs	X				
Rosalee Shorter	X				

Motion approved.

**AB 637 (Campos)** This bill would allow nurse practitioners and physician assistants to sign the Physician Orders for Life Sustaining Treatment form (Treatment Form). This Treatment Form allows terminally-ill patients to inform their loved ones and health care professionals of their end-of-life wishes. By expanding the number of people who are allowed to sign the Treatment Form, the intent of this bill is to assist terminally-ill patients in making their end-of-life wishes known to their families and health care providers. This bill would impact licensees of the Physician Assistant Board and the Board of Registered Nursing.

Public comment – Teresa Anderson, California Academy of Physician Assistants (CAPA) commented that they had a large response from their members in support of this bill; therefore, CAPA is in support of the bill.

M/ Rosalee Shorter S/ Sonya Earley C/ to:

Take a support position on AB 637.

Member	Yes	No	Abstain	Absent	Recusal
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz	X				
Sonya Earley	X				
Jed Grant	X				
Catherine Hazelton	X				
Xavier Martinez	X				
Robert Sachs	X				
Rosalee Shorter	X				

Motion approved.

**AB 1060 (Bonilla)** This bill would authorize a board, upon suspension or revocation of a license, to provide the ex-licensee with certain information pertaining to rehabilitation, reinstatement, or penalty reduction through first-class mail or by electronic means.

M/ Sonya Earley S/ Robert Sachs C/ to:

Take a support position on AB 1060.

Member	Yes	No	Abstain	Absent	Recusal
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz	X				
Sonya Earley	X				
Jed Grant	X				
Catherine Hazelton	X				
Xavier Martinez	X				
Robert Sachs	X				
Rosalee Shorter	X				

Motion approved.

**SB 337 (Pavley)** This bill would require medical records to reflect the supervising physician for each episode of care; require a physician assistant who transmits an oral order to identify the supervising physician; recast medical record review provisions to require the supervising physician to utilize one or more mechanisms; and recast prescribing provisions to allow a physician assistant to prescribe Schedule II controlled substances.

Mr. Sachs recused himself from the discussion of SB 337 because of his service on the California Academy of Physician Assistants (CAPA) nominating officer selection committee. He turned the discussion over to the vice-chair Mr. Grant.

Public comment – Teresa Anderson, Public Policy Director, CAPA

Ms. Anderson explained that the first part of the bill provides three different options for documenting supervision. CAPA believes the bill will provide innovative ways for practice management between the supervising physician and physician assistant. The different options for documentation include:

1. Case review currently required in the physician assistant laws and regulations.
2. Have 10 record review meetings.
3. Combination of items 1 and 2.

Ms. Anderson added that SB 337 will also amend the law to allow for 20% co-signature on Schedule II drug orders. When Hydrocodone was rescheduled as a Schedule II drug, CAPA noted that this is impacting practices. Having to sign 100% of these drug orders has become very onerous. Ms. Anderson noted that SB 337 would allow for a minimum 20% chart review and co-signature only if a Controlled Substance course has been taken.

Ms. Anderson noted that SB 337 addresses how the supervising physician and the physician assistant as a team chooses to review and document chart review authority delegated by law.

Ms. Schieldge stated that she believes SB 337 does not precisely define when the ten meetings take place during the year. As currently defined, the ten annual meetings could potentially and legally occur in one month, one day or one hour. She added that there are no documentation provisions for these meetings. She believes that documentation should address when the review takes place and the outcomes regarding the patient charts reviewed. Another issue raised by legal counsel was that there should be a baseline of the number of cases reviewed at the meetings. The Board members shared similar concerns.

M/ Michael Bishop S/ \_\_\_\_\_ C/ to:

Take a support if amended position of SB 337. Amendments should address:

1. How often the meetings occur?
2. What percentage of charts should be reviewed?
3. Level of documentation?

Motion withdrawn

M/ Cristina Gomez-Vidal Diaz S/ \_\_\_\_\_ C/ to:

Watch and recommend position of SB 337. Amendments should address:

1. More description about threshold of number of records.
2. Documentation process.
3. Time specific of meetings, how often? No shorter than three weeks between meetings.

Motion withdrawn

M/ Catherine Hazelton S/ Sonya Earley C/ to:

Take an oppose unless amended position on SB 337. Amendments should address:

1. Require that the 10 meetings be defined as throughout the year.

2. Content of the meetings be documented in some form.
3. There is a threshold of a number or percentage of cases that are reviewed.

Public comment – Teresa Anderson, Public Policy Director, CAPA

Ms. Anderson suggested that CAPA would like to address the Board’s concerns and possibly review these concerns at a teleconference prior to the next Board meeting so that the bill can move forward.

<b>Member</b>	<b>Yes</b>	<b>No</b>	<b>Abstain</b>	<b>Absent</b>	<b>Recusal</b>
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz	X				
Sonya Earley	X				
Jed Grant		X			
Catherine Hazelton	X				
Xavier Martinez	X				
Robert Sachs					X
Rosalee Shorter		X			

Motion carried.

## **12. The Education/Workforce Development Advisory Committee: Update**

Mr. Grant summarized what had transpired in previous meetings which resulted in the forming of this committee. He discussed the training program national accreditation process, the closing of two California Associate Degree PA programs, and how the closure of these programs are impacting the applicant pool for physician assistant training programs and physician assistant work force issues.

Mr. Grant reported that the Board contacted the Accreditation Review Commission on Education for Physician Assistants (ARC-PA), which is the only organization in the United States for physician assistant program accreditation. Their response was that they do not respond to any state board’s requests. Mr. Grant stated this is somewhat troubling as we have the same mission that PA’s are adequately trained.

Mr. Grant briefly gave a history of the ARC-PA. Originally the ARC-PA was part of the Commission on Accreditation on Allied Health Education Programs (CAAHEP), but became their own accreditation body in 2001. CAAHEP was the oversight component for ARC-PA, but now that component is missing and the ARC-PA is now an independent body with no oversight from other bodies.

The ARC-PA is requiring all accreditation training programs to offer a post graduate degree by 2020. Programs wishing to offer an Associate Degree or Certificate are being required to align themselves with an education institute that offers a post graduate degree. Programs that are not in compliance with the degree requirements by January 1, 2021 will have their accreditation withdrawn by ARC-PA.

The committee informally surveyed ten program directors and various stakeholders both within and outside of California regarding their perceptions of the ARC-PA and discussed trends to see if the perceived issues in California are common nationally. The Physician Assistant Education Association (PAEA) has noted a trend of the

ARC-PA “stacking citations” on programs. PAEA has created a task force on accreditation issues.

Mr. Grant discussed the possible issues associated with state accreditation of PA programs. The cost associated with developing a state accreditation would include standards having to be written and approved, a mechanism for enforcement to be in place and compliance would need to be verified. The state would then have to develop and validate a licensing examination. Mr. Grant added that establishing a “California PA license” may create credentialing issues at some hospitals and PAs may not be able to bill Medicare/Medicaid. Additionally California licensed PA’s may not be able to obtain licenses outside of California as they would be unable to take the NCCPA PANCE because they had not attended an ARC-PA accreditation physician assistant training program. Having two different PA licenses may also lead to patient confusion. Many in the profession are opposed to the establishment of a separate state license.

There was additional discussion involving clarification of some aspects of Mr. Grant’s report. There was a general consensus among members to work with the system that is already in place instead of trying to change it. The discussion included whether to get the legislature involved and what other stakeholders might be interested in this issue.

Public Comment: Teresa Anderson – California Academy of Physician Assistants (CAPA) stated the CAPA does not have an official position on this issue, but would like to be involved.

M/ Michael Bishop S/ \_\_\_\_\_ C/ to:

Direct the committee to:

1. Request staff to coordinate with the Medical Board of California (MBC) to see if they would like to be a part of this process and if they could be of any assistance to the Board.
2. Collect data on what’s happening in California in regard to the access to care and how programs are impacting the workforce.

Motion withdrawn

M/ Jed Grant S/ Michael Bishop C/ to:

Delegate to the committee to work with staff on the following:

1. Write to CAAHEP and ask them to look into ARC-PA’s conduct on the closure of the two programs.
2. Staff to contact PAEA and ask if the Board can participate in their task force on accreditation.
3. Contact ARC-PA and ask for a timeline as to when programs will come online in California through their process.
4. Schedule a stakeholder meeting for people in California to find out if there are other things the Board needs to do and coordinate with the MBC.

Member	Yes	No	Abstain	Absent	Recusal
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz	X				
Sonya Earley	X				
Jed Grant	X				
Catherine Hazelton	X				
Xavier Martinez	X				
Robert Sachs	X				
Rosalee Shorter	X				

Motion approved.

### 13. Medical Board of California activities summary and update

Dr. Bishop reported that the Medical Board will hold its Board meeting on May 7 and 8, 2015 in Los Angeles. At this meeting, the Board will be discussing numerous bills related to the practice of medicine impacting physicians. The Board will also be provided with a new document developed by the Department of Health Care Services and the Department of Social Services that provides guidelines for the use of psychotropic medication for children and youth in foster care. This is a significant issue that has been discussed at many legislative hearings. The Board has also placed this document on its website.

The Board is also noted that its regulations for the uniform standards for substance abusing physicians has been approved by the Office of Administrative Law and will become effective on July 1, 2015. The Board will be working with the Attorney General's Office and the Office of Administrative Hearings to ensure all future disciplinary decisions contain the uniform standards as required by law.

The Board will also be looking at a resolution talking about the importance of timely investigating and petitioning for interim suspension orders. The Board believes that if a physician is a danger to the public, the removal of that physician from practice should be its top priority. The Board must work with the Department of Consumer Affairs Division of Investigation and the Department of Justice Health Quality Enforcement Section to obtain such an order. The Board wants to ensure all its partners are working together expeditiously to protect consumers.

As Dr. Bishop reported at the last PAB meeting, at the January MBC meeting, the Board heard a presentation by Board staff and the Federation of State Medical Boards staff on a proposed Interstate Compact. The Medical Board approved the interstate compact in concept and asked staff to review the issues presented by members of the audience. The Board has received the responses to the issues raised and those responses will be discussed at the Board Meeting.

The Medical Board held its first Annual Legislative Day on February 26, 2015. Board Members, in teams of two, visited numerous legislative members' offices and discussed the roles and functions of the Board. Dr. Bishop reported that the day was extremely successful and the Legislative Members were thankful that the Board Members took the time to meet with them. It was helpful to educate members on the Board and to also put the face of the Board forward and let the Legislative Members know how importantly the Board takes its role of consumer protection.

Dr. Bishop noted that the Board will be holding an interested parties meeting in late May or June to discuss its licensing requirements, specifically the number of postgraduate training years. The Board currently requires one year for US or Canadian medical school graduates or two years for international medical school graduates. The Board is looking at requiring three years of postgraduate training for both types of applicants. The Board will be identifying the pros and cons and any unintended consequences of such a change. The Board believes this is a consumer protection issue but knows that a lot of discussion must take place prior to moving forward on this proposal.

Lastly, as the Chair of the Prescribing Task Force, Dr. Bishop informed members of the PAB that they had a productive meeting on April 13, 2015. The Task Force heard from the California Department of Public Health on the work being done by its Prescription Opioid Misuse and Overdose Prevention Workgroup, which is a group made up of several state entities. The Division of Workers Compensation also spoke about their new guidelines that are going through the process of review and completion. The Task Force also learned of updates on the CURES program. The Task Force then opened the meeting to discuss best practices used to battle this epidemic. The Board heard a lot of good ideas and also found out that a lot of work is already being done by multiple parties on this issue. The Board will continue to put together best practices that can then be placed into its newsletter and on its website. The Board also may be looking to have some of these individuals speak at future meetings of the Board.

#### **14. Budget Update**

Taylor Schick, Manager of the Budget Office, Department of Consumer Affairs (DCA) and Wilbert Rumbaoa, Budget Analyst, DCA, reported the one-time funding Augmentation Request to the Department of Finance for \$117,000.00 was approved.

Mr. Rumbaoa reported on the Board's expenditure projection and fund condition. The revenue report showed that the Board was doing fairly well for the past 4 years, being able to revert around \$180,000.00 each year.

Mr. Schick explained that an appropriation approved by the Department of Finance and the Legislature is an obligation against the PA Fund and a reversion was defined as what appropriations were left at the end of the fiscal year, which is reverted back into the PA Fund.

There was general discussion about the \$1.5 million loan that was made to the General Fund. It was determined that this loan is scheduled for repayment during the fiscal year of 2017/2018. The repayment of this loan could cause the Board to be close to exceeding the 24 month reserve which is limited in statute and could trigger requiring the Board to reduce fees so as not to exceed the 24 month reserve limit mandate.

#### **15. PAB Policy Manual**

Ms. Schieldge was able to review the required training requirements for newly appointed Board Members; this includes those members reappointed to the Board. Ms. Schieldge noted that the department's Training/Orientation Policy has been updated as follows:

1. Board Member Orientation Training must be completed within one year of appointment or reappointment of a Board member.
2. Ethics Training must be taken every two years, but it does not have to be repeated at DCA if the Board member already completed an equivalent course through another state agency and it has not been more than two years since they last took the course.
3. Sexual Harassment Training must be taken every two years, but does not have to be repeated at DCA if the Board member received the training at DCA and it has not been more than two years since they last took the course.
4. Defensive Driver Training must be taken every four years, but does not have to be repeated as long as the training occurred through DGS within the last 4 years prior to appointment or re-appointment and it has not been more than four years since they last took the course.

**16. Discussion of compliance with Title 16 of the California Code of Regulations Section 1399.546: Reporting of Physician Assistant Supervision – Electronic Records and Signatures**

Mr. Sachs stated that most medical practices now use Electronic Medical Records (EMR) in place of paper patient records. He added that physician assistants and supervising physicians often experience difficulty in complying with Title 16 California Code of Regulations Section 1399.546 with regard to entering the supervisor's name in the EMR. Mr. Sachs was concerned that the inability to enter this information could lead to possible disciplinary actions against the physician assistant for noncompliance to the regulation. He suggested that the Board may wish to amend Section 1399.546 to address the now common use of EMRs.

Ms. Schieldge questioned how electronic documentation is inputted and how is it authenticated using EMRs. She suggested that the regulation could possibly be amended to accommodate EMR documentation.

Members discussed that there are several different EMR programs available, but the common denominator was that the supervising physician was a line item to be entered on every record.

Ms. Schieldge suggested that staff determine what other states were doing. EMRs still need to have the ability to link the supervising physician to the physician assistant in order to comply with California Code of Regulation Section 1399.546 to protect the public.

**17. Agenda items for the next meeting**

- a. Sunset Report
- b. Report from the Physician Assistant Education/Workforce Committee on stakeholder teleconference
- c. Report from the Legislation Committee – SB 323
- d. Interim teleconference SB 337 report

- e. Discussion of compliance with Title 16 of the California Code of Regulations Section 1399.546: Reporting of Physician Assistant Supervision – Electronic Records and Signatures

## **18. Adjournment**

With no further business the meeting was adjourned at 3:50 P.M.

Agenda

Item

4

## MEETING MINUTES

July 13, 2015  
**PHYSICIAN ASSISTANT BOARD**  
Teleconference Meeting – Various Locations  
2:30 P.M – 4:30 P.M.

The teleconference sites for this meeting were at the following locations:

1232 Campbell Hall  
Los Angeles, CA 90095

4995 Murphy Canyon Rd, #207  
San Diego, CA 92123

2020 Zonal Ave, IRD Bldg. Rm 628  
Los Angeles, CA 90638

8344 W Mineral King Ave  
Visalia, CA 93291

1 Bush St, #800  
San Francisco, CA 94104

1520 San Pablo St, #4300  
Los Angeles, CA 90033

2005 Evergreen St, Ste. 1120  
Sacramento, CA 95815

### 1. Call to Order by the Chair

Mr. Sachs called the meeting to order at 2:32 P.M.

### 2. Roll Call

Mr. Sachs called the roll. A quorum was present.

Board Members Present:

Robert Sachs, PA-C  
Charles Alexander, Ph.D.  
Michael Bishop, M.D.  
Sonya Earley  
Jed Grant, PA-C  
Catherine Hazelton  
Xavier Martinez  
Cristina Gomez-Vidal Diaz

Staff Present:

Glenn L Mitchell, Jr., Executive Officer  
Kristy Schieldge, Senior Staff Counsel  
Lynn Forsyth, Enforcement Analyst  
Anita Winslow, Administrative Analyst

### 3. Public Comment on items not on the Agenda

There was no public comment at this time.

#### 4. Legislation of Interest to the Physician Assistant Board

SB 337 (Pavley) This bill would require medical records to reflect the supervising physician for each episode of care; require a physician assistant who transmits an oral order to identify the supervising physician; recast medical record review provisions to require the supervising physician to utilize one or more mechanisms; and recast prescribing provisions to allow a physician assistant to prescribe Schedule II controlled substances.

Public Comment – Teresa Anderson, Public Policy Director, California Academy of Physician Assistants (CAPA), introduced Elise Thureau, Legislative Director, Senator Pavley's office.

Ms. Thureau noted that Senator Pavley is hopeful that the Board's concerns with SB 337 are addressed at this meeting.

Kathryn Scott, representative of CAPA, summarized the Board's concern with the bill including:

1. The bill did not specify when the 10 meetings should take place throughout the year.
2. The bill did not state how the meetings would be documented.
3. How many cases should be reviewed at the meeting either a percentage or a specific number.

Jeremy Adler, liaison and past CAPA President, noted that physician assistants practice under protocols in which the existing law requires a co-signature for a sample of work after care of the patient.

Greg Minnie, CAPA member and a physician assistant practicing for 25 years, spoke about the need to increase options for supervising physicians and physician assistants to ensure that they are consistent with current community standards. He noted that the bill does not change the supervision requirements, it allows for several different options of supervision review.

Adam Marks, CAPA representative, asked the Board to support SB 337.

Ana Maldonado, CAPA Vice-President, asked the Board to support SB 337. She added that the bill recognizes the relationship between the supervising physician and the physician assistant.

Kristy Schieldge, Legal Counsel, Department of Consumer Affairs, based on her review of the latest amendments of SB 337, had additional concerns, specifically:

1. (i) What is an objective measure that assures adequate and sufficient supervision? There appears to be no objective standard set forth in the bill's proposed amendments to Business and Professions Code Section 3502. It is too subject to interpretation as drafted, which could result in legal challenge to the board in enforcing it or result in physician assistants being unsupervised.
2. (ii) The definition of a medical records review meeting that may occur by "electronic means" is not clear. Since this is intended to replace co-signatures, should the requirement be inter-active?
3. (iii) Concerns were raised that no minimum thresholds are set forth in the proposed language for the combined mechanisms. The combined concepts are still unclear. Due to the ambiguity, staff would not be able to explain the concept to practitioners. Legal

Counsel requested CAPA to provide an example of how the combined meetings and co-signature mechanisms would work in the real world and how the language would be interpreted.

Further discussion between the Board members, legal counsel, and CAPA representatives indicated that the Board was still concerned about the number of sample records to be reviewed, and who determines what records to review and how often they should be reviewed.

Ms. Anderson presented to the Board a new revision to SB 337, which she believes would address the Board's and legal council's concerns. The amendments presented by Ms. Anderson were discussed by the Board members.

M/ Jed Grant S/ Sonya Earley C/ to:

If SB 337 is amended to incorporate the latest amendments submitted by CAPA at today's meeting the Board is taking a support if amended position on SB 337 – Exhibit A attached.

<b>Member</b>	<b>Yes</b>	<b>No</b>	<b>Abstain</b>	<b>Absent</b>	<b>Recusal</b>
Charles Alexander	X				
Michael Bishop	X				
Cristina Gomez-Vidal Diaz	X				
Sonya Earley	X				
Jed Grant	X				
Catherine Hazelton		X			
Xavier Martinez	X				
Robert Sachs					
Rosalee Shorter				X	

Motion carried.

**5. Closed Session**

Pursuant to Section 11126(c)(3) of the Government Code, the Board moved into closed session to deliberate on disciplinary matters.

**6. Returned to Open Session**

**7. Adjournment**

With no further business the meeting was adjourned at 4:10 P.M

## EXHIBIT A

(12) "Medical records review meeting" means a meeting between the supervising physician and surgeon and the physician assistant during which medical records are reviewed to ensure adequate supervision of the physician assistant functioning under protocols. Medical records review meetings may occur in person or by electronic communication.

(2) (A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

(ii) The supervising physician and surgeon and physician assistant shall conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.

(iii) The supervising physician and surgeon shall review a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism described in clause (i) and the medical records review meeting mechanism described in clause (ii). During each month for which a sample is reviewed, at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (i) and at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (ii).

Agenda

Item

6.a.3

## **Article 7. Approved Controlled Substance Education Courses**

### **1399.610 Requirements for an Approved Controlled Substance Education Course to Administer, Provide or Issue a Drug Order for Schedule II – V Controlled Substances without Advance Approval From a Supervising Physician.**

A controlled substance education course shall be deemed approved by the board if it meets all of the following criteria:

(a) The course includes all of the following learning objectives:

(1) Describes the applicable federal and state laws and regulations pertaining to the provision, administration and furnishing of controlled substances and the legal and professional relationship between a physician assistant and his or her supervising physician.

(A) This objective shall include a description of the applicable patient charting requirements and the use of secure drug order forms.

(2) Assessment strategies for the recognition, prevention and management of acute and chronic pain.

(3) Comparison of efficacy data and safety profiles which influence the selection, usage and conversion of pharmacological agents.

(4) The evaluation and comparison of the safety and efficacy profiles of controlled substances and the clinical rationale for their use.

(5) Describes disorders routinely requiring a therapeutic regimen of controlled substances for clinical management.

(6) Assessment of a controlled substance's potential for abuse and addiction, its psychosocial aspects, the recognition of the symptoms (including controlled substance-seeking behaviors) thereof and medically appropriate alternatives, if any,

(7) Evaluation of the response and compliance of the patient to the controlled substances.

(8) Provision of appropriate patient education regarding controlled substances.

For the purposes of this subdivision, "controlled substances" means Schedule II through Schedule V controlled substances.

(b) The course includes a comprehensive written examination, proctored by the course provider at the conclusion of the course, of the material presented. The licensee must successfully complete the examination to receive a certificate of completion issued pursuant to subdivision (b) of section 1399.612.

(c) The course is at least six (6) hours in duration, of which a minimum of three (3) hours shall be exclusively dedicated to Schedule II controlled substances. A course provider shall not include the time for the written examination specified in subdivision (b) in the (6) six hour requirement. The course shall be completed on or after January 1, 2008.

(d) The course is provided by one of following entities:

(1) A physician assistant program approved by the board in accordance with section 1399.530.

(2) A continuing education provider approved by the Medical Board of California for Category I continuing medical education.

(3) A Category I continuing education provider approved by American Academy of Physician Assistants.

(4) A Category I continuing education provider approved by the American Medical Association, the California Medical Association and/or the American Osteopathic Association.

### **1399.612. Responsibilities of Course Providers and Attendees.**

(a) A course provider of any controlled substance educational course intended to meet the requirements of section 1399.610 shall use qualified instructors and shall provide course attendees with a written course outline or syllabus, as applicable. For the purposes of this section, a qualified instructor is a person who holds a current valid license to practice in the appropriate healing arts discipline, is free from any disciplinary action by the applicable licensing jurisdiction, and is knowledgeable, current and skilled in the subject matter of the course, as evidenced through either of the following:

- (1) Experience in teaching similar subject matter content within two years immediately preceding the course; or,
- (2) Has at least one year experience within the last two years in the specialized area in which he or she is teaching.

(b) A controlled substance course provider shall issue a certificate of completion to each licensee who has successfully completed the course. A certificate of completion shall include the following information:

- (1) Name and license number of the physician assistant.
- (2) Course title and each instructor's name.
- (3) Provider's name and address.
- (4) Date of course completion.

(c) A controlled substance education course provider shall retain the following records for a period of four years in one location within the State of California or in a place approved by the board:

- (1) Course outlines of each course given.
- (2) The date and physical location for each course given.
- (3) The examination proctored at the conclusion of each course and the score of each physician assistant who took the examination.
- (4) Course instructor curriculum vitae or resumes.
- (5) The name and license number of each physician assistant taking an approved course and a record of any certificate of completion issued to a physician assistant.

A course provider shall make the records specified above available to the board upon request. A course provider may retain the records required by this subdivision in an electronic format.

(d) A physician assistant shall make his or her certificate of completion available for inspection upon the request of his or her employer or prospective employer, supervising physician or the board.

Agenda

Item

6.b.2

# CURES 2.0



**CONTACT:**  
[cures@doj.ca.gov](mailto:cures@doj.ca.gov)  
(916) 227-3843

**June 30, 2015**

RE: CURES 2.0 Soft Launch and Phased Rollout

The Department of Justice (DOJ) and the Department of Consumer Affairs (DCA) are pleased to announce that the state's new Controlled Substance Utilization Review and Evaluation System – commonly referred to as “CURES 2.0” – will go live on July 1, 2015. This upgraded prescription drug monitoring program features a variety of performance improvements and added functionality.

In order to ensure a smooth transition from the current system, CURES 2.0 will be rolled out to users in phases over the next several months, beginning with early adoption by a select group of users who currently use CURES and meet the CURES 2.0 security standards, including minimum browser specifications.<sup>1</sup> DOJ is currently identifying prescribers and dispensers who meet these criteria and will contact and coordinate their enrollment into CURES 2.0. For all other current users, access to CURES 1.0 will not change and no action is needed at this time. For users and entities not currently enrolled in CURES, further notification will be provided in August as to the enrollment/registration process.

Practitioners and health systems should begin to prepare for universal adoption of the system by January 2016, at which point all users will be required to meet CURES 2.0's security standards. If you have any questions please contact [cures@doj.ca.gov](mailto:cures@doj.ca.gov).

Thank you for your continued support of the CURES program.

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<sup>1</sup> CURES 2.0 users will be required to use Microsoft Internet Explorer Version 11.0 or greater, Mozilla FireFox, Google Chrome, or Safari when accessing the system.

Agenda

Item

6.b.3

### **Healthcare Workforce Survey for Initial Licenses and Renewals**

Recent legislation has passed requiring the Board to collect certain demographic data relating to our licensees at the time of licensure and renewal and report this data to the Office of Statewide Health Planning and Development. Completion of this survey will help the State analyze and report gaps in the health care workforce in California to the California Legislature.

You are required to complete a short survey to comply with this legislation when you receive your initial license and at renewal.

The survey is available for you at

**[https://www.dca.ca.gov/webapps/oshpd\\_survey.php](https://www.dca.ca.gov/webapps/oshpd_survey.php)**. Please go to this web address and complete the survey at this time. Instructions will be provided with the survey. If you do not have internet service available to you, please contact the Physician Assistant Board at 916-561-8780 and request that the survey be mailed to you.

## OSHPD's Healthcare Workforce Survey

The information requested on this survey is mandatory, except for the cultural/ethnic background.<sup>1</sup> Completion of the survey helps determine health professionals' shortages and improves access to patient care.

**1. Location of Practice (a and b):** If working in more than two locations, provide information for the two locations where you spend the majority of your time. If not currently practicing in a position that requires licensure, skip to Question 2.

**1a. Primary and Secondary Practice Location:** \*Check one for each practice

Primary: Zip Code \_\_\_\_\_  
 Secondary: Zip Code \_\_\_\_\_

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City: \_\_\_\_\_  
 City: \_\_\_\_\_

County (select from below)  
 County (select from below)

**Primary Secondary**

- Alameda
- Alpine
- Amador
- Butte
- Calaveras
- Colusa
- Contra Costa
- Del Norte
- El Dorado
- Fresno
- Glenn
- Humboldt
- Imperial
- Inyo
- Kern
- Kings
- Lake
- Lassen
- Los Angeles
- Madera

**Primary Secondary**

- Marin
- Mariposa
- Mendocino
- Merced
- Modoc
- Mono
- Monterey
- Napa
- Nevada
- Orange
- Placer
- Plumas
- Riverside
- Sacramento
- San Benito
- San Bernardino
- San Diego
- San Francisco
- San Joaquin
- San Luis Obispo

**Primary Secondary**

- San Mateo
- Santa Barbara
- Santa Clara
- Santa Cruz
- Shasta
- Sierra
- Siskiyou
- Solano
- Sonoma
- Stanislaus
- Sutter
- Tehama
- Trinity
- Tulare
- Tuolumne
- Ventura
- Yolo
- Yuba
- Out of State

**Health Occupation:** Check all that apply

**Primary Secondary**

- Clinical Nurse Specialist
- Nurse Anesthetist
- Nurse Midwife Furnishing
- Nurse Practitioner
- Nurse Practitioner Furnishing
- Nurse-Midwife
- Physician Assistant

**Primary Secondary**

- Psychiatric Technician
- Psych/Mental Health Nurse
- Public Health Nurse
- Registered Nurses
- Respiratory Care Practitioner
- Vocational Nurse

**Work setting:** Which of the following best describes the type of setting of your primary and secondary work setting?

Check only one for primary and one for secondary.

**Primary Secondary**

- Call Center/telenursing center
- Clinics/community health center
- Correctional Facility
- Durable medical equipment
- Government Agency
- Home Health Care
- Hospital
- Inpatient hospice (not hospital-based)
- Long-term acute care/ rehabilitation / sub-acute care
- Managed Care Organization
- Mental Health/Substance Abuse Facility

**Primary Secondary**

- Nursing Home or Skilled Nursing Facility
- Outpatient Dialysis
- Private Practice
- Manufacturer/distributor
- School Health Service
- Self-Employed
- University or college (academic department)
- Urgent Care Center
- Retired
- Not currently working
- Other setting, please describe:

Other Primary #1 \_\_\_\_\_  
 Other Primary #2 \_\_\_\_\_

**2. Educational Background** Check only one.

Select highest degree/certification obtained:

Certification (non-degree)  Associate  Bachelor  Master  Doctorate  Other \_\_\_\_\_

Year degree/certification was earned

**Postgraduate Training (Years Completed)**

1  2  3  4  5  6  7  8  9+

**3. Gender:**  Male  Female

**Race or Ethnicity OPTIONAL** (you may select more than one)

**Decline to State**

African American/Black/African-Born

American Indian/Native American/Alaskan Native

Caucasian/White European/Middle Eastern

Latino/Hispanic (If Latino/Hispanic, please select one of the following)

Central American  Cuban  Mexican

Puerto Rican  South American  Other Hispanic

Asian (If Asian, please select one of the following)

Cambodian  Indonesian  Malaysian  Vietnamese

Chinese  Japanese  Pakistani  Other Asian

Hmong  Korean  Singaporean

Indian  Laotian  Thai

Native Hawaiian/Pacific Islander (If Native Hawaiian/Pacific Islander, please select one of the following)

Fijian  Guamanian  Samoan  Other Pacific Islander

Filipino  Hawaiian  Tongan

Other (not listed above)

**5. Languages Spoken – In addition to English, indicate additional languages in which you are proficient**

Other African Languages

Hebrew

Panjabi (Punjabi)

Turkish

American Sign Language

Hindi

Persian (Farsi)

Ukrainian

Amharic

Hmong

Polish

Urdu

Arabic

Hungarian

Portuguese

Vietnamese

Armenian

Ilocano

Russian

Xiang Chinese

Cantonese

Indonesian

Samoan

Yiddish

Croatian

Italian

Scandinavian/Nordic

Yoruba

Fijian

Japanese

Languages

Other Chinese

Formosan (Amis)

Korean

Serbian

Other Non-English

French

Lao

Spanish

Other Sign

French Creole

Mandarin

Tagalog

Other (not listed)

German

Mien

Telugu

Greek

Mon-Khmer (Cambodian)

Thai

Decline to State

Gujarati

Navajo

Tongan

None

**Notice of Collection of Personal Information**

Except the for the race or ethnicity question, the information requested on this survey is mandatory and must be collected pursuant to Business and Professions Code sections 2717, 2852.5, 3518.1, 3770.1 and 4506. Once aggregated by license category, the information provided will be used to analyze workforce data from licensees for future workforce planning. The information will be provided to the Office of Statewide Health Planning and Development (OSHPD) and may be provided to other governmental agencies or in response to a court order or a subpoena. You have a right of access to records containing personal information unless the records are exempted from disclosure by law. Individuals may obtain information regarding the location of his or her records containing these survey responses by contacting the DCA's Consumer Information Center at 1625 N Market Blvd., Suite N-112, Sacramento, CA 95834 or (800) 952-5210 ([dca@dca.ca.gov](mailto:dca@dca.ca.gov)).

Agenda

Item

6.c

**PHYSICIAN ASSISTANT BOARD**  
**LICENSING PROGRAM ACTIVITY REPORT**

**INITIAL LICENSES ISSUED**

	<b>May 1, 2015- July 31, 2015</b>	<b>May 1, 2014- July 31, 2014</b>
Initial Licenses	200	256

**SUMMARY OF RENEWED/CURRENT LICENSES**

	<b>As of July 31, 2015</b>	<b>As of July 30, 2014</b>
Physician Assistant	10,293	9,540

Agenda

Item

6.d

**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 July 2015	As of 1 July 2014	As of 1 July 2013
Voluntary referrals	03	03	01
Board referrals	09	10	13
Total number of participants	12	13	14

**HISTORICAL STATISTICS**

(Since program inception: 1990)

Total intakes into program as of 1 July 2015:	133
Closed Cases as of 1 July 2015	
• Participant expired:	01
• Successful completion:	45
• Dismissed for failure to receive benefit:	04
• Dismissed for non-compliance:	24
• Voluntary withdrawal:	22
• Not eligible:	22
Total closed cases:	118

**OTHER DCA BOARD DIVERSION PROGRAM PARTICIPANTS**

(As of 31 June 2015)

Dental Board of California:	28
Osteopathic Medical Board of California:	14
Board of Pharmacy:	66
Physical Therapy Board of California:	11
Board of Registered Nursing:	444
Veterinary Board of California:	4

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Item

6.e

**PHYSICIAN ASSISTANT BOARD  
ENFORCEMENT ACTIVITY REPORT**

**May 1, 2015 to July 30, 2015**

**Disciplinary Decisions**

License Denied .....	0
Probation .....	0
Public Reprimand/Reproval .....	0
Revocation .....	0
Surrender .....	0
Probationary Licenses Issued .....	0
Petition for Reinstatement Denied .....	0
Petition for Reinstatement Granted .....	0
Petition for Termination of Prob Denied .....	0
Petition for Termination of Prob Granted .....	0
Other .....	0

**Accusation/Statement of Issues**

Accusation Filed .....	0
Accusation Withdrawn .....	0
Statement of Issues Filed .....	0
Statement of Issues Withdrawn .....	0
Petition to Revoke Probation Filed .....	0
Petition to Compel Psychiatric Exam .....	0
Interim Suspension Orders (ISO)/PC23 .....	0

**Citation and Fines**

Pending from previous FY .....	5
Issued .....	1
Closed .....	7
Withdrawn .....	0
Sent to AG/noncompliance .....	0
Pending .....	0
Initial Fines Issued .....	\$1700
Modified Fines Due .....	\$1700
Fines Received .....	\$250

**Current Probationers**

Active .....	56
Tolled .....	10

# Agenda Item

11

**AB**

**12**

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**SENATE COMMITTEE ON GOVERNMENTAL ORGANIZATION**  
**Senator Isadore Hall, III**  
**Chair**  
**2015 - 2016 Regular**

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**Bill No:** AB 12 **Hearing Date:** 7/14/2015  
**Author:** Cooley  
**Version:** 4/22/2015 Amended  
**Urgency:** No **Fiscal:** Yes  
**Consultant:** Arthur Terzakis

**SUBJECT:** State government: administrative regulations: review

**DIGEST:** This bill requires each state agency, on or before January 1, 2018, to review, adopt, amend or repeal any applicable regulations that are duplicative, overlapping, inconsistent, or out of date and revise those identified regulations, as specified.

**ANALYSIS:**

Existing law:

- 1) Provides a process, known as the Administrative Procedure Act (APA), for the adoption, amendment, or repeal of regulations by state agencies charged with the implementation of statutes, and for legal review of those regulatory actions by the Office of Administrative Law (OAL). (Government Code Section 11340 et seq.)
- 2) Directs OAL, at the request of any standing, select, or joint committee of the Legislature, to initiate a priority review of any regulation that the committee believes does not meet the standards of (a) necessity, (b) authority, (c) clarity, (d) reference, and (e) nonduplication. (Government Code Section 11349.7)
- 3) Specifies that if OAL is notified of, or on its own becomes aware of, an existing regulation for which the statutory authority has been repealed or becomes ineffective, then the OAL shall order the agency to show cause why the regulation should not be repealed, and shall notify the Legislature in writing of this order. (Government Code Section 11349.8)
- 4) Authorizes an agency that is considering adopting, amending, or repealing a regulation to consult with interested persons before initiating any regulatory action. (Government Code Section 11346)

This bill:

- 1) Requires state agencies, on or before January 1, 2018, to adopt, amend or repeal, using procedures provided in current law, those regulations identified as duplicative, overlapping, inconsistent or out of date.
- 2) Requires state agencies to hold at least one public hearing, notice that hearing on the Internet and accept public comment on proposed revisions.
- 3) Requires state agencies to notify the appropriate policy and fiscal committees of the Legislature of the proposed revisions to regulations, and then to report to the Governor and the Legislature the number and content of the regulations identified as duplicative, overlapping, inconsistent, or out of date and actions to address those regulations.
- 4) Requires specified agencies to identify any existing regulations of a department, board, or other unit within that agency that may be duplicative, overlapping or inconsistent with regulations of other departments, boards or units within that agency.
- 5) Contains various legislative findings that the APA does not require agencies to individually review their regulations to identify overlapping, inconsistent, duplicative, or out-of-date regulations that may exist. Also, finds and declares that it is important that state agencies systematically undertake to identify, publicly review, and eliminate overlapping, inconsistent, duplicative, or out-of-date regulations, both to ensure they more efficiently implement and enforce laws and to reduce unnecessary and outdated rules and regulations.
- 6) Contains a January 1, 2019 sunset provision.

## **Background**

*Purpose of AB 12.* The author's office notes that "numerous economists and business leaders agree that one of the greatest obstacles to California job growth is the 'thicket' of government regulations that constrain business owners." Under current law, any state agency may review, adopt, amend or repeal any regulation within its statutory authority at any time. The OAL reports that as of December 26, 2014, the number of regulations adopted totaled 67,176. Of those, state agencies had repealed 14,319, or approximately 21%. With 52,857 regulations still active, the author believes more needs to be done. This bill requires state agencies to review their regulatory framework within a two-year timeframe.

The author's office cites an October 2011 report published by the Milton Marks Little Hoover Commission on California State Government Organization and Economy (Little Hoover Commission) titled, *Better Regulation: Improving California's Rulemaking Process* which contained several recommendations for improving the state's rulemaking process, including the state establishing a look-back mechanism to determine if regulations are effective and still needed.

According to the author's office, this bill is intended to implement the "look-back mechanism" approach by establishing a two-year window within which agencies, and the departments, boards and other units within them, must review all regulations that pertain to the mission and programs under their statutory authority. Upon completion of this review, the identified regulations that are deemed to be duplicative, overlapping, inconsistent or out of date may be repealed using the existing processes already provided in the APA. This bill also provides for public hearings and comments and requires that regulatory changes be reported to the Legislature and the Governor.

*Staff comments.* While it is no doubt true that California has seen a significant increase in the volume and scope of administrative agency regulations in recent years, it should be noted that none of those regulations could ever have been adopted without express, statutory authorization by the Legislature.

### **Prior/Related Legislation**

AB 797 (Steinorth, 2015) requires OAL to submit to the appropriate policy committees of each house of the Legislature for review a copy of each major regulation that it submits to the Secretary of State. The bill also provides that a regulation does not become effective if the Legislature passes a statute to override the regulation. (Held in this committee at author's request)

SB 981 (Huff, 2014) would have required each state agency to review each regulation adopted prior to January 1, 2014, and to develop a report to the Legislature containing prescribed information. (Held in this Committee)

SB 617 (Calderon, Chapter 496, Statutes of 2011) revised various provisions of the APA and required each state agency to prepare a standardized regulatory impact analysis, as specified, with respect to the adoption, amendment, or repeal of a major regulation, proposed on or after November 1, 2013.

SB 591 (Gaines, 2011) would have enacted the California Smart Regulation Act and required state agencies to reduce the total number of regulations they impose by 33 percent. (Held in this Committee)

SB 553 (Fuller, 2011) would have required that a regulation or an order of repeal of a regulation that has been identified by the agency as having, or as being reasonably likely to have, an adverse economic impact of at least \$10 million become effective 180 days after the date it is filed with the Secretary of State, except as provided. (Held in this Committee)

SB 401 (Fuller, 2011), among other things, would have required every regulation proposed by an agency after January 1, 2012, include a provision repealing the regulation in 5 years. (Held in Senate Environmental Quality Committee)

SB 396 (Huff, 2011) would have required each agency to review each regulation adopted prior to January 1, 2011, and develop a report with prescribed information to be submitted to the Legislature on or before January 1, 2013. (Held in Senate Environmental Quality Committee)

SB 366 (Calderon, 2011) would have required each state agency to review its regulations to identify duplicative, overlapping, inconsistent or outdated provisions and repeal or amend identified regulations. Also, would have created a Streamlined Permit Review Team charged with improving the efficiency of the state permitting process for development projects. (Held in this Committee)

AB 429 (Knight, 2011) would have required an agency, for any regulation that it has identified as having a gross cost of \$15 million or more, an increased cost of 5% or more over the cost of an existing regulation, or both, to submit a copy of the rulemaking record for that regulation to the appropriate policy committee in each house of the Legislature when the agency submits the regulation to OAL for approval. (Held in Assembly policy committee)

SB 942 (Dutton, 2010) would have established an Economic Analysis Unit within OAL and would have required agencies to make publicly available and submit to the unit specified cost estimates related to a proposed regulation and specified information used to develop the cost estimates. (Held in Senate Appropriations Committee)

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

**SUPPORT:**

American Federation of State, County and Municipal Employees  
Associated Builders and Contractors of California  
Building Owners and Managers Association of California

California Asian Pacific Chamber of Commerce  
California Association of Bed & Breakfast Inns  
California Building Industry Association  
California Business Properties Association  
California Business Roundtable  
California Chamber of Commerce  
California Construction and Industrial Materials Association  
California Grocers Association  
California Hotel & Lodging Association  
California League of Food Processors  
California Manufacturers & Technology Association  
California Retailers Association  
California Taxpayers Association  
Commercial Real Estate Development Association  
Consumer Specialty Products Association  
Family Business Association  
Industrial Environmental Association  
International Council of Shopping Centers  
National Federation of Independent Business/California  
Small Business California  
USANA Health Services, Inc.  
Western States Petroleum Association

**OPPOSITION:**

None received

**ARGUMENTS IN SUPPORT:** Proponents state that “AB 12 simply directs agencies to look at their regulations and ask the basic questions of necessity, contradiction and complication. We believe that the answers to these regulations will provide greater balance to the laws and regulations and open the door for modernization as the California economy changes with the advent of new industries and technologies.” Proponents also contend that reducing regulatory overlaps, contradictions, and complications would diminish the cost of compliance for California businesses without lowering environmental, health, and safety standards.

AMENDED IN ASSEMBLY APRIL 22, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 12**

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**Introduced by Assembly Member Cooley  
(Coauthors: Assembly Members Chang, Daly, and Wilk)**

December 1, 2014

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An act to amend Section 11349.1.5 of, and to add and repeal Chapter 3.6 (commencing with Section 11366) of Part 1 of Division 3 of Title 2 of, of the Government Code, relating to state agency regulations.

LEGISLATIVE COUNSEL'S DIGEST

AB 12, as amended, Cooley. State government: administrative regulations: review.

~~(1) Existing~~

*Existing* law authorizes various state entities to adopt, amend, or repeal regulations for various specified purposes. The Administrative Procedure Act requires the Office of Administrative Law and a state agency proposing to adopt, amend, or repeal a regulation to review the proposed changes for, among other things, consistency with existing state regulations.

This bill would, until January 1, 2019, require each state agency to, on or before January 1, 2018, ~~and after a noticed public hearing, review and revise that agency's regulations to eliminate any inconsistencies, overlaps, or outdated provisions in the regulations, adopt the revisions as emergency regulations, review that agency's regulations, identify any regulations that are duplicative, overlapping, inconsistent, or out of date, to revise those identified regulations, as provided, and report to the Legislature and Governor, as specified.~~ The bill would further

require each agency to, on or before January 1, 2017, compile an overview of the statutory law that agency administers.

~~(2) The act requires a state agency proposing to adopt, amend, or repeal a major regulation, as defined, to prepare a standardized regulatory impact analysis of the proposed change. The act requires the office and the Department of Finance to, from time to time, review the analyses for compliance with specific department regulations. The act further requires the office to, on or before November 1, 2015, submit a report on the analyses to the Senate and Assembly Committees on Governmental Organization, as specified.~~

This bill would instead require the office and department to annually review the analyses. The bill would also require the office to annually submit a report on the analyses to the Senate Committee on Governmental Organization and the Assembly Committee on Accountability and Administrative Review.

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

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

1 SECTION 1. ~~Section 11349.1.5 of the Government Code is~~  
2 ~~amended to read:~~

3 11349.1.5. (a) ~~The Department of Finance and the office shall~~  
4 ~~annually review the standardized regulatory impact analyses~~  
5 ~~required by subdivision (c) of Section 11346.3 and submitted to~~  
6 ~~the office pursuant to Section 11347.3, for adherence to the~~  
7 ~~regulations adopted by the department pursuant to Section~~  
8 ~~11346.36.~~

9 (b)(1) ~~On or before November 1, 2015, and annually thereafter,~~  
10 ~~the office shall submit to the Senate Committee on Governmental~~  
11 ~~Organization and the Assembly Committee on Accountability and~~  
12 ~~Administrative Review a report describing the extent to which~~  
13 ~~submitted standardized regulatory impact analyses for proposed~~  
14 ~~major regulations for the fiscal year ending in June 30, of that year~~  
15 ~~adhere to the regulations adopted pursuant to Section 11346.36.~~  
16 ~~The report shall include a discussion of agency adherence to the~~  
17 ~~regulations as well as a comparison between various state agencies~~  
18 ~~on the question of adherence. The report shall also include any~~  
19 ~~recommendations from the office for actions the Legislature might~~  
20 ~~consider for improving state agency performance and compliance~~

1 in the creation of the standardized regulatory impact analyses as  
2 described in Section 11346.3.

3 ~~(2) The report shall be submitted in compliance with Section~~  
4 ~~9795 of the Government Code.~~

5 ~~(c) In addition to the annual report required by subdivision (b),~~  
6 ~~the office shall notify the Legislature of noncompliance by a state~~  
7 ~~agency with the regulations adopted pursuant to Section 11346.36,~~  
8 ~~in any manner or form determined by the office and shall post the~~  
9 ~~report and notice of noncompliance on the office's Internet Web~~  
10 ~~site.~~

11 ~~SEC. 2.~~

12 *SECTION 1.* Chapter 3.6 (commencing with Section 11366)  
13 is added to Part 1 of Division 3 of Title 2 of the Government Code,  
14 to read:

15  
16 CHAPTER 3.6. REGULATORY REFORM

17  
18 Article 1. Findings and Declarations

19  
20 11366. The Legislature finds and declares all of the following:

21 (a) The Administrative Procedure Act (Chapter 3.5 (commencing  
22 with Section 11340), Chapter 4 (commencing with Section 11370),  
23 Chapter 4.5 (commencing with Section 11400), and Chapter 5  
24 (commencing with Section 11500)) requires agencies and the  
25 Office of Administrative Law to review regulations to ensure their  
26 consistency with law and to consider impacts on the state's  
27 economy and businesses, including small businesses.

28 (b) However, the act does not require agencies to individually  
29 review their regulations to identify overlapping, inconsistent,  
30 duplicative, or out-of-date regulations that may exist.

31 (c) At a time when the state's economy is slowly recovering,  
32 unemployment and underemployment continue to affect all  
33 Californians, especially older workers and younger workers who  
34 received college degrees in the last seven years but are still awaiting  
35 their first great job, and with state government improving but in  
36 need of continued fiscal discipline, it is important that state  
37 agencies systematically undertake to identify, publicly review, and  
38 eliminate overlapping, inconsistent, duplicative, or out-of-date  
39 regulations, both to ensure they more efficiently implement and

1 enforce laws and to reduce unnecessary and outdated rules and  
2 regulations.

3 ~~(d) The purpose of this chapter is to require each agency to~~  
4 ~~compile an overview of the statutory law that agency oversees or~~  
5 ~~administers in its regulatory activity that includes a synopsis of~~  
6 ~~key programs, when each key program was authorized or instituted,~~  
7 ~~and any emerging challenges the agency is encountering with~~  
8 ~~respect to those programs.~~

9  
10 Article 2. Definitions

11  
12 11366.1. For the ~~purpose~~ *purposes* of this chapter, the following  
13 definitions shall apply:

14 (a) “State agency” means a state agency, as defined in Section  
15 11000, except those state agencies or activities described in Section  
16 11340.9.

17 (b) “Regulation” has the same meaning as provided in Section  
18 11342.600.

19  
20 Article 3. State Agency Duties

21  
22 11366.2. On or before January 1, 2018, each state agency shall  
23 do all of the following:

24 (a) Review all provisions of the California Code of Regulations  
25 applicable to, or adopted by, that state agency.

26 (b) Identify any regulations that are duplicative, overlapping,  
27 inconsistent, or out of date.

28 (c) Adopt, amend, or repeal regulations to reconcile or eliminate  
29 any duplication, overlap, inconsistencies, or out-of-date ~~provisions.~~  
30 *provisions, and shall comply with the process specified in Article*  
31 *5 (commencing with Section 11346) of Chapter 3.5, unless the*  
32 *addition, revision, or deletion is without regulatory effect and may*  
33 *be done pursuant to Section 100 of Title 1 of the California Code*  
34 *of Regulations.*

35 (d) Hold at least one noticed public hearing, that shall be noticed  
36 on the Internet Web site of the state agency, for the purposes of  
37 accepting public comment on proposed revisions to its regulations.

38 (e) Notify the appropriate policy and fiscal committees of each  
39 house of the Legislature of the revisions to regulations that the  
40 state agency proposes to make at least ~~90 days~~ prior to a noticed

1 ~~public hearing pursuant to subdivision (d) and at least 90 days~~  
2 ~~prior to the proposed adoption, amendment, or repeal of the~~  
3 ~~regulations pursuant to subdivision (f), for the purpose of allowing~~  
4 ~~those committees to review, and hold hearings on, the proposed~~  
5 ~~revisions to the regulations.~~

6 ~~(f) Adopt as emergency regulations, consistent with Section~~  
7 ~~11346.1, those changes, as provided for in subdivision (e), to a~~  
8 ~~regulation identified by the state agency as duplicative,~~  
9 ~~overlapping, inconsistent, or out of date. *least 30 days prior to*~~  
10 ~~*initiating the process under Article 5 (commencing with Section*~~  
11 ~~*11346) of Chapter 3.5 or Section 100 of Title 1 of the California*~~  
12 ~~*Code of Regulations.*~~

13 (g) (1) Report to the Governor and the Legislature on the state  
14 agency's compliance with this chapter, including the number and  
15 content of regulations the state agency identifies as duplicative,  
16 overlapping, inconsistent, or out of date, and the state agency's  
17 actions to address those regulations.

18 (2) The report shall be submitted in compliance with Section  
19 9795 of the Government Code.

20 11366.3. (a) On or before January 1, 2018, each agency listed  
21 in Section 12800 shall notify a department, board, or other unit  
22 within that agency of any existing regulations adopted by that  
23 department, board, or other unit that the agency has determined  
24 may be duplicative, overlapping, or inconsistent with a regulation  
25 adopted by another department, board, or other unit within that  
26 agency.

27 (b) A department, board, or other unit within an agency shall  
28 notify that agency of revisions to regulations that it proposes to  
29 make at least 90 days prior to a noticed public hearing pursuant to  
30 subdivision (d) of Section 11366.2 and at least 90 days prior to  
31 adoption, amendment, or repeal of the regulations pursuant to  
32 ~~subdivision (f) of subdivision (c) of Section 11366.2.~~ The agency  
33 shall review the proposed regulations and make recommendations  
34 to the department, board, or other unit within 30 days of receiving  
35 the notification regarding any duplicative, overlapping, or  
36 inconsistent regulation of another department, board, or other unit  
37 within the agency.

38 11366.4. An agency listed in Section 12800 shall notify a state  
39 agency of any existing regulations adopted by that agency that

1 may duplicate, overlap, or be inconsistent with the state agency's  
2 regulations.

3 ~~11366.43. On or before January 1, 2017, each state agency~~  
4 ~~shall compile an overview of the statutory law that state agency~~  
5 ~~oversees or administers. The overview shall include a synopsis of~~  
6 ~~the state agency's key programs, when each program was~~  
7 ~~authorized or instituted, when any statute authorizing a program~~  
8 ~~was significantly revised to alter, redirect, or extend the original~~  
9 ~~program and the reason for the revision, if known, and an~~  
10 ~~identification of any emerging challenges the state agency is~~  
11 ~~encountering with respect to the programs.~~

12 11366.45. This chapter shall not be construed to weaken or  
13 undermine in any manner any human health, public or worker  
14 rights, public welfare, environmental, or other protection  
15 established under statute. This chapter shall not be construed to  
16 affect the authority or requirement for an agency to adopt  
17 regulations as provided by statute. Rather, it is the intent of the  
18 Legislature to ensure that state agencies focus more efficiently and  
19 directly on their duties as prescribed by law so as to use scarce  
20 public dollars more efficiently to implement the law, while  
21 achieving equal or improved economic and public benefits.

22  
23 Article 4. Chapter Repeal

24  
25 11366.5. This chapter shall remain in effect only until January  
26 1, 2019, and as of that date is repealed, unless a later enacted  
27 statute, that is enacted before January 1, 2019, deletes or extends  
28 that date.

**AB**

**85**

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**SENATE COMMITTEE ON GOVERNMENTAL ORGANIZATION**  
**Senator Isadore Hall, III**  
**Chair**  
**2015 - 2016 Regular**

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**Bill No:** AB 85 **Hearing Date:** 7/14/2015  
**Author:** Wilk  
**Version:** 4/15/2015 Amended  
**Urgency:** Yes **Fiscal:** Yes  
**Consultant:** Arthur Terzakis

**SUBJECT:** Open meetings

**DIGEST:** This bill modifies the Bagley-Keene Open Meeting Act to require two-member advisory committees of a “state body” (as defined in the Act) to hold open, public meetings if at least one member of the advisory committee is a member of the larger state body and the advisory committee is supported, in whole or in part, by state funds.

**ANALYSIS:**

Existing law:

- 1) Requires that all meetings of a state body, as defined, be open and public and that all persons be permitted to attend and participate in a meeting of a state body, subject to certain conditions and exceptions. (The Bagley-Keene Open Meeting Act, set forth in Government Code Sections 11120-11132)
- 2) Defines a state body, for purposes of the Bagley-Keene Open Meeting Act, to mean each of the following:
  - a) Every state board, or commission, or similar multimember body of the state that is created by statute or required by law to conduct official meetings and every commission created by executive order.
  - b) A board, commission, committee, or similar multimember body that exercises any authority of a state body delegated to it by that state body.
  - c) An advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body of a state body, if created by formal action of the state body or of any member of the state body, and if the advisory body so created consists of three or more persons.

- d) A board, commission, committee, or similar multimember body on which a member of a body that is a state body pursuant to this section serves in his or her official capacity as a representative of that state body and that is supported, in whole or in part, by funds provided by the state body, whether the multimember body is organized and operated by the state body or by a private corporation.

This bill:

- 1) Clarifies that, under the Bagley-Keene Act, a two-member advisory committee of a state body is a state body if a member of that state body sits on the advisory committee and the committee receives funds from the state body.
- 2) Contains an urgency clause to take effect immediately.

### **Background**

The Bagley-Keene Open Meeting Act, set forth in Government Code Sections 11120-11132, covers all state boards and commissions and generally requires these bodies to publicly notice their meetings, prepare agendas, accept public testimony and conduct their meetings in public unless specifically authorized by the Act to meet in closed session. The Ralph M. Brown Act, set forth in Government Code Section 54950 et seq., governs meetings of legislative bodies of local agencies. In general, both Acts are virtually identical. While both acts contain specific exceptions from the open meeting requirements where government has demonstrated a need for confidentiality, such exceptions have been narrowly construed by the courts.

When the Legislature enacted the Bagley-Keene Act it essentially said that when a state body sits down to develop its consensus, there needs to be a seat at the table reserved for the public. By reserving this place for the public, the Legislature has provided the public with the ability to monitor and participate in the decision-making process. If the body were permitted to meet in secret, the public's role in the decision-making process would be negated. Therefore, absent a specific reason to keep the public out of the meeting, the public should be allowed to monitor and participate in the decision-making process.

*Purpose of AB 85.* According to the author's office, the current definition of "state body" in the Bagley-Keene Act contains an ambiguity with respect to whether standing committees composed of fewer than three members need to comply with the public notice and open meeting requirements of the Act. The author's office

contends this ambiguity has been interpreted by certain state agencies to allow standing committees to hold closed-door meetings so long as those committees contain fewer than three members and do not vote on action items. The author's office states that AB 85 is simply intended to clarify that all standing committees, including advisory committees, are subject to the transparency of open meeting regulations regardless of committee size or membership.

The author's office notes that prior to 1993, the Brown Act contained language very similar to the current language in the Bagley-Keene Act relative to standing committees. However, in the 90's when a local government entity attempted to claim a loophole existed for two-member standing committees, the Legislature promptly removed any ambiguity on the matter from the Brown Act through enactment of SB 1140 (Calderon, Chapter 1138, Statutes of 1993). A conforming change was not made, however, to the Bagley-Keene Act, as no change was thought necessary.

The author's office believes that the ambiguity left in the Bagley-Keene Act is allowing state bodies to deliberate and direct staff behind closed doors. These state agencies are allowing standing committees to interpret the language of the Bagley-Keene Act in a manner that is contrary to the intent of the Legislature and the public.

*Staff comments.* Last year, the Governor vetoed a similar measure, AB 2058 (Wilk). In this veto message of AB 2058, the Governor wrote, "an advisory committee does not have authority to act on its own and must present any findings and recommendations to a larger body in a public setting for formal action," which he argued should be sufficient for transparency purposes.

### **Prior/Related Legislation**

AB 2058 (Wilk, 2014) would have modified the definition of state body, under the Bagley-Keene Open Meeting Act, to exclude an advisory body with less than 3 individuals, except for certain standing committees. (Vetoed)

AB 2720 (Ting, Chapter 510, Statutes of 2014) required a state body to publicly report any action taken and the vote or abstention on that action of each member present for the action.

AB 245 (Grove, 2013) would have repealed the exemption from the Bagley-Keene Open Meeting Act enacted in 2012 for the Western Climate Initiative (WCI) and instead would have subjected the WCI and its appointees to the Bagley-Keene

Open Meeting Act when performing their duties. (Held in Assembly Governmental Organization Committee)

AB 527 (Gaines, 2013) would have repealed the exemption from the Bagley-Keene Open Meeting Act enacted in 2012 for the Western Climate Initiative (WCI) and provided that a contract between the state and WCI shall be subject to audit by the State Auditor. (Vetoed)

SB 751 (Yee, Chapter 257, Statutes of 2013) required local agencies to publicly report any action taken and the vote or abstention of each member of a legislative body.

SB 103 (Liu, 2011) would have made substantive changes to provisions of the Bagley-Keene Open Meeting Act relating to teleconference meetings. (Died on Assembly Appropriations Suspense File)

SB 962 (Liu, Chapter 482, Statutes of 2010) allowed the use of videoconferencing and teleconferencing at the court's discretion and subject to availability for prisoners to participate in court proceedings for the termination of their parental rights or the court-ordered dependency petition of their child.

SB 519 (Committee on Governmental Organization, Chapter 92, Statutes of 2007) amended the Bagley-Keene Act to authorize the calling of a special meeting to provide for an interim executive officer of a state body upon the death, incapacity, or vacancy in the office of the executive officer.

AB 277 (Mountjoy, Chapter 288, Statutes of 2005) made permanent certain provisions authorizing closed sessions for purposes of discussing security related issues pertaining to a state body.

AB 192 (Canciamilla, Chapter 243, Statutes of 2001) made various changes to the Bagley-Keene Open Meeting Act, which governs meetings held by state bodies, to make it consistent with provisions of the Ralph M. Brown Act, which governs meetings of legislative bodies of local agencies.

SB 95 (Ayala, Chapter 949, Statutes of 1997) made numerous changes to the Bagley-Keene Act by expanding the notice, disclosure and reporting requirements for open and closed meetings of state bodies.

SB 752 (Kopp, Chapter 32 of 1994), SB 1140 (Calderon, Chapter 1138 of 1993), and SB 36 (Kopp, Chapter 1137 of 1993), these bills extensively amended the Ralph M. Brown Act.

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

**SUPPORT:**

California Association of Licensed Investigators, Inc.

**OPPOSITION:**

Board of Behavioral Sciences  
Board of Professional Engineers, Land Surveyors, and Geologists  
California Board of Accountancy  
California Acupuncture Board  
California Board of Psychology  
California Board of Vocational Nursing and Psychiatric Technicians  
California State Board of Pharmacy  
Dental Board of California  
Dental Hygiene Committee of California  
Physician Assistant Board of the Medical Board of California

**ARGUMENTS IN SUPPORT:** Writing in support, the California Association of Licensed Investigators states that AB 85 would provide for enhanced transparency in the proceedings of government.

**ARGUMENTS IN OPPOSITION:** Certain state professional boards contend this bill would essentially prevent them and their various committees from asking fewer than three members to review a document, draft a letter, provide expert analysis, or work on legal language without giving public notice. Opening such advisory activities to the public could greatly increase costs for staff to attend meetings and record minutes as well as contract for public meeting space. Under current law, the advisory activities of two-member bodies are already vetted and voted upon in publically noticed meetings of the whole committee or board.

AMENDED IN ASSEMBLY APRIL 15, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 85**

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**Introduced by Assembly Member Wilk**

January 6, 2015

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An act to amend Section 11121 of the Government Code, relating to state government, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 85, as amended, Wilk. Open meetings.

The Bagley-Keene Open Meeting Act requires that all meetings of a state body, as defined, be open and public and that all persons be permitted to attend and participate in a meeting of a state body, subject to certain conditions and exceptions.

This bill would specify that the definition of "state body" includes an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body of a state body that consists of 3 or more individuals, as prescribed, except a board, commission, committee, or similar multimember body on which a member of a body serves in his or her official capacity as a representative of that state body and that is supported, in whole or in part, by funds provided by the state body, whether the multimember body is organized and operated by the state body or by a private corporation.

~~This bill would make legislative findings and declarations, including, but not limited to, a statement of the Legislature's intent that this bill is declaratory of existing law.~~

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

Vote:  $\frac{2}{3}$ . Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

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

1     ~~SECTION 1. The Legislature finds and declares all of the~~  
2     ~~following:~~

3     ~~(a) The unpublished decision of the Third District Court of~~  
4     ~~Appeals in *Funeral Security Plans v. State Board of Funeral*~~  
5     ~~*Directors* (1994) 28 Cal. App.4th 1470 is an accurate reflection of~~  
6     ~~legislative intent with respect to the applicability of the~~  
7     ~~Bagley-Keene Open Meeting Act (Article 9 (commencing with~~  
8     ~~Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of~~  
9     ~~the Government Code) to a two-member standing advisory~~  
10    ~~committee of a state body.~~

11    ~~(b) A two-member committee of a state body, even if operating~~  
12    ~~solely in an advisory capacity, already is a "state body," as defined~~  
13    ~~in subdivision (d) of Section 11121 of the Government Code, if a~~  
14    ~~member of the state body sits on the committee and the committee~~  
15    ~~receives funds from the state body.~~

16    ~~(c) It is the intent of the Legislature that this bill is declaratory~~  
17    ~~of existing law.~~

18    ~~SEC. 2.~~

19    ~~SECTION 1.~~ Section 11121 of the Government Code is  
20    ~~amended to read:~~

21    ~~11121. As used in this article, "state body" means each of the~~  
22    ~~following:~~

23    ~~(a) Every state board, or commission, or similar multimember~~  
24    ~~body of the state that is created by statute or required by law to~~  
25    ~~conduct official meetings and every commission created by~~  
26    ~~executive order.~~

27    ~~(b) A board, commission, committee, or similar multimember~~  
28    ~~body that exercises any authority of a state body delegated to it by~~  
29    ~~that state body.~~

30    ~~(c) An advisory board, advisory commission, advisory~~  
31    ~~committee, advisory subcommittee, or similar multimember~~  
32    ~~advisory body of a state body, if created by formal action of the~~  
33    ~~state body or of any member of the state body, and if the advisory~~

1 body so created consists of three or more persons, except as in  
2 subdivision (d).

3 (d) A board, commission, committee, or similar multimember  
4 body on which a member of a body that is a state body pursuant  
5 to this section serves in his or her official capacity as a  
6 representative of that state body and that is supported, in whole or  
7 in part, by funds provided by the state body, whether the  
8 multimember body is organized and operated by the state body or  
9 by a private corporation.

10 ~~SEC. 3.~~

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

15 In order to avoid unnecessary litigation and ensure the people's  
16 right to access the meetings of public bodies pursuant to Section  
17 3 of Article 1 of the California Constitution, it is necessary that  
18 *this act take effect ~~immediately~~ immediately.*

**AB**

**611**

There is no  
analysis of  
this bill  
available.

AMENDED IN ASSEMBLY APRIL 15, 2015

AMENDED IN ASSEMBLY APRIL 13, 2015

AMENDED IN ASSEMBLY MARCH 24, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 611**

---

**Introduced by Assembly Member Dahle**

February 24, 2015

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

LEGISLATIVE COUNSEL'S DIGEST

AB 611, as amended, Dahle. Controlled substances: prescriptions: reporting.

Existing law requires certain health care practitioners and pharmacists to apply to the Department of Justice to obtain approval to access information contained in the Controlled Substance Utilization Review and Evaluation System (CURES) Prescription Drug Monitoring Program (PDMP) regarding the controlled substance history of a patient under his or her care. Existing law requires the Department of Justice, upon approval of an application, to provide the approved health care practitioner or pharmacist the history of controlled substances dispensed to an individual under his or her care. Existing law authorizes an application to be denied, or a subscriber to be suspended, for specified reasons, including, among others, a subscriber accessing information for any reason other than caring for his or her patients.

This bill would also authorize an individual designated to investigate a holder of a professional license to apply to the Department of Justice to obtain approval to access information contained in the CURES PDMP

regarding the controlled substance history of an applicant or a licensee for the purpose of investigating the alleged substance abuse of a licensee. The bill would, upon approval of an application, require the department to provide to the approved individual the history of controlled substances dispensed to the licensee. The bill would clarify that only a subscriber who is a health care practitioner or a pharmacist may have an application denied or be suspended for accessing subscriber information for any reason other than caring for his or her patients. The bill would also specify that an application may be denied, or a subscriber may be suspended, if a subscriber who has been designated to investigate the holder of a professional license accesses information for any reason other than investigating the holder of a professional license.

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

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

1 SECTION 1. Section 11165.1 of the Health and Safety Code  
2 is amended to read:  
3 11165.1. (a) (1) (A) (i) A health care practitioner authorized  
4 to prescribe, order, administer, furnish, or dispense Schedule II,  
5 Schedule III, or Schedule IV controlled substances pursuant to  
6 Section 11150 shall, before January 1, 2016, or upon receipt of a  
7 federal Drug Enforcement Administration (DEA) registration,  
8 whichever occurs later, submit an application developed by the  
9 Department of Justice to obtain approval to access information  
10 online regarding the controlled substance history of a patient that  
11 is stored on the Internet and maintained within the Department of  
12 Justice, and, upon approval, the department shall release to that  
13 practitioner the electronic history of controlled substances  
14 dispensed to an individual under his or her care based on data  
15 contained in the CURES Prescription Drug Monitoring Program  
16 (PDMP).  
17 (ii) A pharmacist shall, before January 1, 2016, or upon  
18 licensure, whichever occurs later, submit an application developed  
19 by the Department of Justice to obtain approval to access  
20 information online regarding the controlled substance history of  
21 a patient that is stored on the Internet and maintained within the  
22 Department of Justice, and, upon approval, the department shall  
23 release to that pharmacist the electronic history of controlled

1 substances dispensed to an individual under his or her care based  
2 on data contained in the CURES PDMP.

3 (iii) (I) An individual designated by a board, bureau, or  
4 program within the Department of Consumer Affairs to investigate  
5 a holder of a professional license may, for the purpose of  
6 investigating the alleged substance abuse of a licensee, submit an  
7 application developed by the Department of Justice to obtain  
8 approval to access information online regarding the controlled  
9 substance history of a licensee that is stored on the Internet and  
10 maintained within the Department of Justice, and, upon approval,  
11 the department shall release to that individual the electronic history  
12 of controlled substances dispensed to the licensee based on data  
13 contained in the CURES PDMP. ~~An application for an individual  
14 designated by a board, bureau, or program that does not regulate  
15 health care practitioners authorized to prescribe, order, administer,  
16 furnish, or dispense Schedule II, Schedule III, or Schedule IV  
17 controlled substances pursuant to Section 11150~~ The application  
18 shall contain facts demonstrating the probable cause to believe the  
19 licensee has violated a law governing controlled substances.

20 (II) *This clause does not require an individual designated by a  
21 board, bureau, or program within the Department of Consumer  
22 Affairs that regulates health care practitioners to submit an  
23 application to access the information stored within the CURES  
24 PDMP.*

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

28 (i) Materially falsifying an application for a subscriber.

29 (ii) Failure to maintain effective controls for access to the patient  
30 activity report.

31 (iii) Suspended or revoked federal DEA registration.

32 (iv) Any subscriber who is arrested for a violation of law  
33 governing controlled substances or any other law for which the  
34 possession or use of a controlled substance is an element of the  
35 crime.

36 (v) Any subscriber described in clause (i) or (ii) of subparagraph

37 (A) accessing information for any other reason than caring for his  
38 or her patients.

- 1 (vi) Any subscriber described in clause (iii) of subparagraph
- 2 (A) accessing information for any other reason than investigating
- 3 the holder of a professional license.
- 4 (C) Any authorized subscriber shall notify the Department of
- 5 Justice within 30 days of any changes to the subscriber account.
- 6 (2) A health care practitioner authorized to prescribe, order,
- 7 administer, furnish, or dispense Schedule II, Schedule III, or
- 8 Schedule IV controlled substances pursuant to Section 11150 or
- 9 a pharmacist shall be deemed to have complied with paragraph
- 10 (1) if the licensed health care practitioner or pharmacist has been
- 11 approved to access the CURES database through the process
- 12 developed pursuant to subdivision (a) of Section 209 of the
- 13 Business and Professions Code.
- 14 (b) Any request for, or release of, a controlled substance history
- 15 pursuant to this section shall be made in accordance with guidelines
- 16 developed by the Department of Justice.
- 17 (c) In order to prevent the inappropriate, improper, or illegal
- 18 use of Schedule II, Schedule III, or Schedule IV controlled
- 19 substances, the Department of Justice may initiate the referral of
- 20 the history of controlled substances dispensed to an individual
- 21 based on data contained in CURES to licensed health care
- 22 practitioners, pharmacists, or both, providing care or services to
- 23 the individual.
- 24 (d) The history of controlled substances dispensed to an
- 25 individual based on data contained in CURES that is received by
- 26 an authorized subscriber from the Department of Justice pursuant
- 27 to this section shall be considered medical information subject to
- 28 the provisions of the Confidentiality of Medical Information Act
- 29 contained in Part 2.6 (commencing with Section 56) of Division
- 30 1 of the Civil Code.
- 31 (e) Information concerning a patient's controlled substance
- 32 history provided to an authorized subscriber pursuant to this section
- 33 shall include prescriptions for controlled substances listed in
- 34 Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code
- 35 of Federal Regulations.

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**AB**

**637**

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THIRD READING

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Bill No: AB 637  
Author: Campos (D)  
Introduced: 2/24/15  
Vote: 21

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SENATE HEALTH COMMITTEE: 8-0, 6/10/15  
AYES: Hernandez, Nguyen, Hall, Mitchell, Monning, Pan, Roth, Wolk  
NO VOTE RECORDED: Nielsen

ASSEMBLY FLOOR: 75-0, 4/16/15 - See last page for vote

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**SUBJECT:** Physician Orders for Life Sustaining Treatment forms

**SOURCE:** California Medical Association  
Coalition for Compassionate Care of California

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**DIGEST:** This bill allows a nurse practitioner or a physician assistant acting under the supervision of a physician to sign a completed Physician Orders for Life Sustaining Treatment form.

**ANALYSIS:**

Existing law:

- 1) Establishes the Physicians Orders for Life Sustaining Treatment (POLST) form and medical intervention and procedures, and requires that POLST be explained by a health care provider, defined as an individual licensed, certified, or otherwise authorized or permitted by the law of this state to provide health care in the ordinary course of business or practice of a profession.
- 2) Requires the form to be completed by a health care provider based on patient preferences and medical indications, and signed by a physician and the patient or his or her legally recognized health care decision maker. Requires the health care provider, during the process of completing form, to inform the patient

about the difference between an advance health care directive and the POLST form.

This bill adds a nurse practitioner (NP), or a physician assistant (PA) acting under the supervision of the physician and within the scope of practice authorized by law, to the POLST law to sign a completed POLST form.

### Comments

- 1) *Author's statement.* According to the author, POLST is viewed by health care professionals as useful, helpful, reliable and most importantly, very effective at ensuring preferences for end-of-life care are honored. Physicians recognize and appreciate the value of the multiple member health care team and support efforts to increase productivity while ensuring quality of care. NPs and PAs are currently having conversations with patients about their end-of-life care options and preferences, and in some instances are able to sign off on other immediately actionable documents under supervision, such as drug orders and medical certificates. By allowing NPs and PAs under physician supervision to sign POLST forms, this bill will improve end-of-life care by increasing the availability of actionable medical orders for medically indicated care consistent with patient preferences.
- 2) *What is POLST?* POLST includes a clinical process designed to facilitate communication between health care professionals and patients with serious illness or frailty (or their authorized surrogate) where the health care professional would not be surprised if the patient died within the next year. The process encourages shared, informed medical decision-making leading to a set of portable medical orders that respects the patient's goals for care in regard to the use of cardiopulmonary resuscitation and other medical interventions, is applicable across health care settings, and can be reviewed and revised as needed. The POLST form is a highly visible, portable medical form that transfers from one setting to another with the patient. It functions as a Do Not Resuscitate order and provides treatment direction for multiple situations. The POLST form itself is outcome neutral, meaning treatment options range from full treatment to comfort care only.
- 3) *POLST and advance directive.* POLST is neither an advance directive nor a replacement for an advance directive. Both documents are helpful for communicating patient wishes when appropriately used. An advance directive is a form in which an individual appoints a person or persons to make health

care decisions for the individual if and when the individual loses capacity to make health care decisions (health care power of attorney) and/or provides guidance or instructions for making health care decisions (living will). An advance directive is from the patient, not a medical order. POLST consists of a set of medical orders that applies to a limited population of patients and addresses a limited number of critical medical decisions. POLST is a complement to advance directives in that it serves as a translation tool and a continuity of care assurance.

- 4) *POLST in California.* According to information presented at a December 3, 2014, briefing on POLST in California, based on an evaluation by UCLA, POLST is widely used in California but there are challenges with completing the form and making sure it travels with the patient. Additional problems include incomplete or inaccurate information and for emergency medical responders the documents are not always available.
- 5) *NPs and PAs.* A PA may perform those medical services as set forth in regulations when the services are rendered under the supervision of a licensed physician and surgeon. A PA may only provide those medical services which he or she is competent to perform and which are consistent with his or her education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that PA. According to the California Association of Nurse Practitioners, NPs are advanced practice registered nurses who are licensed by the Board of Registered Nursing and have pursued higher education, either a master's or doctoral degree, and certification as a NP. NPs provide care in a variety of settings, including hospitals, community clinics, and private practice settings under physician supervision.

### **Related Legislation**

SB 19 (Wolk) establishes a POLST Registry operated by the California Health and Human Services Agency (CHHS) for the purpose of collecting a POLST form received from a physician, or his or her designee, and disseminating the information in the form to persons authorized by CHHS. SB 19 is pending in the Assembly.

SB 128 (Wolk) permits a qualified adult with capacity to make medical decisions, who has been diagnosed with a terminal disease to receive a prescription for an aid in dying drug if certain conditions are met, such as two oral requests, a minimum

of 15 days apart and a signed written request witnessed by two individuals is provided to his or her attending physician, the attending physician refers the patient to an independent, consulting physician to confirm diagnosis and capacity of the patient to make medical decisions, and the attending physician refers the patient for a mental health specialist assessment if there are indications of a mental disorder. SB 128 is set for hearing in the Assembly Health Committee on June 23, 2015.

SB 323 (Hernandez) authorizes a NP who holds a national certification to practice without physician supervision in specified settings. SB 323 is set for hearing in the Assembly Business and Professions Committee on June 30, 2015.

### **Prior Legislation**

SB 1357 (Wolk, 2014) would have established a POLST registry at CHHS and is substantially similar to SB 19. *The bill was held on the Senate Appropriations Committee suspense file.*

AB 3000 (Wolk, Chapter 266, Statutes of 2008) created POLST in California, which is a standardized form to reflect a broader vision of resuscitative or life sustaining requests and to encourage the use of POLST orders to better handle resuscitative or life sustaining treatment consistent with a patient's wishes.

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

**SUPPORT:** (Verified 6/15/15)

California Medical Association (co-source)  
Coalition for Compassionate Care of California (co-source)  
AARP  
Association of Northern California Oncologists  
Blue Shield of California  
California Assisted Living Association  
California Association for Health Services at Home  
California Association for Nurse Practitioners  
California Chapter of the American College of Emergency Physicians  
California Long-Term Care Ombudsman Association  
Contra Costa County Advisory Council on Aging  
Contra Costa County Board of Supervisors  
LeadingAge California  
Medical Board of California  
Medical Oncology Association of Southern California, Inc.

Physician Assistant Board

**OPPOSITION:** (Verified 6/15/15)

California Right to Life Committee, Inc.

**ARGUMENTS IN SUPPORT:** The California Medical Association, this bill's co-sponsor, writes that a POLST becomes actionable when signed by a physician and the patient. NPs and PAs are having conversations with patients about their end-of-life care options and preferences and, in some instances, are able to sign off on other immediately actionable documents under supervision, such as drug orders, and medical certificates. The Coalition for Compassionate Care of California, the other co-sponsor of this bill, writes that the two signature requirement can create a roadblock to timely completion, particularly in rural areas and skilled nursing facilities where timely access to a physician can be difficult to obtain. The situation can create an unnecessarily stressful delay. NPs and PAs receive advanced training that enables them to talk with patients about the medical treatment choices in POLST and they are often able to spend more one-on-one time with patients than physicians. Sixteen states, including Oregon, already allow NPs and PAs to sign POLST forms, and no problems have occurred. The California Chapter of the American College of Emergency Physicians writes that end-of-life decisions a patient sets out in their POLST are often put into practice in the emergency department, and unfortunately, many patients arrive with an invalid POLST not signed by a physician. Allowing a NP or, PA under physician supervision, to sign and validate a POLST form will increase the number of valid POLST forms that emergency physicians can act on, and ensure patient's end-of-life wishes are honored. AARP writes POLST is an effective but underutilized advance-care planning tool and utilization may be improved by authorizing other health care team members such as NPs and PAs who are already discussing health care decisions with patients and/or their decision makers regarding the levels of medical intervention identified on the POLST form.

**ARGUMENTS IN OPPOSITION:** The California Right to Life Committee, Inc. writes that this bill raises the status of NPs and PAs to a level of medical competence that is not warranted by their level of education and knowledge of illness or treatments.

ASSEMBLY FLOOR: 75-0, 4/16/15

AYES: Achadjian, Alejo, Travis Allen, Baker, Bigelow, Bloom, Bonilla, Bonta, Brough, Brown, Burke, Calderon, Campos, Chang, Chau, Chávez, Chiu, Chu, Cooley, Cooper, Dababneh, Dahle, Daly, Frazier, Beth Gaines, Gallagher,

Cristina Garcia, Eduardo Garcia, Gatto, Gomez, Gonzalez, Gordon, Gray, Grove, Hadley, Roger Hernández, Holden, Irwin, Jones, Jones-Sawyer, Kim, Lackey, Levine, Linder, Lopez, Low, Maienschein, Mathis, Mayes, McCarty, Medina, Melendez, Mullin, Nazarian, Obernolte, O'Donnell, Olsen, Patterson, Perea, Rendon, Ridley-Thomas, Rodriguez, Salas, Santiago, Steinorth, Mark Stone, Thurmond, Ting, Wagner, Waldron, Weber, Wilk, Williams, Wood, Atkins

NO VOTE RECORDED: Dodd, Eggman, Gipson, Harper, Quirk

Prepared by: Teri Boughton / HEALTH /  
6/16/15 13:51:05

\*\*\*\* END \*\*\*\*

CHAPTER \_\_\_\_\_

An act to amend Section 4780 of the Probate Code, relating to resuscitative measures.

LEGISLATIVE COUNSEL’S DIGEST

AB 637, Campos. Physician Orders for Life Sustaining Treatment forms.

Existing law defines a request regarding resuscitative measures to mean a written document, signed by an individual, as specified, and the physician, that directs a health care provider regarding resuscitative measures, and includes a Physician Orders for Life Sustaining Treatment form (POLST form). Existing law requires a physician to treat a patient in accordance with the POLST form and specifies the criteria for creation of a POLST form, including that the form be completed by a health care provider based on patient preferences and medical indications, and signed by a physician and the patient or his or her legally recognized health care decisionmaker.

This bill would authorize the signature of a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law to create a valid POLST form.

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

SECTION 1. Section 4780 of the Probate Code is amended to read:

4780. (a) As used in this part:

(1) “Request regarding resuscitative measures” means a written document, signed by (A) an individual with capacity, or a legally recognized health care decisionmaker, and (B) the individual’s physician, that directs a health care provider regarding resuscitative measures. A request regarding resuscitative measures is not an advance health care directive.

(2) “Request regarding resuscitative measures” includes one, or both of, the following:

(A) A prehospital “do not resuscitate” form as developed by the Emergency Medical Services Authority or other substantially similar form.

(B) A Physician Orders for Life Sustaining Treatment form, as approved by the Emergency Medical Services Authority.

(3) “Physician Orders for Life Sustaining Treatment form” means a request regarding resuscitative measures that directs a health care provider regarding resuscitative and life-sustaining measures.

(b) A legally recognized health care decisionmaker may execute the Physician Orders for Life Sustaining Treatment form only if the individual lacks capacity, or the individual has designated that the decisionmaker’s authority is effective pursuant to Section 4682.

(c) The Physician Orders for Life Sustaining Treatment form and medical intervention and procedures offered by the form shall be explained by a health care provider, as defined in Section 4621. The form shall be completed by a health care provider based on patient preferences and medical indications, and signed by a physician, or a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law, and the patient or his or her legally recognized health care decisionmaker. The health care provider, during the process of completing the Physician Orders for Life Sustaining Treatment form, should inform the patient about the difference between an advance health care directive and the Physician Orders for Life Sustaining Treatment form.

(d) An individual having capacity may revoke a Physician Orders for Life Sustaining Treatment form at any time and in any manner that communicates an intent to revoke, consistent with Section 4695.

(e) A request regarding resuscitative measures may also be evidenced by a medallion engraved with the words “do not resuscitate” or the letters “DNR,” a patient identification number, and a 24-hour toll-free telephone number, issued by a person pursuant to an agreement with the Emergency Medical Services Authority.

**AB**

**728**

CONCURRENCE IN SENATE AMENDMENTS

AB 728 (Hadley)

As Amended July 2, 2015

Majority vote

ASSEMBLY: 77-0 (May 7, 2015) SENATE: 39-0 (July 9, 2015)

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Original Committee Reference: **A. & A.R.**

**SUMMARY:** Requires state agencies to post their State Leadership Accountability Act (SLAA) reports on their Web sites within five days of finalization.

**The Senate amendments** make technical non-substantive changes to incorporate the chaptering of a budget trailer bill that affected the same code section in this bill.

**EXISTING LAW:**

- 1) Requires agency heads covered by SLAA to conduct reviews and issue SLAA reports about internal controls and monitoring processes.
- 2) Requires agencies to submit SLAA reports to various state entities, including the State Library, where reports are required to be available for public inspection.

**FISCAL EFFECT:** According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

**COMMENTS:** This bill requires state agencies to post SLAA reports on their Web sites within five days of finalization. These reports, which are due by the end of each odd-number calendar year, assess an agency's systems of internal controls and monitoring practices.

State agencies are currently required to submit SLAA reports to the Legislature, State Auditor, Controller, Department of Finance (Finance), the Secretary of Government Operations, and to the State Library where they must be available for public inspection.

Senate amendments incorporate language in SB 84 (Budget and Fiscal Review Committee), Chapter 25, Statutes of 2015, a budget trailer bill, which change the name of the Financial Integrity and State Manager's Accountability Act of 1983 (FISMA) to SLAA.

**Analysis Prepared by:** Scott Herbstman / A. & A.R. / (916) 319-3600

FN: 0001184

## CHAPTER \_\_\_\_\_

An act to amend Section 13405 of the Government Code, relating to state government.

## LEGISLATIVE COUNSEL'S DIGEST

AB 728, Hadley. State government: financial reporting.

Existing law, the State Leadership Accountability Act, provides that state agency heads are responsible for the establishment and maintenance of a system or systems of internal accounting and administrative control within their agencies, as specified. Existing law requires state agency heads to, biennially, conduct an internal review and prepare a report on the adequacy of the agency's systems of internal accounting, administrative control, and monitoring practices. Copies of the reports are required to be submitted to the Legislature, the California State Auditor, the Controller, the Department of Finance, the Secretary of Government Operations, and to the State Library where the copy is required to be available for public inspection.

This bill would also require the report to be posted on the agency's Internet Web site within 5 days of finalization.

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

SECTION 1. Section 13405 of the Government Code, as amended by Section 18 of Chapter 25 of the Statutes of 2015, is amended to read:

13405. (a) To ensure that the requirements of this chapter are fully complied with, each agency head that the Department of Finance determines is covered by this section shall, on a biennial basis but no later than December 31 of each odd-numbered year, conduct an internal review and prepare a report on the adequacy of the state agency's systems of internal control, and monitoring practices in accordance with the guide prepared by the Department of Finance pursuant to subdivision (d).

(b) The report, including the state agency's response to review recommendations, shall be signed by the agency head and addressed to the agency secretary, or the Director of Finance for

a state agency without a secretary. An agency head shall submit a copy of the report and related response, pursuant to a method determined by the Department of Finance, to the Legislature, the California State Auditor, the Controller, the Department of Finance, the Secretary of Government Operations, and to the State Library where the copy shall be available for public inspection. A copy of the report shall be posted on the agency's Internet Web site within five days of finalization.

(c) The report shall identify any material inadequacy or material weakness in a state agency's systems of internal control that prevents the agency head from stating that the state agency's systems comply with this chapter. Concurrently with the submission of the report pursuant to subdivision (b), the state agency shall provide to the Department of Finance a plan and schedule for correcting the identified inadequacies and weaknesses, that shall be updated every six months until all corrections are implemented.

(d) The Department of Finance in consultation with the California State Auditor and the Controller, shall establish, and may modify from time to time as necessary, a system of reporting and a general framework to guide state agencies in conducting internal reviews of their systems of internal control.

(e) The Department of Finance in consultation with the California State Auditor and the Controller, shall establish, and may modify from time to time as necessary, a general framework of recommended practices to guide state agencies in conducting active, ongoing monitoring of processes for internal control.

**AB**

**1060**

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## SENATE COMMITTEE ON HEALTH

Senator Ed Hernandez, O.D., Chair

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**BILL NO:** AB 1060  
**AUTHOR:** Bonilla  
**VERSION:** June 17, 2015  
**HEARING DATE:** July 15, 2015  
**CONSULTANT:** Teri Boughton

**SUBJECT:** Cancer clinical trials.

**SUMMARY:** Requires the California Health and Human Services Agency to establish a nonprofit Cancer Clinical Trials Foundation to solicit and receive funds from business, industry, foundations, and other private and public sources for the purpose of administering the Cancer Clinical Trials Grant Program to increase patient access to cancer clinical trials.

**Existing law:**

- 1) Establishes the Inclusion of Women and Minorities in Clinical Research Act, which requires a grantee, defined, as any qualified public, private, or nonprofit agency or individual, including, but not limited to, colleges, universities, hospitals, laboratories, research institutions, local health departments, voluntary health agencies, health maintenance organizations, corporations, students, fellows, entrepreneurs, and individuals conducting clinical research using state funds, in conducting or supporting a project of clinical research, as defined, to ensure that women of all ages, and members of minority groups, as defined, are included as subjects in the clinical research projects, except under prescribed circumstances.
- 2) Requires health plans and insurers to provide coverage for all routine patient care costs relative to the treatment of an enrollee or insured diagnosed with cancer and accepted in an U.S. Food and Drug Administration (FDA) approved cancer clinical trial, Phase I-IV, if the enrollee's treating physician recommends participation in the clinical trial after determining such participation has a meaningful potential to benefit the enrollee or insured.

**This bill:**

- 1) Requires the California Health and Human Services Agency (CHHS) to establish a nonprofit public benefit corporation, to be known as the Cancer Clinical Trials Foundation, governed by a five member board, appointed by the Governor, the Speaker of the Assembly, and the Pro Tem of the Senate with a four year term.
- 2) Requires the Governor to appoint the president of the board and requires members of the board to serve without compensation but reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the board.
- 3) Subjects the foundation to the Nonprofit Public Benefit Corporation Law, as specified, except that if there is a conflict with this bill and the Nonprofit Public Benefit Corporation Law, this bill shall prevail.
- 4) Requires CHHS to determine which department in the agency shall administer the foundation.

- 5) Creates the Cancer Clinical Trials Fund, continuously appropriated to the board without regard to fiscal years, for the administration and support of the program.
- 6) Permits the Cancer Clinical Trials Foundation to solicit and receive funds from business, industry, foundations, and other private and public sources for the purpose of administering the Cancer Clinical Trials Grant Program to increase patient access to cancer clinical trials.
- 7) Requires the board to use no more than 20% of funds made available for the Cancer Clinical Trials Grant Program for administrative costs.
- 8) Requires, upon contribution of an unspecified amount of moneys to the foundation, the board to establish the Cancer Clinical Trials Grant Program to increase patient access to cancer clinical trials in underserved or disadvantaged communities and populations, including among women and patients from racial and ethnic minority communities.
- 9) Requires the board to determine the criteria to award grants, and authorize grants to be awarded to either or both, public and private research institutions and hospitals that conduct cancer clinical trials approved by the FDA and nonprofit organizations that specialize in direct patient support for improved clinical trial enrollment and retention, as specified.
- 10) Requires grants to be used for activities to increase patient access to cancer clinical trials, including, but not limited to, any of the following:
  - a) Patient navigator services or programs;
  - b) Education and community outreach;
  - c) Patient-friendly technical tools to assist patients in identifying available clinical trials;
  - d) Translation and interpretation services of clinical trial information;
  - e) Counseling services for clinical trial participants;
  - f) Well-being services for clinical trial participants, including, but not limited to, physical therapy, pain management, stress management, and nutrition management; and,
  - g) Payment of ancillary costs for patients and caregivers, including, but not limited to: airfare during the clinical trial, lodging during the clinical trial, rental cars during the clinical trial, fuel during the clinical trial, local transportation via bus, train, or other public transportation during the clinical trial, meals during the clinical trial, and child care costs during the clinical trial.
- 11) Requires grant recipients to report to the board to ensure the appropriate use of funds within one year of receiving a grant.
- 12) Requires the board to report to the Legislature to ensure the appropriate use of the funds. Requires the report to include accountability measures, including, but not limited to, a description of how the funds were used, an evaluation of the grant program, and recommendations for the program, and to be submitted by January 1, 2020.
- 13) Makes the requirement for submitting a report imposed under this bill inoperative on January, 1, 2024, as specified.

- 14) States legislative intent to establish a program to enable willing patients of low to moderate income to participate in cancer clinical trials in order to boost participation rates, ensure these trials are widely accessible, improve the development of cancer therapies, and enhance innovation.

**FISCAL EFFECT:** This version of the bill has not been analyzed by a fiscal committee.

**PRIOR VOTES:** The prior votes are not relevant to this version of the bill.

**COMMENTS:**

- 1) *Author's statement.* According to the author, access to clinical trials is an important part of our health care system. It allows people to try innovative, alternative treatments when traditional treatments have not been successful and helps to get these new treatments approved for mainstream use. Unfortunately, we have seen limited access to clinical trials for women and people of color. One of the top reasons that patients report not participating in clinical trials is economic hardship. There are many costs associated with participating in a clinical trial including transportation costs, hotel costs, and companion traveling expenses. In addition, there are other barriers to trials such as lack of education and awareness of available cancer clinical trials. AB 1060 takes a step to increase access to cancer clinical trials by creating a privately funded grant program to connect patients with the appropriate clinical trial.
- 2) *Clinical Trial Challenges.* A 2010 Workshop Summary of Transforming Clinical Research in the United States (Summary) provides some background into the clinical trial process. According to the summary, because clinical trials are necessary to obtain regulatory approval in the United States, they are a high priority to companies. Industry-sponsored trials are conducted largely to gain FDA approval to market a new drug or a previously approved drug for a new indication. Pre-approval trials include a simple protocol (i.e., ask a limited number of questions) and test a drug in a highly selected patient group designed to provide the most robust evidence on the drug's benefits and risks. Conversely, the federal government conducts large clinical trials to answer medical questions unrelated to gaining regulatory approval for a new drug or therapy. These studies can involve a wide range of patients and seek to answer a number of relevant clinical questions at once.

Clinical trial costs can vary widely depending on the number of patients being sought, the number and location of research sites, the complexity of the trial protocol, and the reimbursement provided to investigators. The total cost can reach \$300–\$600 million to implement, conduct, and monitor a large, multicenter trial to completion.

The Summary includes a discussion about patient challenges. According to the summary, many workshop participants noted that patients often are unaware of the possibility of enrolling in a clinical trial. If they are aware of this opportunity, it is often difficult for them to locate a trial. Patients may reside far from study centers; even the largest multicenter trials can pose geographic challenges for those wishing to participate. Depending on the number of clinic visits required by the study protocol, significant travel and time costs may be associated with participation. In addition, trials designed with narrow eligibility criteria for participation purposely eliminate many patients who might have the disease being studied but are ineligible because of other characteristics (e.g., age, level of disease progression, exposure to certain medicines). Trials often require patients to temporarily leave the care of their regular doctor and receive services from unfamiliar providers, confronting interruptions in care. If a patient reaches the point of enrolling in a clinical trial, the extensive paperwork

associated with the informed consent process can be confusing and burdensome. Informed consent forms are developed to meet legal requirements and can contribute to the confusion patients feel regarding the trial and what it entails. In addition, there is sometimes a mistrust of industry-sponsored trials among the public. These feelings of mistrust can further complicate the already difficult decision about whether to join a trial.

- 3) *Disparities.* A Cancer Clinical Trial Fact Sheet made possible by an unrestricted educational grant from Genentech, provided by the author, indicates that only about 3-5% of the 10.1 million adults with cancer in the U.S. participate in cancer trials. This compares to 60% participation rate for children with cancer. The National Cancer Institute is the largest sponsor of cancer clinical trials at 3,000 sites. Over 30,000 patients are enrolled in cancer clinical trials annually. A review of FDA approved drugs from 1995-1999 revealed that African Americans, Asian/Pacific Islanders, Hispanics/Latinos and Native Americans collectively represented less than 10% of participants in trials that were testing cancer drugs. In 2004, the SELECT prostate cancer prevention trial completed recruiting over 35,000 men of whom 21% were minorities. With regard to challenges, the Fact Sheet indicates that 85% of respondents to a national survey were unaware that participating in a clinical trial was a treatment option for them. According to a review of enrollment decisions for health research studies, racial and ethnic minorities were less likely to be invited to participate in research studies compared with non-Hispanic/Latino whites.
- 4) *Prior legislation.* AB 2038 (Alquist Chapter 250, Statutes of 2000), establishes the Inclusion of Women and Minorities in Clinical Research Act.
- 5) *Support.* According to the Lazarex Cancer Foundation this bill seeks to remedy the problem of low patient participation in clinical trials, especially participation by women and underrepresented communities. The American Medical Association conducted a study on cancer trial participation and found from 1996 to 2002, of the 75,215 patients enrolled in the National Cancer Institute trials for breast, lung, colorectal, and prostate cancers, only 3.1% were Hispanic, 9.2% were black, and 1.9% were Asian/Pacific Islanders, while 85.6% were white. The lack of diversity impacts researcher's ability to evaluate the effect of new treatments on different populations, and speaks to a lack of access to potentially lifesaving trials for a large portion of the populations. The Association of Northern California Oncologists Board of Directors writes that clinical trials are essential component of developing new and innovative treatments for all types of cancer and give vulnerable patients access to new treatment options that would not otherwise be available to them. This new foundation could raise funds to overcome barriers, helping the entire research process. The University of Southern California writes that this bill is an innovative approach focused on addressing barriers to patient participation in clinical trials. Biocom writes that although many companies operating in this space already have established programs to address this issue of clinical trial participation in underrepresented communities, it is hoped that a concerted state effort may reach trial candidates and their physicians more effectively.
- 6) *Amendments.* The author requests the adoption of amendments to direct the foundation, or an authorized representative thereof, to apply for tax exempt status under Section 501 (c)(3) of the Internal Revenue Code.

**SUPPORT AND OPPOSITION:**

**Support:** Lazarex Cancer Foundation (sponsor)  
Association of Northern California Oncologists  
Biocom  
California Life Sciences Association  
Pharmaceutical Researchers and Manufacturers of America  
University of Southern California

**Oppose:** None received

**– END –**

AMENDED IN SENATE JULY 16, 2015  
AMENDED IN SENATE JUNE 17, 2015  
AMENDED IN ASSEMBLY MARCH 26, 2015  
CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1060**

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**Introduced by Assembly Member Bonilla**

February 26, 2015

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An act to add Chapter 2 (commencing with Section 101990) to Part 6 of Division 101 of the Health and Safety Code, relating to cancer, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1060, as amended, Bonilla. Cancer clinical trials.

Existing law establishes the scope and function of the California Health and Human Services Agency, which includes departments charged with administering laws pertaining to public health and social services, among other things. Existing law also establishes the Inclusion of Women and Minorities in Clinical Research Act, which is designed to promote the inclusion of women and minority groups in clinical research, including clinical trials.

This bill would create the Cancer Clinical Trials Foundation in the Health and Human Services Agency, to be governed by a board of trustees. Members of the board would be appointed as specified. The bill would also create the Cancer Clinical Trials Fund, and would continuously appropriate this fund to the board, thereby making an appropriation. The bill would authorize the board to solicit and receive money, as specified. The bill would require the board, upon contribution of an unspecified amount of money to the fund, to establish the Cancer

Clinical Trials Grant Program, in order to increase patient access to cancer clinical trials in specified populations. The bill would require that grant money be used for designated purposes, and would also require grant recipients to report to the board. The bill would require the board to report to the Legislature, as specified. This bill would make related findings.

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

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

- 1 SECTION 1: The Legislature finds and declares the following:
- 2 (a) Almost 50 percent of clinical trial studies are not finished  
3 in time due to low patient participation, recruitment and navigation  
4 difficulties, and other barriers for patients. Due to economic and  
5 socioeconomic circumstances and lack of patient knowledge,  
6 clinical oncology trial participation and retention are both very  
7 low as they relate to eligible participants.
- 8 (b) Overall, only 3 percent of eligible cancer patients participate  
9 in clinical trials, and of those only 5 percent of trial participants  
10 are from racial or ethnic minority communities.
- 11 (c) One barrier that prevents patients from participating in  
12 federal Food and Drug Administration clinical trials is finances.  
13 Patients of low to moderate income are often unable to bear the  
14 burden of the ancillary costs of participating, such as airfare,  
15 lodging, rental cars, and fuel.
- 16 (d) The American Medical Association conducted a study on  
17 cancer trial participation. The study found that from 1996 to 2002,  
18 of the 75,215 patients enrolled in the National Cancer Institute  
19 trials for breast, lung, colorectal, and prostate cancers, only 3.1  
20 percent were Hispanic, 9.2 percent were Black, and 1.9 percent  
21 were Asian or Pacific Islanders, while 85.6 percent were White.  
22 This lack of diversity is ~~alarming~~ *of concern* because of its impact  
23 on researchers' ability to evaluate the effect of new treatments on  
24 different populations. It also speaks to a lack of access to  
25 potentially lifesaving trials for a large portion of the population.
- 26 (e) It is the intent of the Legislature to establish a program to  
27 enable willing patients of low to moderate income to participate  
28 in cancer clinical trials in order to boost participation rates, ensure

1 these trials are widely accessible, improve the development of  
2 cancer therapies, and enhance innovation.

3 SEC. 2. Chapter 2 (commencing with Section 101990) is added  
4 to Part 6 of Division 101 of the Health and Safety Code, to read:

5  
6 CHAPTER 2. CANCER CLINICAL TRIALS

7  
8 101990. (a) "Board" means the Board of Trustees of the Cancer  
9 Clinical Trials Foundation.

10 (b) "Foundation" means the Cancer Clinical Trials Foundation.

11 (c) "Fund" means the Cancer Clinical Trials Fund.

12 101991. (a) The agency shall establish a nonprofit public  
13 benefit corporation, to be known as the Cancer Clinical Trials  
14 Foundation, that shall be governed by a board consisting of a total  
15 of five members. Three members shall be appointed by the  
16 Governor. Of these members, one shall be from a public cancer  
17 research institution, and one shall be from a private cancer research  
18 institution. One member shall be appointed by the Speaker of the  
19 Assembly. One member shall be appointed by the President pro  
20 Tempore of the Senate.

21 (b) The Governor shall appoint the president of the board from  
22 among those members appointed by the Governor, the Speaker of  
23 the Assembly, and the President pro Tempore of the Senate.

24 (c) *The foundation, or an authorized representative thereof,*  
25 *shall apply for tax exempt status under Section 501(c)(3) of the*  
26 *Internal Revenue Code.*

27 (e)

28 (d) Members of the board shall serve without compensation but  
29 shall be reimbursed for any actual and necessary expenses incurred  
30 in connection with their duties as members of the board.

31 (d)

32 (e) The foundation shall be subject to the Nonprofit Public  
33 Benefit Corporation Law (Part 2 (commencing with Section 5110)  
34 of Division 2 of Title 2 of the Corporations Code), ~~except that if~~  
35 ~~there is a conflict with this chapter and the Nonprofit Public Benefit~~  
36 ~~Corporation Law, this chapter shall prevail. Code).~~

37 (e)

38 (f) The California Health and Human Services Agency shall  
39 determine which department in the agency shall administer the  
40 foundation.

1 101992. (a) Of the members of the board first appointed by  
2 the Governor pursuant to Section 101991, one member shall be  
3 appointed to serve a two-year term, one member shall be appointed  
4 to serve a three-year term, and one member shall be appointed to  
5 serve a four-year term.

6 (b) Of the members of the board first appointed by the Speaker  
7 of the Assembly and the President pro Tempore of the Senate  
8 pursuant to Section 101991, each member shall be appointed to  
9 serve a four-year term.

10 (c) Upon the expiration of the initial appointments for the board,  
11 each member shall be appointed to serve a four-year term.

12 101993. (a) There is hereby created the Cancer Clinical Trials  
13 Fund. Notwithstanding Section 13340 of the Government Code,  
14 all money in the fund is continuously appropriated to the board  
15 without regard to fiscal years, for the administration and support  
16 of the program created pursuant to this chapter.

17 (b) The Cancer Clinical Trials Foundation may solicit and  
18 receive funds from business, industry, foundations, and other  
19 private and public sources for the purpose of administering the  
20 Cancer Clinical Trials Grant Program to increase patient access  
21 to cancer clinical trials.

22 (c) The board shall use no more than 20 percent of funds made  
23 available for the Cancer Clinical Trials Grant Program for  
24 administrative costs.

25 101994. (a) Upon contribution of an unspecified amount of  
26 moneys to the foundation, the board shall establish the Cancer  
27 Clinical Trials Grant Program to increase patient access to cancer  
28 clinical trials in underserved or disadvantaged communities and  
29 populations, including among women and patients from racial and  
30 ethnic minority communities. The board shall determine the criteria  
31 to award grants, and may award grants to either or both of the  
32 following:

33 (1) Public and private research institutions and hospitals that  
34 conduct cancer clinical trials approved by the federal Food and  
35 Drug Administration.

36 (2) Nonprofit organizations described in Section 501(c)(3) of  
37 the Internal Revenue Code of 1954 that are exempt from income  
38 tax under Section 501(a) of that code and that specialize in direct  
39 patient support for improved clinical trial enrollment and retention.

1 (b) Grants awarded pursuant to subdivision (a) shall be used for  
2 activities to increase patient access to cancer clinical trials,  
3 including, but not limited to, any of the following:

4 (1) Patient navigator services or programs.

5 (2) Education and community outreach.

6 (3) Patient-friendly technical tools to assist patients in  
7 identifying available clinical trials.

8 (4) Translation and interpretation services of clinical trial  
9 information.

10 (5) Counseling services for clinical trial participants.

11 (6) Well-being services for clinical trial participants, including,  
12 but not limited to, physical therapy, pain management, stress  
13 management, and nutrition management.

14 (7) Payment of ancillary costs for patients and caregivers,  
15 including, but not limited to:

16 (A) Airfare during the clinical trial.

17 (B) Lodging during the clinical trial.

18 (C) Rental cars during the clinical trial.

19 (D) Fuel during the clinical trial.

20 (E) Local transportation via bus, train, or other public  
21 transportation during the clinical trial.

22 (F) Meals during the clinical trial.

23 (G) Child care costs during the clinical trial.

24 101995. (a) Grant recipients shall report to the board to ensure  
25 the appropriate use of funds within one year of receiving a grant.

26 (b) (1) The board shall report to the Legislature to ensure the  
27 appropriate use of the funds. The report shall include accountability  
28 measures, including, but not limited to, a description of how the  
29 funds were used, an evaluation of the grant program, and  
30 recommendations for the program. This report shall be submitted  
31 by January 1, 2020.

32 (2) The requirement for submitting a report imposed under  
33 paragraph (1) is inoperative on January, 1, 2024, pursuant to  
34 Section 10231.5 of the Government Code.



*California*  
LEGISLATIVE INFORMATION

**AB-1060 Cancer clinical trials.** (2015-2016)

AMENDED IN SENATE JUNE 17, 2015

AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE— 2015–2016 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1060**

**Introduced by Assembly Member Bonilla**

**February 26, 2015**

An act to ~~amend Section 491 of the Business and Professions Code, relating to professions and vocations; add Chapter 2 (commencing with Section 101990) to Part 6 of Division 101 of the Health and Safety Code, relating to cancer, and making an appropriation therefor.~~

**LEGISLATIVE COUNSEL'S DIGEST**

AB 1060, as amended, Bonilla. ~~Professions and vocations: licensure. Cancer clinical trials.~~

*Existing law establishes the scope and function of the California Health and Human Services Agency, which includes departments charged with administering laws pertaining to public health and social services, among other things. Existing law also establishes the Inclusion of Women and Minorities in Clinical Research*

*Act, which is designed to promote the inclusion of women and minority groups in clinical research, including clinical trials.*

*This bill would create the Cancer Clinical Trials Foundation in the Health and Human Services Agency, to be governed by a board of trustees. Members of the board would be appointed as specified. The bill would also create the Cancer Clinical Trials Fund, and would continuously appropriate this fund to the board, thereby making an appropriation. The bill would authorize the board to solicit and receive money, as specified. The bill would require the board, upon contribution of an unspecified amount of money to the fund, to establish the Cancer Clinical Trials Grant Program, in order to increase patient access to cancer clinical trials in specified populations. The bill would require that grant money be used for designated purposes, and would also require grant recipients to report to the board. The bill would require the board to report to the Legislature, as specified. This bill would make related findings.*

~~Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes a board to suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued. Existing law requires the board, upon suspension or revocation of a license, to provide the ex-licensee with certain information pertaining to rehabilitation, reinstatement, or reduction of penalty, as specified:~~

~~This bill would require the board to provide that information through first-class mail and by email if the board has an email address on file for the ex-licensee.~~

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

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

### **SECTION 1.** *The Legislature finds and declares the following:*

*(a) Almost 50 percent of clinical trial studies are not finished in time due to low patient participation, recruitment and navigation difficulties, and other barriers for patients. Due to economic and socioeconomic circumstances and lack of patient knowledge, clinical oncology trial participation and retention are both very low as they relate to eligible participants.*

*(b) Overall, only 3 percent of eligible cancer patients participate in clinical trials, and of those only 5 percent of trial participants are from racial or ethnic minority communities.*

*(c) One barrier that prevents patients from participating in federal Food and Drug*

*Administration clinical trials is finances. Patients of low to moderate income are often unable to bear the burden of the ancillary costs of participating, such as airfare, lodging, rental cars, and fuel.*

*(d) The American Medical Association conducted a study on cancer trial participation. The study found that from 1996 to 2002, of the 75,215 patients enrolled in the National Cancer Institute trials for breast, lung, colorectal, and prostate cancers, only 3.1 percent were Hispanic, 9.2 percent were Black, and 1.9 percent were Asian or Pacific Islanders, while 85.6 percent were White. This lack of diversity is alarming because of its impact on researchers' ability to evaluate the effect of new treatments on different populations. It also speaks to a lack of access to potentially lifesaving trials for a large portion of the population.*

*(e) It is the intent of the Legislature to establish a program to enable willing patients of low to moderate income to participate in cancer clinical trials in order to boost participation rates, ensure these trials are widely accessible, improve the development of cancer therapies, and enhance innovation.*

**SEC. 2.** *Chapter 2 (commencing with Section 101990) is added to Part 6 of Division 101 of the Health and Safety Code, to read:*

**CHAPTER 2. Cancer Clinical Trials**

**101990.** *(a) "Board" means the Board of Trustees of the Cancer Clinical Trials Foundation.*

*(b) "Foundation" means the Cancer Clinical Trials Foundation.*

*(c) "Fund" means the Cancer Clinical Trials Fund.*

**101991.** *(a) The agency shall establish a nonprofit public benefit corporation, to be known as the Cancer Clinical Trials Foundation, that shall be governed by a board consisting of a total of five members. Three members shall be appointed by the Governor. Of these members, one shall be from a public cancer research institution, and one shall be from a private cancer research institution. One member shall be appointed by the Speaker of the Assembly. One member shall be appointed by the President pro Tempore of the Senate.*

*(b) The Governor shall appoint the president of the board from among those members appointed by the Governor, the Speaker of the Assembly, and the President pro Tempore of the Senate.*

*(c) Members of the board shall serve without compensation but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the board.*

*(d) The foundation shall be subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the*

*Corporations Code), except that if there is a conflict with this chapter and the Nonprofit Public Benefit Corporation Law, this chapter shall prevail.*

*(e) The California Health and Human Services Agency shall determine which department in the agency shall administer the foundation.*

**101992.** *(a) Of the members of the board first appointed by the Governor pursuant to Section 101991, one member shall be appointed to serve a two-year term, one member shall be appointed to serve a three-year term, and one member shall be appointed to serve a four-year term.*

*(b) Of the members of the board first appointed by the Speaker of the Assembly and the President pro Tempore of the Senate pursuant to Section 101991, each member shall be appointed to serve a four-year term.*

*(c) Upon the expiration of the initial appointments for the board, each member shall be appointed to serve a four-year term.*

**101993.** *(a) There is hereby created the Cancer Clinical Trials Fund. Notwithstanding Section 13340 of the Government Code, all money in the fund is continuously appropriated to the board without regard to fiscal years, for the administration and support of the program created pursuant to this chapter.*

*(b) The Cancer Clinical Trials Foundation may solicit and receive funds from business, industry, foundations, and other private and public sources for the purpose of administering the Cancer Clinical Trials Grant Program to increase patient access to cancer clinical trials.*

*(c) The board shall use no more than 20 percent of funds made available for the Cancer Clinical Trials Grant Program for administrative costs.*

**101994.** *(a) Upon contribution of an unspecified amount of moneys to the foundation, the board shall establish the Cancer Clinical Trials Grant Program to increase patient access to cancer clinical trials in underserved or disadvantaged communities and populations, including among women and patients from racial and ethnic minority communities. The board shall determine the criteria to award grants, and may award grants to either or both of the following:*

*(1) Public and private research institutions and hospitals that conduct cancer clinical trials approved by the federal Food and Drug Administration.*

*(2) Nonprofit organizations described in Section 501(c)(3) of the Internal Revenue Code of 1954 that are exempt from income tax under Section 501(a) of that code and that specialize in direct patient support for improved clinical trial enrollment and retention.*

*(b) Grants awarded pursuant to subdivision (a) shall be used for activities to increase patient access to cancer clinical trials, including, but not limited to, any*

*of the following:*

- (1) Patient navigator services or programs.*
- (2) Education and community outreach.*
- (3) Patient-friendly technical tools to assist patients in identifying available clinical trials.*
- (4) Translation and interpretation services of clinical trial information.*
- (5) Counseling services for clinical trial participants.*
- (6) Well-being services for clinical trial participants, including, but not limited to, physical therapy, pain management, stress management, and nutrition management.*
- (7) Payment of ancillary costs for patients and caregivers, including, but not limited to:*
  - (A) Airfare during the clinical trial.*
  - (B) Lodging during the clinical trial.*
  - (C) Rental cars during the clinical trial.*
  - (D) Fuel during the clinical trial.*
  - (E) Local transportation via bus, train, or other public transportation during the clinical trial.*
  - (F) Meals during the clinical trial.*
  - (G) Child care costs during the clinical trial.*

**101995.** *(a) Grant recipients shall report to the board to ensure the appropriate use of funds within one year of receiving a grant.*

*(b) (1) The board shall report to the Legislature to ensure the appropriate use of the funds. The report shall include accountability measures, including, but not limited to, a description of how the funds were used, an evaluation of the grant program, and recommendations for the program. This report shall be submitted by January 1, 2020.*

*(2) The requirement for submitting a report imposed under paragraph (1) is inoperative on January 1, 2024, pursuant to Section 10231.5 of the Government Code.*

~~SECTION 1. Section 491 of the Business and Professions Code is amended to read:~~

~~491.(a) Upon suspension or revocation of a license by a board on one or more of~~

~~the grounds specified in Section 490, the board shall:~~

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

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

~~(b) Subdivision (a) shall be satisfied through first-class mail and by email if the board has an email address on file for the ex-licensee.~~

**AB**

**1351**

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## SENATE COMMITTEE ON PUBLIC SAFETY

Senator Loni Hancock, Chair

2015 - 2016 Regular

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**Bill No:** AB 1351                      **Hearing Date:** July 14, 2015  
**Author:** Eggman  
**Version:** June 1, 2015  
**Urgency:** No                                      **Fiscal:** Yes  
**Consultant:** JM

**Subject:** *Deferred Entry of Judgment: Pretrial Diversion*

### HISTORY

**Source:** Drug Policy Alliance  
Immigrant Legal Resource Center

**Prior Legislation:** SB 1369 (Kopp), Chapter 1132, Statutes of 1996

**Support:** American Civil Liberties Union of California (Co-Sponsor); Coalition for Humane Immigrant Rights of Los Angeles (Co-Sponsor); Mexican American Legal Defense and Education Fund (MALDEF) (Co-Sponsor); National Council of La Raza (Co-Sponsor); African Advocacy Network; Asian Americans Advancing Justice – Asian Law Caucus; Asian Americans Advancing Justice – L.A. ; Asian Law Alliance; California Attorneys for Criminal Justice; California Immigrant Policy Center; California Partnership; California Public Defenders Association; California Rural Legal Assistance Foundation; Californians for Safety and Justice; Californians United for a Responsible Budget; Central American Resource Center – Los Angeles; Chinese for Affirmative Action; Community United Against Violence; Congregations Building Community; Del Sol Group; Dolores Street Community Services; Faith in Action Kern County; Friends Committee on Legislation of California; Harvey Milk LGBT Democratic Club; Human Rights Watch; Immigration Action Group; Institute for Justice; Lawyers' Committee for Civil Rights of the San Francisco Bay Area; Legal Services for Prisoners with Children; Los Angeles Regional Reentry Partnership; Justice Not Jails; MAAC; Mujeres Unidas y Activas; National Association of Social Workers – California Chapter; National Day Laborer Organizing Network; National Immigration Law Center; Pangea Legal Services; PICO California; Placer People of Faith; Presente.org; Progressive Christians Uniting; Red Mexicana de Lideres y Organizaciones Migrantes; Santa Clara County Public Defender's Office; Silicon Valley De-Bug; Solutions for Immigrants; William C. Velasquez Institute; Vital Immigrant Defense Advocacy and Services (VIDAS); One private individual

**Opposition:** California District Attorneys Association; California State Board of Pharmacy; California State Sheriffs' Association

**Assembly Floor Vote:**

47 - 30

**PURPOSE**

***The purpose of this bill is to: 1) convert the existing system of deferred entry of judgment (DEJ) for qualified drug possession offenders - generally those with no prior convictions or non-drug current charges - to a true diversion system, under which eligible defendants are admitted to an education and treatment program prior to conviction and granted of a dismissal of the charges upon successful completion of the program; 2) allow persons previously convicted of a drug possession offense, or who have previously participated in a diversion or DEJ program, or those for whom parole or probation has been revoked may participate in a diversion program; and 3) set the length of the program from six months to one year, except that the court can extend that time for good cause.***

*Existing law:*

Provides that the entry of judgment may be deferred for a defendant charged with specific controlled substance offenses if the defendant meets specific criteria, including that he or she has no prior convictions for any offense involving a controlled substance and no prior felony convictions within five years. (Pen. Code § 1000.)

Provides that upon successful completion of a deferred entry of judgment, the arrest upon which the judgment was deferred shall be deemed to never have occurred. The defendant may in response to any question in regard to his or her prior criminal record that he or she was not arrested or granted deferred entry of judgment, except as specified. (Pen. Code § 1000.4, subd. (a).)

States that a record pertaining to an arrest resulting in successful completion of a deferred entry of judgment program shall not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate. (Pen. Code § 1000.4, subd. (a).)

Requires that a defendant be advised that regardless of his or her successful completion of a deferred entry of judgment program, the arrest upon which the case was based, may be disclosed by the Department of Justice (DOJ) in response to any peace officer application request, and that the defendant is obligated to disclose the arrest in response to any direct question on the application. (Pen. Code § 1000.4, subd. (b).)

Provides that a superior court may administer a pre-plea drug diversion program if the court, the county district attorney and the public defender agree. (Pen. Code § 1000.5.)

*This bill:*

Changes the existing deferred entry of judgment (DEJ) program for specified offenses involving personal use or possession of controlled substances into a pretrial drug diversion program.

Requires, to be eligible for diversion, that the defendant must not have a prior conviction for a controlled substance offense other than the offenses that may be diverted; the offense charged must not have involved violence or threatened violence; there must be no evidence in the current incident that the defendant committed a drug offense other than an offense that may be diverted; and the defendant must not have any conviction for a serious or violent felony, as define, within five years of the current charges.

Provides that a defendant's participation in pretrial diversion shall not constitute a conviction or an admission of guilt in any action or proceeding.

Changes the minimum time allowed prior to dismissal of the case from 18 months to six months, and the maximum time the proceedings in the case can be suspended from three years to one year, except the court can extend the length of the program for good cause.

Provides that if the prosecuting attorney, the court, or the probation department believes that the defendant is performing unsatisfactorily in the program, or that he or she has been convicted of an offense that indicates the defendant is prone to violence, or the defendant is convicted of a felony, the prosecuting attorney, the court, or the probation department may move for termination of diversion.

Provides that if the court finds that the defendant is not performing satisfactorily in the assigned program, or the court finds that the defendant has been convicted of a specified type of crime, the court shall reinstate the criminal charge or charges and schedule the matter for further proceedings.

States if the defendant has completed pretrial diversion, at the end of that period, the criminal charge or charges shall be dismissed. Upon successful completion of a pretrial diversion program, the arrest upon which the defendant was diverted shall be deemed to have never occurred.

Retains provisions in the current DEJ law that are consistent with to pre-trial diversion.

States that a participant in a pretrial diversion program or a preguilty plea program shall be allowed, under the direction of a licensed practitioner, to use medications - including but not limited to methadone, buprenorphine and levoalphacetylmethadol (LAAM) - to treat substance use disorders if the participant allows release of his or her medical records to the court for the limited purpose of determining whether or not the participant is using such medications under the direction of a licensed practitioner and is in compliance with the pretrial diversion or preguilty plea program rules.

#### RECEIVERSHIP/OVERCROWDING CRISIS AGGRAVATION

For the past eight years, this Committee has scrutinized legislation referred to its jurisdiction for any potential impact on prison overcrowding. Mindful of the United States Supreme Court ruling and federal court orders relating to the state's ability to provide a constitutional level of health care to its inmate population and the related issue of prison overcrowding, this Committee has applied its "ROCA" policy as a content-neutral, provisional measure necessary to ensure that the Legislature does not erode progress in reducing prison overcrowding.

On February 10, 2014, the federal court ordered California to reduce its in-state adult institution population to 137.5% of design capacity by February 28, 2016, as follows:

- 143% of design bed capacity by June 30, 2014;
- 141.5% of design bed capacity by February 28, 2015; and,
- 137.5% of design bed capacity by February 28, 2016.

In February of this year the administration reported that as “of February 11, 2015, 112,993 inmates were housed in the State’s 34 adult institutions, which amounts to 136.6% of design bed capacity, and 8,828 inmates were housed in out-of-state facilities. This current population is now below the court-ordered reduction to 137.5% of design bed capacity.”( Defendants’ February 2015 Status Report In Response To February 10, 2014 Order, 2:90-cv-00520 KJM DAD PC, 3-Judge Court, *Coleman v. Brown, Plata v. Brown* (fn. omitted).

While significant gains have been made in reducing the prison population, the state now must stabilize these advances and demonstrate to the federal court that California has in place the “durable solution” to prison overcrowding “consistently demanded” by the court. (Opinion Re: Order Granting in Part and Denying in Part Defendants’ Request For Extension of December 31, 2013 Deadline, NO. 2:90-cv-0520 LKK DAD (PC), 3-Judge Court, *Coleman v. Brown, Plata v. Brown* (2-10-14). The Committee’s consideration of bills that may impact the prison population therefore will be informed by the following questions:

- Whether a proposal erodes a measure which has contributed to reducing the prison population;
- Whether a proposal addresses a major area of public safety or criminal activity for which there is no other reasonable, appropriate remedy;
- Whether a proposal addresses a crime which is directly dangerous to the physical safety of others for which there is no other reasonably appropriate sanction;
- Whether a proposal corrects a constitutional problem or legislative drafting error; and
- Whether a proposal proposes penalties which are proportionate, and cannot be achieved through any other reasonably appropriate remedy.

## COMMENTS

### 1. Need for This Bill

According to the author:

This bill seeks to limit harsh consequences to immigrants by changing the current process for nonviolent, misdemeanor drug offenses from deferred entry of judgment (DEJ) to pretrial diversion. While the current DEJ process eliminates a conviction if a defendant successfully completes DEJ, the defendant may still face federal consequences, including deportation if the defendant is undocumented, or the prohibition from becoming a U.S. citizen if the defendant is a legal permanent resident. This is systemic injustice to immigrants in this country, but even U.S. citizens may face federal consequences, including loss of federal housing and educational benefits.

Given that President Obama has publicly called for immigration officials to focus on violent, dangerous felons, this bill will have a profoundly positive impact on more than \$2 million undocumented immigrants and the more than 3 million legal permanent residents living in California by eliminating the draconian consequences faced by immigrants who participate in diversion programs in good faith. This bill will keep families together, help people retain eligibility for U.S. citizenship, and also preserve access to other benefits for those who qualify.

## 2. DEJ as Compared to Diversion

Under existing law, a defendant charged with violations of certain specified drug may be eligible to participate in a DEJ program if he or she meets specified criteria. (Pen. Code §§ 1000 et seq.) With DEJ, a defendant must enter a guilty plea and entry of judgment on the defendant's guilty plea is deferred pending successful completion of a program or other conditions. If a defendant placed in a DEJ program fails to complete the program or comply with conditions imposed, the court may resume criminal proceedings and the defendant, having already pleaded guilty, would be sentenced. If the defendant successfully completes DEJ, the arrest shall be deemed to never have occurred and the defendant may indicate in response to any question concerning his or her prior criminal record that he or she was not arrested or granted pretrial diversion for the offense.

Diversion on the other hand suspends the criminal proceedings without requiring the defendant to enter a plea. Diversion also requires the defendant to successfully complete a program and other conditions imposed by the court. Unlike DEJ however, if a defendant does not successfully complete the diversion program, criminal proceedings resume but the defendant, having not entered a plea, may still proceed to trial or enter a plea. If diversion is successfully completed, the criminal charges are dismissed and the defendant may, with certain exceptions, legally answer that he or she has never been arrested or charged for the diverted offense.

In order to avoid adverse immigration consequences, diversion of an offense is preferable to DEJ because the defendant is not required to plead guilty in order to participate in the program. Having a conviction for possession of controlled substances, even if dismissed, could trigger deportation proceedings or prevent a person from becoming a U.S. citizen. (*Paredes-Urrestarazu v. U.S. INS* (9th Cir. 1994) 36 F3d. 801.) This bill seeks to minimize the potential exposure to adverse immigration consequences for persons who commit minor drug possession offenses by re-establishing a pretrial diversion program for minor drug possession.

Prior to 1997, the program pursuant to Penal Code § 1000 et seq. was a pretrial diversion program. SB 1369 (Kopp), Chapter 1132, Statutes of 1996, changed the diversion program to a DEJ program. Proponents of SB 1369 and its DEJ provisions argued that DEJ would provide more effective drug treatment than diversion courts. While many involved in DEJ and drug court programs believe in the effectiveness of the programs, research has not established the superiority of DEJ or drug court programs over other forms of drug treatment. SB 1369 did include a provision allowing any county to elect to operate a drug possession diversion program, with the approval of the presiding judge, the district attorney and the public defender. It is unknown whether studies have been done comparing the effectiveness of DEJ and true diversion, including long-term outcomes.

## 3. Drug Treatment in the Courts

Recent research has considered the effectiveness of varying forms of court-based drug treatment with other forms or sources of treatment demand.<sup>1</sup> UCLA studies of the effectiveness of SACPA – Proposition 36 of 2000 were released in 2003 and 2006.<sup>2</sup> SACPA requires drug treatment without incarceration for non-violent drug possession. UCLA found that the SACPA model was

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<sup>1</sup> Much of the basis for this comment is a report or monograph written by Senate Fellow, Bethany Renfree at the request of Senator Jackson.

<sup>2</sup> [http://www.uclaisap.org/prop36/documents/sacpa\\_costanalysis.pdf](http://www.uclaisap.org/prop36/documents/sacpa_costanalysis.pdf)

as effective as drug court or voluntary treatment models and produced \$2.50 in savings from every dollar spent. Improvements in funding allocations and programs would have produced better results.

State funding for SACPA ended in 2006. Individual counties must bear the costs of the program. The California Society of Addiction Medicine has more recently found that SACPA produced positive results, including for participants who did not complete the full program.

An extensive 2007 study of 474 drug offenders in drug court in Maricopa County Arizona (the Phoenix area) compared the outcomes in drug court treatment for persons who were subject to jail sanctions against those who were not subject to sanctions. The study found that the threat of jail sanctions did not affect the participant's rate of retention in or completion of the program.

There has been some published research concluding that specific drug court models may be effective in reducing drug abuse, at least in the short term. The model is the HOPE program in Hawaii, in which the court engages in very close, direct and constant monitoring of participants in the program. Participants are drug tested frequently and must follow program conditions or be subject to immediate, short-term incarceration.

#### **4. Deferred Entry of Judgment or Pre-Plea Diversion and the Substance Abuse and Crime Prevention Act of 2000 (SACPA – Proposition 36 of the 2000 General Election)**

Deferred entry of judgment and true pre-plea diversion (DEJ) are distinct programs from the Substance Abuse and Crime Prevention Act – SACPA (“Prop 36”) – program. After enactment of SACPA in 2000, the California Attorney General opined that SACPA did not repeal DEJ by implication. (84 Ops. Cal. Atty. Gen. 85 – 2001.) Deferred entry of judgment – as the name of the program denotes – applies prior to imposition of judgment and sentence. SACPA is a probation program under which a person convicted of a non-violent drug possession offense must be offered treatment, without incarceration, on probation. Further, the offenses covered by the two programs, while overlapping to a great extent, are not the same. The offenses covered under SACPA are broader than those included under DEJ.

The procedures for the programs are also different. The prosecutor determines if the defendant meets the eligibility requirements for DEJ. The trial court cannot overturn the prosecutor's determination of ineligibility. If the defendant disagrees with the prosecutor's determination, his or her only remedy is by appeal to the Court of Appeal. In contrast, the trial court determines whether a convicted defendant is eligible for probation under SACPA. A defendant must plead guilty before being placed in a DEJ program. A person who is convicted at trial of non-violent drug possession is eligible for SACPA, unless a disqualifying factor, such as possession of a weapon at the time of the offense. A defendant who fails in a DEJ program is subject to imposition of judgment and sentencing. However, if the defendant's conviction is for a non-violent drug possession offense, he or she shall be offered treatment on probation under SACPA. (*In re Scoggins* (2001) 94 Cal.App.4th 650, 652-658.) As the covered offenses and eligibility requirements are broader under SACPA than DEJ, it is most likely that a person who fails in DEJ would be eligible for SACPA.

## 5. Argument in Support

The Immigrant Legal Resource Center (ILRC) argues:

According to data published by Syracuse University, over 250,000 people have been deported from the U.S. for nonviolent drug offenses since 2008. A nonviolent drug offense was the cause of deportation for more than one in every ten people deported in 2013 for any reason.

This is particularly devastating to families in California, which is the most immigrant-rich state in America. One out of every four persons living in the state is foreign-born. Half of California's children live in households headed by at least one foreign-born parent – and the majority of these children are U.S. citizens. It is estimated that 50,000 parents of U.S. citizen children were deported in a little over two years, leaving many children parentless. Deportation due to minor drug offenses destroys California families.

AB 1351 will amend Penal Code 1000 et seq. to allow courts to order pre-trial diversion, rather than require a guilty plea. This was the way that PC 1000 worked until 1997. Because there will be no guilty plea, there will be no 'conviction' for federal immigration purposes. For any person who fails to adhere to conditions of a pre-trial diversion program, the court could reinstate the charges and schedule proceedings pursuant to existing law. Diversion will not be allowed for any person charged with drug sale, or possession for sale, nor will be allowed for persons who involve minors in drug sales or provide drugs to minors.

## 6. Argument in Opposition

According to the California District Attorneys Association:

AB 1351 would turn [the current] process on its head, allowing the defendant to enter a treatment program before entering a plea. If the program was not completed successfully, only then would criminal proceedings actually begin. From a practical standpoint, this creates tremendous problems for prosecutors, as it becomes much more difficult to locate witnesses and maintain evidence many months after the offense has occurred.

Additionally, AB 1351 would reduce the length of drug treatment programs down to one-third of what they currently are. Right now, someone participates in drug diversion for 18 months to 36 months. This bill would only allow 6 to 12 months of treatment. Much of the success of drug diversion is based on this long-term treatment. Reducing the required length of treatment might lead to more people completing their programs, but it also reduces the likelihood that those programs will actually have positive long-term outcomes for drug offenders. It's unclear how reducing the amount of drug treatment that someone receives would have any positive impact on their immigration consequences.

Further, AB 1351 removes many of the pre-requisites for participation in drug diversion. Currently, a defendant must not have any prior drug convictions in order to be eligible for drug diversion. Under AB 1351, as long as the prior

offenses were all diversion-eligible offenses, there is no limit to the number of drug offenses someone could accumulate while maintaining drug diversion eligibility. This bill also eliminates the requirement that a defendant have no felony convictions in the previous five years, instead only requiring that a defendant not have any prior serious or violent felonies.

**7. Related Legislation**

AB 1352 (Eggman) requires a court to allow a defendant to withdraw his or her guilty or nolo contendere plea and thereafter dismiss the case upon a finding that the case was dismissed after the defendant completed DEJ and that the plea may result in the denial of, or loss to, the defendant denial of any employment, benefit, license, or certificate, as specified. AB 1352 will be heard by this Committee today.

-- END --

AMENDED IN ASSEMBLY JUNE 1, 2015

AMENDED IN ASSEMBLY APRIL 16, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1351**

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**Introduced by Assembly Member Eggman**  
*(Coauthor: Senator Hall)*

February 27, 2015

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An act to amend Sections 1000, 1000.1, 1000.2, 1000.3, 1000.4, 1000.5, and 1000.6 of the Penal Code, relating to deferred entry of judgment.

LEGISLATIVE COUNSEL'S DIGEST

AB 1351, as amended, Eggman. Deferred entry of judgment: pretrial diversion.

Existing law allows individuals charged with specified crimes to qualify for deferred entry of judgment. A defendant qualifies if he or she has no conviction for any offense involving controlled substances, the charged offense did not involve violence, there is no evidence of a violation relating to narcotics or restricted dangerous drugs other than a violation that qualifies for the program, the defendant's record does not indicate that probation or parole has ever been revoked without being completed, and the defendant's record does not indicate that he or she has been granted diversion, deferred entry of judgment, or was convicted of a felony within 5 years prior to the alleged commission of the charged offense.

Under the existing deferred entry of judgment program, an eligible defendant may have entry of judgment deferred, upon pleading guilty to the offenses charged and entering a drug treatment program for 18

months to 3 years. If the defendant does not perform satisfactorily in the program, does not benefit from the program, is convicted of specified crimes, or engages in criminal activity rendering him or her unsuitable for deferred entry of judgment, the defendant's guilty plea is entered and the court enters judgment and proceeds to schedule a sentencing hearing. If the defendant completes the program, the criminal charges are dismissed. Existing law allows the presiding judge of the superior court, with the district attorney and public defender, to establish a pretrial diversion drug program.

This bill would change the deferred entry of judgment program into a pretrial diversion program. Under the pretrial diversion program created by this bill, a defendant would qualify if he or she has no prior conviction for any offense involving controlled substances other than the offenses that qualify for diversion, the charged offense did not involve violence, there is no evidence of a violation relating to narcotics or restricted dangerous drugs other than a violation that qualifies for the program and the defendant has no prior conviction for a serious or violent felony within 5 years prior to the alleged commission of the charged offense.

Under the pretrial diversion program created by this bill, a qualifying defendant would ~~not enter a guilty plea, but instead~~ *enter a not guilty plea, and* would suspend the proceedings in order to enter a drug treatment program for 6 months to ~~one year~~ *year, or longer if requested by the defendant with good cause*. If the defendant does not perform satisfactorily in the program or is convicted of specified crimes, the court would terminate the program and the criminal proceedings would be reinstated. If the defendant completes the program, the criminal charges would be dismissed.

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

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

1 SECTION 1. Section 1000 of the Penal Code is amended to  
2 read:  
3 1000. (a) This chapter shall apply whenever a case is before  
4 any court upon an accusatory pleading for a violation of Section  
5 11350, 11357, 11364, or 11365, paragraph (2) of subdivision (b)  
6 of Section 11375, Section 11377, or Section 11550 of the Health  
7 and Safety Code, or subdivision (b) of Section 23222 of the Vehicle

1 Code, or Section 11358 of the Health and Safety Code if the  
2 marijuana planted, cultivated, harvested, dried, or processed is for  
3 personal use, or Section 11368 of the Health and Safety Code if  
4 the narcotic drug was secured by a fictitious prescription and is  
5 for the personal use of the defendant and was not sold or furnished  
6 to another, or subdivision (d) of Section 653f if the solicitation  
7 was for acts directed to personal use only, or Section 381 or  
8 subdivision (f) of Section 647 of the Penal Code, if for being under  
9 the influence of a controlled substance, or Section 4060 of the  
10 Business and Professions Code, and it appears to the prosecuting  
11 attorney that, except as provided in subdivision (b) of Section  
12 11357 of the Health and Safety Code, all of the following apply  
13 to the defendant:

14 (1) The defendant has no prior conviction for any offense  
15 involving controlled substances other than the offenses listed in  
16 this subdivision.

17 (2) The offense charged did not involve a crime of violence or  
18 threatened violence.

19 (3) There is no evidence of a violation relating to narcotics or  
20 restricted dangerous drugs other than a violation of the sections  
21 listed in this subdivision.

22 (4) The defendant has no prior conviction within five years prior  
23 to the alleged commission of the charged offense for a serious  
24 felony, as defined in subdivision (c) of Section 1192.7, or a violent  
25 felony, as defined in subdivision (c) of Section 667.5.

26 (b) The prosecuting attorney shall review his or her file to  
27 determine whether or not paragraphs (1) to (4), inclusive, of  
28 subdivision (a) apply to the defendant. If the defendant is found  
29 eligible, the prosecuting attorney shall file with the court a  
30 declaration in writing or state for the record the grounds upon  
31 which the determination is based, and shall make this information  
32 available to the defendant and his or her attorney. This procedure  
33 is intended to allow the court to set the hearing for pretrial diversion  
34 of judgment at the arraignment. If the defendant is found ineligible  
35 for pretrial diversion, the prosecuting attorney shall file with the  
36 court a declaration in writing or state for the record the grounds  
37 upon which the determination is based, and shall make this  
38 information available to the defendant and his or her attorney. The  
39 sole remedy of a defendant who is found ineligible for pretrial  
40 diversion is a postconviction appeal.

1 (c) All referrals for pretrial diversion granted by the court  
2 pursuant to this chapter shall be made only to programs that have  
3 been certified by the county drug program administrator pursuant  
4 to Chapter 1.5 (commencing with Section 1211) of Title 8, or to  
5 programs that provide services at no cost to the participant and  
6 have been deemed by the court and the county drug program  
7 administrator to be credible and effective. The defendant may  
8 request to be referred to a program in any county, as long as that  
9 program meets the criteria set forth in this subdivision.

10 (d) Pretrial diversion for an alleged violation of Section 11368  
11 of the Health and Safety Code shall not prohibit any administrative  
12 agency from taking disciplinary action against a licensee or from  
13 denying a license. Nothing in this subdivision shall be construed  
14 to expand or restrict the provisions of Section 1000.4.

15 (e) Any defendant who is participating in a program referred to  
16 in this section may be required to undergo analysis of his or her  
17 urine for the purpose of testing for the presence of any drug as part  
18 of the program. However, ~~urine analysis~~ *urinalysis* results shall  
19 not be admissible as a basis for any new criminal prosecution or  
20 proceeding.

21 SEC. 2. Section 1000.1 of the Penal Code is amended to read:

22 1000.1. (a) If the prosecuting attorney determines that this  
23 chapter may be applicable to the defendant, he or she shall advise  
24 the defendant and his or her attorney in writing of that  
25 determination. This notification shall include all of the following:

26 (1) A full description of the procedures for pretrial diversion.

27 (2) A general explanation of the roles and authorities of the  
28 probation department, the prosecuting attorney, the program, and  
29 the court in the process.

30 (3) A clear statement that the court may grant pretrial diversion  
31 with respect to any crime specified in subdivision (a) of Section  
32 1000 that is charged, provided that the defendant *pleads not guilty*  
33 *to the charge or charges*, waives the right to a speedy preliminary  
34 hearing, if applicable, and that upon the defendant's successful  
35 completion of a program, as specified in subdivision (c) of Section  
36 1000, the positive recommendation of the program authority and  
37 the motion of the defendant, prosecuting attorney, the court, or the  
38 probation department, but no sooner than six months and no later  
39 than one year from the date of the defendant's referral to the

1 program, the court shall dismiss the charge or charges against the  
2 defendant.

3 (4) A clear statement that upon any failure of treatment or  
4 condition under the program, or any circumstance specified in  
5 Section 1000.3, the prosecuting attorney or the probation  
6 department or the court on its own may make a motion to the court  
7 to terminate pretrial diversion and schedule further proceedings  
8 as otherwise provided in this code.

9 (5) An explanation of criminal record retention and disposition  
10 resulting from participation in the pretrial diversion program and  
11 the defendant's rights relative to answering questions about his or  
12 her arrest and pretrial diversion following successful completion  
13 of the program.

14 (b) If the defendant consents and waives his or her right to a  
15 speedy trial and a speedy preliminary hearing, if applicable, the  
16 court may refer the case to the probation department or the court  
17 may summarily grant pretrial diversion. When directed by the  
18 court, the probation department shall make an investigation and  
19 take into consideration the defendant's age, employment and  
20 service records, educational background, community and family  
21 ties, prior controlled substance use, treatment history, if any,  
22 demonstrable motivation, and other mitigating factors in  
23 determining whether the defendant is a person who would be  
24 benefited by education, treatment, or rehabilitation. The probation  
25 department shall also determine which programs the defendant  
26 would benefit from and which programs would accept the  
27 defendant. The probation department shall report its findings and  
28 recommendations to the court. The court shall make the final  
29 determination regarding education, treatment, or rehabilitation for  
30 the defendant. If the court determines that it is appropriate, the  
31 court shall grant pretrial diversion if the defendant *pleads not guilty*  
32 *to the charge or charges and* waives the right to a speedy trial and  
33 to a speedy preliminary hearing, if applicable.

34 (c) (1) No statement, or any information procured therefrom,  
35 made by the defendant to any probation officer or drug treatment  
36 worker, that is made during the course of any investigation  
37 conducted by the probation department or treatment program  
38 pursuant to subdivision (b), and prior to the reporting of the  
39 probation department's findings and recommendations to the court,

1 shall be admissible in any action or proceeding brought subsequent  
2 to the investigation.

3 (2) No statement, or any information procured therefrom, with  
4 respect to the specific offense with which the defendant is charged,  
5 that is made to any probation officer or drug program worker  
6 subsequent to the granting of pretrial diversion shall be admissible  
7 in any action or proceeding.

8 (d) A defendant's participation in pretrial diversion pursuant to  
9 this chapter shall not constitute a conviction or an admission of  
10 guilt for any purpose.

11 SEC. 3. Section 1000.2 of the Penal Code is amended to read:

12 1000.2. (a) The court shall hold a hearing and, after  
13 consideration of any information relevant to its decision, shall  
14 determine if the defendant consents to further proceedings under  
15 this chapter and if the defendant should be granted pretrial  
16 diversion. If the defendant does not consent to participate in pretrial  
17 diversion the proceedings shall continue as in any other case.

18 (b) At the time that pretrial diversion is granted, any bail bond  
19 or undertaking, or deposit in lieu thereof, on file by or on behalf  
20 of the defendant shall be exonerated, and the court shall enter an  
21 order so directing.

22 (c) The period during which pretrial diversion is granted shall  
23 be for no less than six months nor longer than one year. *However,*  
24 *the defendant may request and the court shall grant, for good*  
25 *cause shown, an extension of time to complete a program specified*  
26 *in subdivision (c) of Section 1000. Progress reports shall be filed*  
27 *by the probation department with the court as directed by the court.*

28 SEC. 4. Section 1000.3 of the Penal Code is amended to read:

29 1000.3. (a) If it appears to the prosecuting attorney, the court,  
30 or the probation department that the defendant is performing  
31 unsatisfactorily in the assigned program, or that the defendant is  
32 convicted of an offense that reflects the defendant's propensity for  
33 violence, or the defendant is convicted of a felony, the prosecuting  
34 attorney, the court on its own, or the probation department may  
35 make a motion for termination from pretrial diversion.

36 (b) After notice to the defendant, the court shall hold a hearing  
37 to determine whether pretrial diversion shall be terminated.

38 (c) If the court finds that the defendant is not performing  
39 satisfactorily in the assigned program, or the court finds that the  
40 defendant has been convicted of a crime as indicated in subdivision

1 (a) the court shall ~~reinstate the criminal charge or charges and~~  
2 schedule the matter for further proceedings as otherwise provided  
3 in this code.

4 (d) If the defendant has completed pretrial diversion, at the end  
5 of that period, the criminal charge or charges shall be dismissed.

6 (e) Prior to dismissing the charge or charges or terminating  
7 pretrial diversion, the court shall consider the defendant's ability  
8 to pay and whether the defendant has paid a diversion restitution  
9 fee pursuant to Section 1001.90, if ordered, and has met his or her  
10 financial obligation to the program, if any. As provided in Section  
11 1203.1b, the defendant shall reimburse the probation department  
12 for the reasonable cost of any program investigation or progress  
13 report filed with the court as directed pursuant to Sections 1000.1  
14 and 1000.2.

15 SEC. 5. Section 1000.4 of the Penal Code is amended to read:

16 1000.4. (a) Any record filed with the Department of Justice  
17 shall indicate the disposition in those cases referred to pretrial  
18 diversion pursuant to this chapter. Upon successful completion of  
19 a pretrial diversion program, the arrest upon which the defendant  
20 was diverted shall be deemed to have never occurred. The  
21 defendant may indicate in response to any question concerning his  
22 or her prior criminal record that he or she was not arrested or  
23 granted pretrial diversion for the offense, except as specified in  
24 subdivision (b). A record pertaining to an arrest resulting in  
25 successful completion of a pretrial diversion program shall not,  
26 without the defendant's consent, be used in any way that could  
27 result in the denial of any employment, benefit, license, or  
28 certificate.

29 (b) The defendant shall be advised that, regardless of his or her  
30 successful completion of the pretrial diversion program, the arrest  
31 upon which pretrial diversion was based may be disclosed by the  
32 Department of Justice in response to any peace officer application  
33 request and that, notwithstanding subdivision (a), this section does  
34 not relieve him or her of the obligation to disclose the arrest in  
35 response to any direct question contained in any questionnaire or  
36 application for a position as a peace officer, as defined in Section  
37 830.

38 SEC. 6. Section 1000.5 of the Penal Code is amended to read:

39 1000.5. (a) The presiding judge of the superior court, or a  
40 judge designated by the presiding judge, together with the district

1 attorney and the public defender, may agree in writing to establish  
2 and conduct a preguilty plea drug court program pursuant to the  
3 provisions of this chapter, wherein criminal proceedings are  
4 suspended without a plea of guilty for designated defendants. The  
5 drug court program shall include a regimen of graduated sanctions  
6 and rewards, individual and group therapy, ~~urine analysis~~ *urinalysis*  
7 testing commensurate with treatment needs, close court monitoring  
8 and supervision of progress, educational or vocational counseling  
9 as appropriate, and other requirements as agreed to by the presiding  
10 judge or his or her designee, the district attorney, and the public  
11 defender. If there is no agreement in writing for a preguilty plea  
12 program by the presiding judge or his or her designee, the district  
13 attorney, and the public defender, the program shall be operated  
14 as a pretrial diversion program as provided in this chapter.

15 (b) The provisions of Section 1000.3 and Section 1000.4  
16 regarding satisfactory and unsatisfactory performance in a program  
17 shall apply to preguilty plea programs. If the court finds that (1)  
18 the defendant is not performing satisfactorily in the assigned  
19 program, (2) the defendant is not benefiting from education,  
20 treatment, or rehabilitation, (3) the defendant has been convicted  
21 of a crime specified in Section 1000.3, or (4) the defendant has  
22 engaged in criminal conduct rendering him or her unsuitable for  
23 the preguilty plea program, the court shall reinstate the criminal  
24 charge or charges. If the defendant has performed satisfactorily  
25 during the period of the preguilty plea program, at the end of that  
26 period, the criminal charge or charges shall be dismissed and the  
27 provisions of Section 1000.4 shall apply.

28 SEC. 7. Section 1000.6 of the Penal Code is amended to read:

29 1000.6. (a) Where a person is participating in a pretrial  
30 diversion program or a preguilty plea program pursuant to this  
31 chapter, the person shall be allowed, under the direction of a  
32 licensed health care practitioner, to use medications including, but  
33 not limited to, methadone, buprenorphine, or  
34 levoalphacetylmethadol (LAAM) to treat substance use disorders  
35 if the participant allows release of his or her medical records to  
36 the court presiding over the participant's preguilty plea or pretrial  
37 diversion program for the limited purpose of determining whether  
38 or not the participant is using such medications under the direction  
39 of a licensed health care practitioner and is in compliance with the  
40 pretrial diversion or preguilty plea program rules.

1 (b) If the conditions specified in subdivision (a) are met, using  
2 medications to treat substance use disorders shall not be the sole  
3 reason for exclusion from a pretrial diversion or preguilty plea  
4 program. A patient who uses medications to treat substance use  
5 disorders and participates in a preguilty plea or pretrial diversion  
6 program shall comply with all court program rules.

7 (c) A person who is participating in a pretrial diversion program  
8 or preguilty plea program pursuant to this chapter who uses  
9 medications to treat substance use disorders shall present to the  
10 court a declaration from their health care practitioner, or their  
11 health care practitioner's authorized representative, that the person  
12 is currently under their care.

13 (d) Urinalysis results that only establish that a person described  
14 in this section has ingested medication duly prescribed to that  
15 person by his or her physician or psychiatrist, or medications used  
16 to treat substance use disorders, shall not be considered a violation  
17 of the terms of the pretrial diversion or preguilty plea program  
18 under this chapter.

19 (e) Except as provided in subdivisions (a) to (d), inclusive, this  
20 section shall not be interpreted to amend any provisions governing  
21 diversion programs.

**AB**

**1352**

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## SENATE COMMITTEE ON PUBLIC SAFETY

Senator Loni Hancock, Chair

2015 - 2016 Regular

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**Bill No:** AB 1352                      **Hearing Date:** July 14, 2015  
**Author:** Eggman  
**Version:** May 19, 2015  
**Urgency:** No                                      **Fiscal:** Yes  
**Consultant:** JM

**Subject:** *Deferred Entry of Judgment: Withdrawal of Plea*

### HISTORY

**Source:** Drug Policy Alliance; Immigrant Legal Resource Center

**Prior Legislation:** SB 1369 (Kopp), Chapter 1132, Statutes of 1996

**Support:** American Civil Liberties Union of California (Co-Sponsor); Coalition for Humane Immigrant Rights of Los Angeles (Co-Sponsor); Mexican American Legal Defense and Education Fund (MALDEF) (Co-Sponsor); National Council of La Raza (Co-Sponsor); African Advocacy Network; Asian Americans Advancing Justice – Asian Law Caucus; Asian Americans Advancing Justice – L.A.; Asian Law Alliance; California Attorneys for Criminal Justice; California Immigrant Policy Center; California Partnership; California Public Defenders Association; California Rural Legal Assistance Foundation; Californians for Safety and Justice; Californians United for a Responsible Budget; Central American Resource Center – Los Angeles; Chinese for Affirmative Action; Community United Against Violence; Congregations Building Community; Del Sol Group; Dolores Street Community Services; Faith in Action Kern County; Friends Committee on Legislation of California; Harvey Milk LGBT Democratic Club; Human Rights Watch; Immigration Action Group; Institute for Justice; Lawyers' Committee for Civil Rights of the San Francisco Bay Area; Legal Services for Prisoners with Children; Los Angeles Regional Reentry Partnership; Justice Not Jails; MAAC; Mujeres Unidas y Activas; National Association of Social Workers – California Chapter; National Day Laborer Organizing Network; National Immigration Law Center; Pangea Legal Services; PICO California; Placer People of Faith; Presente.org; Progressive Christians Uniting; Red Mexicana de Lideres y Organizaciones Migrantes; Santa Clara County Public Defender's Office; Silicon Valley De-Bug; Solutions for Immigrants William C. Velasquez Institute; Vital Immigrant Defense Advocacy and Services (VIDAS); One private individual

**Opposition:** California District Attorneys Association; California State Board of Pharmacy; California State Sheriffs' Association

## PURPOSE

***The purpose of this bill is to allow any person who has successfully completed a deferred entry of judgment (DEJ) treatment program to obtain dismissal of the plea upon which DEJ was granted, on the basis that the guilty or no-contest plea underlying DEJ may result in a denial of employment benefit, license or certificate, or have adverse immigration consequences, in conflict with the statement in the governing statute that the plea shall not result in “denial of any employment, benefit, license, or certificate.”***

*Existing law:*

Provides that a defendant may qualify for DEJ of specified non-violent drug possession offenses if the following apply to the defendant:

- The defendant has no prior conviction for any offense involving controlled substances;
- The offense charged did not involve a crime of violence or threatened violence;
- There is no evidence of a violation relating to narcotics or restricted dangerous drugs other than a violation of the specified deferrable drug offenses;
- The defendant's record does not indicate that probation or parole has ever been revoked without thereafter being completed;
- The defendant's record does not indicate that he or she has successfully completed or been terminated from diversion or deferred entry of judgment pursuant to this chapter within five years prior to the alleged commission of the charged offense;
- The defendant has no prior felony conviction within five years prior to the alleged commission of the charged offense. (Pen. Code § 1000, subd. (a).)

States that a prosecutor has a duty to determine whether a defendant is eligible for DEJ. The prosecuting attorney shall file with the court a declaration in writing or state for the record the grounds upon which the determination is based, and shall make this information available to the defendant and his or her attorney. This procedure is intended to allow the court to set the hearing for DEJ at the arraignment. (Pen. Code § 1000, subd. (b).)

Requires that all DEJ referrals for DEJ shall be made only to programs that have been certified by the county drug program administrator, or to programs that provide services at no cost to the participant and have been deemed by the court and the county drug program administrator to be credible and effective. The defendant may request to be referred to a program in any county, as long as that program meets the criteria specified. (Pen. Code § 1000, subd. (c).)

Provides that the court shall hold a hearing and, after consideration of any information relevant to its decision, shall determine if the defendant consents to further proceedings and if the defendant should be granted DEJ. If the court does not find that the defendant would be benefit by deferred entry of judgment, or if the defendant does not consent to participate, the proceedings shall continue as in any other case. Deferred entry of judgment shall be granted for no less than 18 months, but no longer than three years. Progress reports shall be filed by the probation department as directed by the court. (Pen. Code § 1000.2.)

Requires, if the defendant has performed satisfactorily in the DEJ program, the criminal charge or charges shall be dismissed. If the defendant does not perform satisfactorily, the court shall find the defendant guilty pursuant to his or her plea, enter judgment and set a sentencing hearing. (Pen. Code § 1000.3.)

States that upon successful completion of DEJ, the arrest that led to the defendant's plea shall be deemed to have never occurred. The defendant may state that he or she was not arrested or granted deferred entry of judgment for the offense, except as specified for employment as a peace officer. A record pertaining to an arrest resulting in successful completion of a DEJ program shall not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate. (Pen. Code § 1000.4, subd. (a).)

Authorizes counties to establish and conduct a preguilty plea drug court program wherein criminal proceedings are suspended without a plea of guilty for designated defendants. The presiding judge, the district attorney and the public defender must agree to establish a preguilty plea diversion program. If the defendant is not performing satisfactorily in the program, the court may reinstate criminal proceedings. If the defendant has performed satisfactorily during the period of the preguilty plea program, at the end of that period, the criminal charge or charges shall be dismissed. (Pen. Code § 1000.5.)

Provides that where a defendant has fulfilled the terms of probation, or been discharged from probation, the defendant shall, if he or she is not then serving a sentence for any offense, on probation for any offense, or charged with any offense, be granted the following relief: The court shall dismiss the conviction or allow the defendant to withdraw his or her guilty plea. The court shall then dismiss the accusations against the defendant. Where the person has successfully completed probation, but he or she did not fulfill all terms of probation throughout the probationary term, the court may grant the relief in the interests of justice. (Pen. Code § 1203.4, subd. (a).)

Provides that a person who was convicted of a felony and served a felony jail sentence pursuant to Penal Code Section 1170, subdivision (h), may apply for dismissal of his her conviction or withdrawal of his or her plea in the underlying case, in the discretion of the court and in the interests of justice. (Pen. Code § 1203.41.)

Provides that the court may only dismiss the conviction of person who served a felony jail sentence after the lapse of one year following the petitioner's completion of the sentence, provided that the petitioner is not under post-release community supervision pursuant to realignment or is not serving a sentence for, on probation for, or charged with the commission of any offense. (Pen. Code § 1203.41.)

Specifies that a non-citizen may be deported if he or she has been convicted of a violation of any law or regulation of a state, the United States, or a foreign country relating to a controlled substance, as defined, other than a single offense involving possession for one's own use of 30 grams or less of marijuana. (8 U.S.C.S. § 1227, subd. (a)(2)(B)(i).)

Provides that a defendant's plea of guilty is valid only where it is knowingly and voluntary made. In order that a defendant's plea be knowing, the defendant must understand and explicitly waive his or her constitutional rights to a jury trial, confront witnesses and the 5<sup>th</sup> Amendment privilege against self-incrimination. The defendant may withdraw a plea that was not knowingly

and voluntarily made. (*Boykin v. Alabama* (1969) 395 U.S. 238; *In re Tahl* (1969) 1 Cal.3rd 122, 130.)

Provides that in accepting a plea of guilty or no-contest, the court must advise the defendant that if he or she is not a citizen, the plea may result in adverse immigration consequences. (Pen. Cod § 1016.5) Section 1016.5 does not refer to programs or statutes under which a defendant's arrest or conviction would be dismissed.

Provides that in order to provide effective assistance of counsel under the 6<sup>th</sup> Amendment, an attorney for a criminal defendant must advise a defendant of the consequences of a plea of guilty or no contest. Specifically, failure to advise a defendant of the possible adverse immigration consequences of a plea constitutes ineffective assistance of counsel that may be prejudicial. Prejudice in this context essentially means that in the absence of the incorrect advice, the defendant would not have entered the plea. (*Padilla v. Kentucky* (2010) 130 S.Ct.1473

*This bill:*

Provides that in any case in which a defendant was granted deferred entry of judgment (DEJ), on or after January 1, 1997, after pleading guilty or nolo contendere to the charged offense, the defendant shall be permitted by the court to withdraw the plea of guilty or nolo contendere and enter a plea of not guilty if the defendant attests to and both of the following:

- The charges were dismissed after the defendant performed satisfactorily during the DEJ period; and,
- The plea may result in the denial or loss to the defendant of any employment, benefit, license, or certificate, including, but not limited to, causing a noncitizen defendant to potentially be found inadmissible, deportable, or subject to any other kind of adverse immigration consequence.

Directs the Judicial Council to develop a form for use by persons seeking the relief authorized by this bill to attest to the information required for such relief.

Requires a defendant seeking relief under this bill to submit documentation, as specified, of dismissal of charges pursuant to successful completion of DEJ, in addition to attesting to information required for relief.

Requires the court to dismiss the complaint or information against the defendant if the defendant shows that he or she performed satisfactorily under DEJ and that the plea underlying DEJ may result in a denial of employment benefit, license or certificate, or have adverse immigration consequences.

States the following legislative findings and declarations:

- The statement in Penal Code Section 1000.4, that "successful completion of a DEJ program shall not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate" constitutes misinformation about the actual consequences of the plea underlying DEJ.

- Specifically, in the case of some defendants, including all noncitizen defendants, the disposition of the case may cause adverse consequences, including adverse immigration consequences.
- Because of this misinformation and the potential harm of the plea, the defendant's prior plea is invalid.

#### RECEIVERSHIP/OVERCROWDING CRISIS AGGRAVATION

For the past eight years, this Committee has scrutinized legislation referred to its jurisdiction for any potential impact on prison overcrowding. Mindful of the United States Supreme Court ruling and federal court orders relating to the state's ability to provide a constitutional level of health care to its inmate population and the related issue of prison overcrowding, this Committee has applied its "ROCA" policy as a content-neutral, provisional measure necessary to ensure that the Legislature does not erode progress in reducing prison overcrowding.

On February 10, 2014, the federal court ordered California to reduce its in-state adult institution population to 137.5% of design capacity by February 28, 2016, as follows:

- 143% of design bed capacity by June 30, 2014;
- 141.5% of design bed capacity by February 28, 2015; and,
- 137.5% of design bed capacity by February 28, 2016.

In February of this year the administration reported that as "of February 11, 2015, 112,993 inmates were housed in the State's 34 adult institutions, which amounts to 136.6% of design bed capacity, and 8,828 inmates were housed in out-of-state facilities. This current population is now below the court-ordered reduction to 137.5% of design bed capacity."( Defendants' February 2015 Status Report In Response To February 10, 2014 Order, 2:90-cv-00520 KJM DAD PC, 3-Judge Court, *Coleman v. Brown, Plata v. Brown* (fn. omitted).

While significant gains have been made in reducing the prison population, the state now must stabilize these advances and demonstrate to the federal court that California has in place the "durable solution" to prison overcrowding "consistently demanded" by the court. (Opinion Re: Order Granting in Part and Denying in Part Defendants' Request For Extension of December 31, 2013 Deadline, NO. 2:90-cv-0520 LKK DAD (PC), 3-Judge Court, *Coleman v. Brown, Plata v. Brown* (2-10-14). The Committee's consideration of bills that may impact the prison population therefore will be informed by the following questions:

- Whether a proposal erodes a measure which has contributed to reducing the prison population;
- Whether a proposal addresses a major area of public safety or criminal activity for which there is no other reasonable, appropriate remedy;
- Whether a proposal addresses a crime which is directly dangerous to the physical safety of others for which there is no other reasonably appropriate sanction;
- Whether a proposal corrects a constitutional problem or legislative drafting error; and
- Whether a proposal proposes penalties which are proportionate, and cannot be achieved through any other reasonably appropriate remedy.

## COMMENTS

### 1. Need for This Bill

According to the author:

AB 1352 provides a minor expungement procedure to prevent the needless disruption of thousands of California families. The expungement proposed by this bill does not retroactively change the effect of the person's DEJ disposition under California law. Instead, it will eliminate the disposition as a conviction for federal immigration purposes. It also will make right the injustice inadvertently committed against the immigrant defendants who relied upon PC 1000.4 in deciding to enter a guilty plea.

This bill will prevent terrible harm to California families and immigrant communities. The last several years have seen mass deportations from the U.S. Of deportations based on criminal conviction, the largest number has been for minor, non-trafficking drug offenses. This especially affects California, the nation's most immigrant-rich state, where one out of two children lives in a household headed by at least one foreign born person (and the great majority of the children are U.S. citizens). Deportation of a parent devastates a family emotionally and economically and can drain state resources as U.S. citizen children go into foster care, homes go into foreclosure, and remaining citizen family seek public benefits.

### 2. True Expungement of Conviction in Contrast with Dismissal Granted Under Penal Code Section 1203.4

To "expunge" is to erase or destroy. The expungement of a record is the removal of a conviction from a person's criminal record. (*United States v. Hayden* (9th Cir. 2001) 255 F.3d 768, 771.) In California, Penal Code section 1203.4 is the statute typically referred to as the expungement statute. Defendants who have successfully completed probation can petition the court to set aside a guilty verdict or permit withdrawal of the guilty or nolo contendere plea and dismiss the complaint, accusation, or information. (Pen. Code, §1203.4.) However, the relief under Penal Code section 1203.4 does not actually provide expungement of the defendant's records. The prior conviction may still be used in a "subsequent prosecution of the defendant for any other offense," and if plead and proven, "shall have the same effect as if probation had not been granted or the accusation or information dismissed." (Pen. Code, § 1203.4, subd. (a).) Instead, there will be an entry made on the record that states that the case was dismissed. The records still remain fully a public document.

A dismissal under section 1203.4 does not constitute "expungement" as defined in the Federal Sentencing Guidelines, and therefore may be considered as a prior conviction when calculating a defendant's criminal history. (*Hayden, supra*, 255 F3d at p. 774.) In *Hayden*, the court looked at the specific language contained in 1203.4 to find that because the statute expressly authorizes the dismissed case to be used as a prior conviction in a subsequent prosecution, it is clear that the prior conviction is not expunged or erased so it could be considered for federal immigration purposes. (*Id.* at p. 772.)

In order to constitute an actual expungement, the withdrawal of the plea and dismissal of the case must not be allowed to be used for any purpose. Because immigration is the purview of the federal government, state laws cannot mandate what the federal government can consider in immigration proceedings. However, the state can craft a statute that avoids or minimizes a person's exposure to adverse immigration consequences. One of the circumstances that may trigger deportation proceedings is a conviction related to controlled substances. (8 U.S.C.S. § 1227, subd. (a)(2)(B)(i).) This bill allows a person to withdraw a guilty or nolo contendere plea that exposed the person to adverse immigration consequences and requires the court thereafter to dismiss the case. The intended outcome is that the person would not have a "conviction" as interpreted under federal law to cause the person to be deported. However, the bill is silent as to whether, after the case is re-dismissed, the records are expunged or completely erased from a person's record. Therefore, it is unclear whether the dismissal created under this bill prevents the federal government from accessing those records for immigration purposes.

### 3. Deferred Entry of Judgment

In a DEJ program, a defendant enters a guilty plea, but entry of judgment on the plea is deferred pending successful completion of a program. If the defendant successfully completes DEJ, the arrest shall be deemed to never have occurred. The Legislature intended the benefits and protections of a successful completion of DEJ be given the broadest possible application. (*B.W. v. Board of Med. Quality Assurance* (1985) 169 Cal.App. 3d 219.) A defendant who completes DEJ and has his or her case dismissed cannot have the offense used against him or her to deny any employment benefit, license or certificate unless the defendant consents to the release of his or her record. (Pen. Code § 1000.3.)

The most common form of DEJ allows non-violent drug offenders to participate in drug treatment programming and probation supervision rather than being subject to sentencing, imprisonment and other consequences of conviction. The purpose of dismissal upon successful completion of DEJ is to allow offenders to avoid the adverse consequences and stigma of a criminal conviction so that they can get or retain jobs and become or remain productive members of society. However, a dismissal after completion of a DEJ program for a drug offense may subject a non-citizen to immigration consequences such as deportation. (*Paredes-Urrestarazu v. U.S. INS* (9th Cir. 1994) 36 F3d. 801.)

This bill requires a court to allow a defendant to withdraw his or her guilty or nolo contendere plea upon a showing that charges were dismissed after successful completion of DEJ period, and that the plea may lead to a denial of a benefit, including adverse immigration consequences. A defendant's lack of knowledge of immigration consequences can constitute good cause to withdraw a guilty plea. (*People v. Superior Court (Giron)* (1974) 11 Cal. 3d 793.)

### 4. Withdrawal of a Plea from a Dismissed Case

This bill grants a court limited jurisdiction to accept the withdrawal of a guilty or nolo contendere plea by a person whose underlying case was dismissed after successful completion of DEJ. To qualify for this relief, the defendant must show that the plea may result in the denial or loss of any employment, benefit, license, or certificate, including adverse immigration consequences such as deportation.

The limited jurisdiction of a court over a dismissed case was confirmed in the context of another drug-treatment law. In *People v. DeLong* (2002), 101 Cal. App. 4th 482, the defendant successfully completed drug treatment pursuant to a SACPA<sup>1</sup> program. Thereafter, her conviction was set aside and the court dismissed the complaint against her. The statute authorizing the dismissal states that "the conviction is deemed never to have occurred" and the defendant is "released from all penalties and disabilities" resulting from the conviction. (*Id.*, at p. 491; Pen. Code § 1210.1, subd. (e)(1).) DeLong subsequently appealed her conviction and the prosecution argued that the appeal was moot because the case had been dismissed. The court held that the appeal was not moot because the conviction continues to exist for certain purposes, and the defendant "continues to suffer disadvantageous and prejudicial collateral consequences therefrom. . ." (*Id.*, at pp. 491-492) Similarly, in cases dismissed pursuant to DEJ, the conviction continues to exist for certain purposes and may disadvantage the defendant, even though the defendant is advised that the completion of the program "shall not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate." (Pen. Code § 1000.4, subd. (a).)

## 5. Argument in Support

The American Civil Liberties Union argues in support:

AB 1352 will allow persons who have successfully completed deferred entry of judgment for minor drug offenses to expunge the guilty plea from their record. AB 1352 will eliminate the harsh and unintended federal consequences that flow from minor drug offenses, including deportation. This bill will keep California families together, support the law's rehabilitation goals, and promote equal justice.

Current California law provides for deferred entry of judgment (DEJ) for minor drug offenses. Under the program, a defendant is required to plead guilty, waive his or her right to a speedy trial, and complete a drug treatment program. If the defendant successfully completes the program, the charges against the defendant are dismissed. Participants are told that once the charges are dismissed, there will be no conviction for any purpose, the arrest will be deemed never to have occurred, and they will not be denied any legal benefit based on the disposition. Unfortunately, the dismissal of the charges following completion of deferred entry of judgment does not, in fact, protect defendants from certain federal consequences. This is because the guilty plea remains on their record and counts as a "conviction" for certain purposes under federal law. Even for U.S. citizens, these guilty pleas can carry long-term negative consequences, including loss of federal housing and educational benefits. For noncitizens, the consequences can be immediate and devastating, including deportation, mandatory detention, and permanent separation from families.

This is particularly devastating to families in California, which is the most immigrant-rich state in America. One out of every four persons living in the state is foreign-born. Half of California's children live in households headed by at least one foreign-born parent – and the majority of these children are U.S. citizens. It is estimated that 50,000 parents of California U.S. citizen children

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<sup>1</sup> The Substance Abuse and Crime Prevention Act of 2000 - Proposition 36.

were deported in a little over two years, leaving many children parentless. Deportation due to minor drug offenses destroys California families.

## 6. Argument in Opposition

The California District Attorneys Association argues in opposition:

We must object, on principle, to the idea of allowing people to withdraw pleas (some dating back nearly 20 years) that were obtained lawfully as a condition of their participation in a deferred entry of judgment program. California law, and the Sixth Amendment of the Constitution, provides many safeguards to ensure that defendants are made aware of the potential consequences before entering a guilty plea.

Beyond the constitutional right to effective defense counsel, who has an obligation to ensure that a defendant understands the terms and ramifications of a plea, Penal Code 1016.5 already requires the court to administer an advisement to the defendant about potential adverse immigration consequences prior to accepting a guilty plea.

Allowing defendants to petition the court for this form of relief, simply because those consequences ultimately occurred, would create tremendous workload issues within the criminal justice system in terms of calendaring and preparing for hearings. By making this remedy available to anyone who was granted deferred entry of judgment since 1997, tens of thousands of individuals will be eligible for a determination on whether they may withdraw their pleas – many of whom have suffered no adverse consequences at all.

For those whose pleas may trigger some immigration action, certainly any adverse consequences – immigration, employment, or otherwise – would have already been suffered in the intervening 18 years. Conversely, if those adverse consequences have not yet occurred, perhaps the problem that AB 1352 seeks to address is not as prevalent as initially thought.

– END –

AMENDED IN SENATE MAY 19, 2015  
AMENDED IN ASSEMBLY APRIL 27, 2015  
CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1352**

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**Introduced by Assembly Member Eggman**

February 27, 2015

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An act to add Section 1203.43 to the Penal Code, relating to deferred entry of judgment.

LEGISLATIVE COUNSEL'S DIGEST

AB 1352, as amended, Eggman. Deferred entry of judgment: withdrawal of plea.

Existing law allows judgment to be deferred with respect to a defendant who is charged with certain crimes involving possession of controlled substances and who meets certain criteria, including that he or she has no prior convictions for any offense involving controlled substances and has had no felony convictions within the 5 years prior, as specified. Existing law prohibits the record pertaining to an arrest resulting in successful completion of a deferred entry of judgment program from being used in any way that could result in the denial of employment, benefit, license, or certificate.

This bill would require a court to allow a defendant who was granted deferred entry of judgment on or after January 1, 1997, after pleading guilty or nolo contendere to the charged offense, to withdraw his or her plea and enter a plea of not guilty, and would require the court to dismiss the complaint or information against the defendant, if the defendant performed satisfactorily during the deferred entry of judgment period and the defendant ~~shows~~ *attests* that the plea may result in the denial

or loss to the defendant of any employment, benefit, license, or certificate, including, but not limited to, causing a noncitizen defendant to potentially be found inadmissible, deportable, or subject to any other kind of adverse immigration consequence. *The bill would require the Judicial Council to develop a form to allow the defendant to make this attestation. Pursuant to the bill, the completion, signing, and submission of the form with specified documentation would be presumed to satisfy the requirement for the withdrawal of the plea and dismissal of the complaint.*

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

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

1 SECTION 1. Section 1203.43 is added to the Penal Code, to  
2 read:

3 1203.43. (a) (1) The Legislature finds and declares that the  
4 statement in Section 1000.4, that “successful completion of a  
5 deferred entry of judgment program shall not, without the  
6 defendant’s consent, be used in any way that could result in the  
7 denial of any employment, benefit, license, or certificate”  
8 constitutes misinformation about the actual consequences of  
9 making a plea in the case of some defendants, including all  
10 noncitizen defendants, because the disposition of the case may  
11 cause adverse consequences, including adverse immigration  
12 consequences.

13 (2) Accordingly, the Legislature finds and declares that based  
14 on this misinformation and the potential harm, the defendant’s  
15 prior plea is invalid.

16 (b) In any case in which a defendant was granted deferred entry  
17 of judgment on or after January 1, 1997, after pleading guilty or  
18 nolo contendere to the charged offense, the defendant shall be  
19 permitted by the court to withdraw the plea of guilty or nolo  
20 contendere and enter a plea of not guilty, and thereafter the court  
21 shall dismiss the complaint or information against the defendant,  
22 if the defendant ~~shows~~ *attests to* both of the following:

23 (1) The charges were dismissed after the defendant performed  
24 satisfactorily during the deferred entry of judgment period.

25 (2) The plea of guilty or nolo contendere may result in the denial  
26 or loss to the defendant of any employment, benefit, license, or

1 certificate, including, but not limited to, causing a noncitizen  
2 defendant to potentially be found inadmissible, deportable, or  
3 subject to any other kind of adverse immigration consequence.

4 *(c) The Judicial Council shall, by June 1, 2016, develop a form*  
5 *that allows a defendant to attest to the information described in*  
6 *paragraphs (1) and (2) of subdivision (b).*

7 *(d) The defendant shall submit documentation of the dismissal*  
8 *of charges or satisfactory participation in, or completion of,*  
9 *diversion programming. The completion, signing, and submission*  
10 *by the defendant of the form described in subdivision (c) with the*  
11 *documentation specified in this subdivision shall be presumed to*  
12 *satisfy the requirements for withdrawal of the plea and dismissal*  
13 *of the complaint or information against the defendant.*

O

SB

323

Date of Hearing: July 14, 2015

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS

Susan Bonilla, Chair

SB 323(Hernandez) – As Amended July 9, 2015

**SENATE VOTE:** 25-5

**SUBJECT:** Nurse practitioners: scope of practice

**SUMMARY:** Permits Nurse Practitioners (NPs) to practice, without being supervised by a physician and surgeon, if the NP has met specified requirements including possessing liability insurance and national certification.

**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” 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) Holding a valid and active registered nursing license;
  - b) 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,
  - c) Completion of a NP 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 physicians 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 operated for the diagnosis, care, prevention and treatment of physical or mental human illness including convalescence, rehabilitation, care during and after pregnancy or for any one 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 and protocols (SPPs) 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 SPPs 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 that the SPP must list which NPs may furnish or order drugs or devices. (BPC § 2836.1(c)(1))
  - 16) Requires that the physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include collaboration to create the SPP, 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 Legislative findings and declarations as to the importance of NPs providing safe and accessible primary care.
- 2) Specifies that, in the interest of providing patients with comprehensive care and consistent with the spirit of the federal Patient Protection and Affordable Care Act, the bill is supportive of the national health care movement towards integrated and team-based health care models.
- 3) Authorizes a NP who holds a national certification from a national certifying body recognized by the BRN ("certified NP") to practice without the supervision of a physician if the certified NP practices in one of the following settings:
  - a) A clinic;
  - b) Specified health facilities, including a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, correctional treatment center, and hospice facility, as specified;
  - c) A county medical facility;
  - d) An accountable care organization;
  - e) A group practice, including a professional medical corporation, another form of corporation controlled by physicians, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services; and,
  - f) A medical group, independent practice association, or any similar association.
- 4) Provides that, in addition to any other practice authorized in statute or regulation, a "certified NP" practicing in specified settings may do all of the following without physician supervision, unless collaboration is specified:
  - a) Order durable medical equipment;
  - b) Certify disability for purposes of unemployment after performance of a physical examination by the certified NP and collaboration, if necessary, with a physician;
  - c) Approve, sign, modify, or add to a plan of treatment or plan of care for individuals receiving home health services or personal care services after consultation, if necessary, with the treating physician and surgeon;
  - d) Assess patients, synthesize and analyze data, and apply principles of health care;
  - e) Manage the physical and psychosocial health status of patients;
  - f) Analyze multiple sources of data, identify a differential diagnosis, and select, implement, and evaluate appropriate treatment;

- g) Establish a diagnosis by client history, physical examination, and other criteria, consistent with this section, for a plan of care;
  - h) Order, furnish, prescribe, or procure drugs or devices;
  - i) Delegate tasks to a medical assistant pursuant to SPPs developed by the NP and medical assistant that are within the medical assistant's scope of practice;
  - j) Order hospice care, as appropriate;
  - k) Order and interpret diagnostic procedures; and,
  - l) Perform additional acts that require education and training and that are recognized by the nursing profession as appropriate to be performed by a NP.
- 5) States that it is unlawful for a "certified NP" to refer a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy or diagnostic imaging goods or services if the NP or his or her immediate family has a financial interest with the person or in the entity that receives the referral.
- 6) Further specifies that the BRN shall review the facts and circumstances of any conviction and take appropriate disciplinary action if the "certified NP" has committed unprofessional conduct and that the BRN may assess fines and appropriate disciplinary action including the revocation of a "certified NP's" license.
- 7) Specifies that a "certified NP" is subject to the peer review process where a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes or professional conduct of licentiates to make recommendations for quality improvement and education in order to do the following:
- a) Determine whether a licentiate may practice or continue to practice in a health care facility, as specified; and,
  - b) To assess and improve the quality of care rendered in a health care facility as specified.
- 8) Requires the BRN to disclose 805 reports, which are the written reports filed with the BRN, as a result of an action of a peer review body, within 15 days after any of the following occur:
- a) A "certified NP's" application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason;
  - b) A "certified NP's" membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason; or,
  - c) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for accumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

- 9) Indicates that if the BRN or licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.
- 10) Requires a “certified NP” to refer a patient to a physician or other licensed health care provider if a situation or condition of the patient is beyond the scope of the education and training of the NP.
- 11) Requires a “certified NP” to maintain professional liability insurance appropriate for the practice setting.
- 12) Specifies that settings where NPs practice shall not interfere with, control, or otherwise direct the professional judgment of a nurse practitioner.

**FISCAL EFFECT:** According to the Senate Appropriations Committee analysis, this bill will result in one-time costs, likely about \$75,000, to update existing regulations. The bill may also result in minor ongoing costs for enforcement.

**COMMENTS:**

**Purpose.** This bill is sponsored by the author. According to the author, “Numerous California editorial boards have endorsed full practice authority for NPs. A 2013 *New York Times* editorial stated ‘There is plenty of evidence that well-trained health workers can provide routine service that is every bit as good or even better than what patients would receive from a doctor. And because they are paid less than the doctors, they can save the patient and the healthcare system money.’”

Californians deserve access to high quality primary care offered by a range of safe, efficient, and regulated providers. NPs have advanced their educational, testing, and certification programs over the past decade. They've enhanced clinical training, moved to advanced degrees, and upgraded program accreditation processes. Other states have recognized advances with NP practice acts that align with professional competence and advanced education. But California has not kept pace.

In California, we have a robust network of providers that are well-trained, evenly distributed throughout the state, and well positioned to pay particular attention to underserved areas. Deploying these professionals in a team-based delivery model where they work collaboratively with physicians will allow us to meet the demands placed on our healthcare systems created by a rapidly aging physician population and expansion of health insurance coverage.”

**Background.** According to the Association of American Medical Colleges, by 2015, the nation will face a shortage of 62,100 physicians, 33,100 primary care practitioners and 29,000 other specialists. Estimates obtained from the Council on Graduate Medical Education indicate that 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. In addition, a 2013 study in *Health Affairs* found that the proportion of U.S. medical students choosing careers in primary care dropped from 60 percent in 1998 to approximately 25 percent in 2013. Some purport that the way to address this shortage is by expanding the role of NPs and other allied healthcare professionals to provide primary care services.

**NP Education and Training.** There are approximately 19,000 NPs licensed by the BRN. 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 (Title 16 California Code of Regulations (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. Data from the Employment Developmental Department indicates that hospitals are the main employer of NPs.

**NP Scope and 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 (16 CCR § 1485). According to the BRN, "SPPs are the legal mechanism for registered nurses, nurse practitioners to perform functions which would otherwise be considered the practice of medicine." 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.

SPPs 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 NP meets the experience, training and/or education requirements to perform the functions. If a NP undertakes a procedure without the competence to do so, such an act may constitute gross negligence and be subject to discipline by the BRN.

The BRN and the Medical Board of California (MBC) jointly promulgated the following guidelines for SPPs: (BRN, 16 CCR § 1474; MBC, 16 CCR § 1379)

"SPPs 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.”

**Nurse-Managed Health Clinics.** Nurse-managed health clinics, of which many are Federally Qualified Health Centers (FQHC) 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. Unlike other FQHC and independent non-profits, these clinics are solely operated by NPs. The Patient Protections and Affordable Care Act (ACA) defines a nurse-managed health clinic as, “...a nurse practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent non-profit health or social services agency.” (42 U.S.C. § 330A-1 (2010))

According to the National Nursing Centers Consortium, nurse-managed health clinics have doubled in their presence since 2013. To date, there are 500 nurse-managed health clinics most of which are located in the East Coast. A small percentage of these 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 health 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, such as GLIDE, have partnerships with other academic programs and provide learning opportunities for medical, pharmacy, social work, public health and other students.

**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.” Similar to the changes to statute proposed in this legislation, under full practice authority, “certified 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, “certified NPs” would continue to consult with and refer patients to other health care providers according to the patient’s needs.

Over the past 50 years, several organizations and research institutions have examined the feasibility of full practice authority for NPs. The Institute of Medicine of the National 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.” In a 2011 report, the IOM noted that three to 14 NPs can be educated for the same cost as one physician. 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 granting full practice authority for NPs 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. The President of the AMA, Dr. Robert M. Wah, was quoted in a 2015 *New York Times* article, “[...nurses practicing independently] would further compartmentalize and fragment health care [which should be] collaborative with the physician at the head of the team.”

**Financial Implications.** Over the past 40 years, there have been a number of studies on the cost-effectiveness of NP practice. Results overwhelmingly show NPs provide equivalent or improved medical care at a lower cost than their physician counterparts. After insurance reform in Massachusetts, the state demonstrated that they could gain a cost savings of \$4.2 to \$8.4 billion, over a 10 year period, from the increased use of NPs (Eibner, E. et al. 2009, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*. RAND Health).

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. A report by the IOM titled "The Future of Nursing, Leading Change, Advancing Health," recommended that the Medicare program be expanded to include coverage of advanced practice registered nurse services just as physician services are covered. The report also recommended that Medicaid reimbursement rates for primary care physicians be extended to advanced practice registered nurses providing similar primary care services.

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](http://www.healthaffairs.org/healthpolicybriefs/brief.php)). If NPs were granted full practice authority, efforts may need to be undertaken in order for NPs to be recognized as primary care providers by insurance companies.

**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, 20 states have adopted full practice authority for NPs. The AMA contends that many of the NPs that practice independently in these states do not deliver care to underserved areas.

**Prior Related Legislation.** SB 491 (Hernandez) of 2013, would have permitted an NP to practice independently after a period of physician supervision if the NP has national certification and liability insurance, and authorizes the NP to perform various other specified tasks related to the practice of nursing without protocols. *NOTE: This bill was held in the Assembly Appropriations Committee.*

#### **ARGUMENTS IN SUPPORT:**

The American Nurses Association/California supports the bill and writes, "Nurse practitioners play an especially important role 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. As primary care providers, nurse practitioners provide for greater access to primary care services in all areas of the state."

The California Association of Physician Groups supports the bill and writes, "This bill increases the ability to provide access in meaningful ways to cope with the expansion of the patient base in California. It modernizes licensure law to reflect the current reality. It allows Nurse Practitioners to practice to the full extent of their education and training. Full practice authority has been proven safe and effective in nineteen other states."

The California Hospital Association also supports the bill and writes, "California hospitals have been leaders in transforming the delivery of health care and preparing for the realities of ACA. NPs' full practice authority as conceptualized in SB 323 will be a pivotal component of our

success in light of current and projected physician shortages, the much greater time and cost to train physicians, and expected increased in the demand for primary care. This is clearly a promising and rational strategy for increasing the supply of primary care providers for California.”

The United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP) supports this bill and writes, “NPs full practice authority as conceptualized in SB 323 will be a pivotal component of our success in light of current and projected physician shortages, the much greater time and cost to train physicians, and expected increased in the demand for primary care. This is a promising strategy for increasing the supply of primary care providers for California.”

#### **ARGUMENTS IN OPPOSITION:**

The American Medical Association opposes the bill. In their letter they write, “The AMA believes that increased use of physician-led teams of multidisciplinary health care professionals will have a positive impact on the nation’s primary care needs. This team-based approach includes physicians and other clinicians working together, sharing decisions and information, to achieve improved care, improved patient health and reduced costs. However, independent practice and team-based care take health care delivery in two very different directions. One approach would further compartmentalize and fragment health care delivery; the other would foster integration and coordination.”

The California Medical Association also opposes the bill and writes, “The intent language in this bill claims that independent practice for nurse practitioners will provide for greater access to primary care services in all areas of the state. 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.”

The Medical Board of California states in their letter of opposition, “NPs are well qualified to provide medical care when practicing under standardized procedures and physician supervision. The standardized procedures and physician supervision, collaboration and consultation are in existing law to ensure that the patient care provided by a NP includes physician involvement and oversight, as physicians should be participating in the patient’s care in order to ensure consumer protection...The Board’s primary mission is consumer protection and by expanding the scope of practice for a certified NP and not requiring any type of physician collaboration, consultation, or oversight, patient care and consumer protection could be compromised.”

The Union of American Physicians and Dentists opposes the bill and writes, “Senate Bill 323 provides no assurances to the general public, and puts patients at risk. Moreover, Senate Bill 323 has grave consequences for public sector physicians, as it would enable state and counties to “supplant” physician services.”

#### **POLICY ISSUES:**

- 1) **Patient Protections.** If granted full practice authority, per the provisions of this bill, “certified NPs” would be required to adhere to a number of patient protection requirements – similar to the requirements for physicians who practice independently. Specifically, this bill would require that a “certified NP,” 1) carry malpractice insurance, 2) adhere to the anti-kickback and referral laws and 3) be subject to the same 805 reporting requirements that

physicians are subject to. However, unlike physicians who are subject to the corporate practice of medicine bar, the NPs would not be subject to this provision.

California law prohibits lay individuals, organizations and corporations from practicing medicine. This prohibition applies to lay entities and prohibits them from hiring or employing physicians or other health care practitioners from interfering with a physician or other health care practitioner's practice of medicine. It also prohibits most lay individuals, organizations and corporations from engaging in the business of providing health care services indirectly by contracting with health care professionals to render such services. This prohibition is designed to protect the public from possible abuses stemming from the commercial exploitation of the practice of medicine (California Physician's Legal Handbook, *Corporate Practice of Medicine Bar*, January, 2015).

According to a 2007 California Research Bureau report titled "The Corporate Practice of Medicine Doctrine," the employment status of physicians in California is applied inconsistently by the application of the doctrine as physicians are exempt from the doctrine if they work in specific settings including: professional medical corporations, local hospital districts, county hospitals, teaching hospitals, non-profit clinics and non-profit corporations.

Opponents of this bill argue that because the duties of "certified NPs" are similar to those of a physician and surgeon, "certified NPs" should be subject to the same corporate practice of medicine bar. Proponents of the measure indicate that nurse anesthetists practice independently and without being subject to the corporate practice of medicine bar. They also note that in the other four states that have a corporate practice of medicine bar and permit NPs to practice without supervision, the NPs are not subject to the corporate practice of medicine bar.

- 2) **Provision of Healthcare in Rural Settings.** The author indicates that passage of this legislation will result in increased access to care. As such, it is important to note that, according to the Office of Statewide Health Planning and Development, there are 62 rural hospitals in California that could benefit from additional healthcare providers. Additionally, according to the Robert Wood Johnson Foundation, NPs are the primary care providers most likely to be working in rural or remote areas. Thus, in context of the amendments which are outlined below, which may limit the ability of NPs to exercise full practice authority in rural hospital settings, the author and Committee may wish to consider if the bill should include provisions permitting NPs to practice without supervision in rural hospitals.
- 3) **Oversight.** Opponents of this bill share concerns about a need for a different oversight structure for the "certified NPs." They argue that this new class of providers needs an oversight mechanism that will include professionals who practice nursing as well as medicine. The author and Committee may wish to consider the necessity of having an oversight body, e.g. committee within the BRN, that contains physicians and NPs to help advise the BRN regarding oversight, e.g. licensing, enforcement etc., of "certified NPs."

#### AMENDMENTS:

- 1) Based on policy issue number 1, pertaining to the corporate practice of medicine bar, the author should amend this measure to include the following language to ensure that the same protections are in place for the practice of "certified NPs." This should include the same

exemptions from the corporate practice of medicine bar that apply to the practice of physicians and surgeons in certain settings:

On page 13, line 17, after “corporation,” insert the following:

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

On page 14, after line 27, insert the following:

(e) Corporations and other artificial legal entities shall have no professional rights, privileges, or powers under this section, except as provided in Sections 2400, 2401, 2402, and 2403.

#### **REGISTERED SUPPORT:**

AARP

Alliance of Catholic Health Care

AltaMed Health Services Corporation

Alzheimer’s Association

American Nurses Association\California

Anthem Blue Cross

Association of California Healthcare Districts

Association of California Nurse Leaders

Bay Area Council

Blue Shield of California

California Association for Health Services at Home

California Association for Nurse Practitioners

California Association of Nurse Anesthetists, Inc.

California Association of Physician Groups

California Association of Public Hospitals and Health Systems

California Commission on Aging

California Council of Community Mental Health Agencies

California El Camino Real Association of Occupational Health Nurses

California Family Health Council

California Health & Wellness (CH&W)

California Hospital Association

California Naturopathic Doctors Association

California Pharmacists Association

California Primary Care Association

California Senior Legislature

California Society of Health-System Pharmacists

California State Association of Occupational Health Nurses

Congress of California Seniors

Johns Hopkins University Division of Occupational and Environment Medicine

Maxim Healthcare Services, Inc.  
MemorialCare Health System  
Pacific Clinics  
Private Essential Access Community Hospitals  
Providence Health & Services  
Sharp HealthCare  
Small Business Majority  
Stanford Health Care  
St. Joseph Health  
United Nurses Associations of California/Union of Health Care Professionals  
University of California  
Western University of Health Sciences

**REGISTERED OPPOSITION:**

American Medical Association  
American Osteopathic Association  
California Academy of Family Physicians (unless amended)  
California Chapter of the American College of Cardiology  
California Chapter of the American College of Emergency Physicians  
California Medical Association  
California Orthopaedic Association  
California Psychiatric Association  
California Society of Anesthesiologists  
California Society of Plastic Surgeons  
Medical Board of California  
Union of American Physicians and Dentists  
Over 600 physicians and individuals

Analysis Prepared by: Le Ondra Clark Harvey, Ph.D. / B. & P. / (916) 319-3301

AMENDED IN ASSEMBLY JULY 9, 2015  
AMENDED IN ASSEMBLY JULY 7, 2015  
AMENDED IN ASSEMBLY JUNE 23, 2015  
AMENDED IN SENATE APRIL 22, 2015  
AMENDED IN SENATE MARCH 26, 2015

**SENATE BILL**

**No. 323**

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**Introduced by Senator Hernandez**  
(Principal coauthor: Assembly Member Eggman)  
(Coauthor: Assembly Member Mark Stone)

February 23, 2015

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An act to amend Sections 650.01 and 805 of, to amend and renumber Section 2837 of, and to add Section 2837 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 323, as amended, Hernandez. Nurse practitioners: scope of practice.

The Nursing Practice Act provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing. The act authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including ordering durable medical equipment in accordance with standardized procedures, certifying disability for purposes of unemployment insurance after physical examination and collaboration with a physician and surgeon, and, for an individual receiving home health services or personal care services, approving, signing, modifying, or adding to a plan of treatment

or plan of care after consultation with a physician and surgeon. A violation of those provisions is a crime.

This bill would authorize a nurse practitioner who holds a national certification from a national certifying body recognized by the board to practice without the supervision of a physician and surgeon, if the nurse practitioner meets existing requirements for nurse practitioners and practices in one of certain specified settings. The bill would prohibit entities described in those specified settings from interfering with, controlling, or otherwise directing the professional judgment of such a nurse practitioner, as specified, and would authorize such a nurse practitioner, in addition to any other practice authorized in statute or regulation, to perform specified acts, including the acts described above, without reference to standardized procedures or the specific need for the supervision of a physician and surgeon. The bill, instead, would require a nurse practitioner to refer a patient to a physician and surgeon or other licensed health care provider if a situation or condition of the patient is beyond the scope of the nurse practitioner's education and training. The bill would require a nurse practitioner practicing under these provisions to maintain professional liability insurance appropriate for the practice setting. By imposing new requirements on nurse practitioners, the violation of which would be a crime, this bill would impose a state-mandated local program.

Existing law prohibits a licensee, as defined, from referring a person for laboratory, diagnostic, nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or his or her immediate family has a financial interest with the person or entity that receives the referral, and makes a violation of that prohibition punishable as a misdemeanor. Under existing law, the Medical Board of California is required to review the facts and circumstances of any conviction for violating the prohibition, and to take appropriate disciplinary action if the licensee has committed unprofessional conduct.

This bill would include a nurse practitioner, as specified, under the definition of a licensee, which would expand the scope of an existing crime and therefore impose a state-mandated local program. The bill would also require the Board of Registered Nursing to review the facts and circumstances of any conviction of a nurse practitioner, as specified, for violating that prohibition, and would require the board to take appropriate disciplinary action if the nurse practitioner has committed unprofessional conduct.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process. Existing law defines the term “licentiate” for those purposes to include, among others, a physician and surgeon.

This bill would include a nurse practitioner, as specified, under the definition of licentiate, and would require the Board of Registered Nursing to disclose reports, as specified.

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

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

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

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

1 SECTION 1. The Legislature finds and declares all of the  
2 following:

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

8 (b) Nurse practitioners will play an especially important part in  
9 the implementation of the federal Patient Protection and Affordable  
10 Care Act (Public Law 111-148), which will bring an estimated  
11 five million more Californians into the health care delivery system,  
12 because they will provide for greater access to primary care  
13 services in all areas of the state. This is particularly true for patients  
14 in medically underserved urban and rural communities.

15 (c) *In the interest of providing patients with comprehensive care*  
16 *and consistent with the spirit of the federal Patient Protection and*  
17 *Affordable Care Act, this measure is supportive of the national*  
18 *health care movement towards integrated and team-based health*  
19 *care models.*

20 (d)  
21 (d) Due to the excellent safety and efficacy record that nurse  
22 practitioners have earned, the Institute of Medicine of the National  
23 Academies has recommended full practice authority for nurse

1 practitioners. Currently, 20 states allow nurse practitioners to  
2 practice to the full extent of their training and education.

3 ~~(d)~~

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

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

11 650.01. (a) Notwithstanding Section 650, or any other  
12 provision of law, it is unlawful for a licensee to refer a person for  
13 laboratory, diagnostic nuclear medicine, radiation oncology,  
14 physical therapy, physical rehabilitation, psychometric testing,  
15 home infusion therapy, or diagnostic imaging goods or services if  
16 the licensee or his or her immediate family has a financial interest  
17 with the person or in the entity that receives the referral.

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

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

24 (2) A "financial interest" includes, but is not limited to, any  
25 type of ownership interest, debt, loan, lease, compensation,  
26 remuneration, discount, rebate, refund, dividend, distribution,  
27 subsidy, or other form of direct or indirect payment, whether in  
28 money or otherwise, between a licensee and a person or entity to  
29 whom the licensee refers a person for a good or service specified  
30 in subdivision (a). A financial interest also exists if there is an  
31 indirect financial relationship between a licensee and the referral  
32 recipient including, but not limited to, an arrangement whereby a  
33 licensee has an ownership interest in an entity that leases property  
34 to the referral recipient. Any financial interest transferred by a  
35 licensee to any person or entity or otherwise established in any  
36 person or entity for the purpose of avoiding the prohibition of this  
37 section shall be deemed a financial interest of the licensee. For  
38 purposes of this paragraph, "direct or indirect payment" shall not  
39 include a royalty or consulting fee received by a physician and  
40 surgeon who has completed a recognized residency training

1 program in orthopedics from a manufacturer or distributor as a  
2 result of his or her research and development of medical devices  
3 and techniques for that manufacturer or distributor. For purposes  
4 of this paragraph, “consulting fees” means those fees paid by the  
5 manufacturer or distributor to a physician and surgeon who has  
6 completed a recognized residency training program in orthopedics  
7 only for his or her ongoing services in making refinements to his  
8 or her medical devices or techniques marketed or distributed by  
9 the manufacturer or distributor, if the manufacturer or distributor  
10 does not own or control the facility to which the physician is  
11 referring the patient. A “financial interest” shall not include the  
12 receipt of capitation payments or other fixed amounts that are  
13 prepaid in exchange for a promise of a licensee to provide specified  
14 health care services to specified beneficiaries. A “financial interest”  
15 shall not include the receipt of remuneration by a medical director  
16 of a hospice, as defined in Section 1746 of the Health and Safety  
17 Code, for specified services if the arrangement is set out in writing,  
18 and specifies all services to be provided by the medical director,  
19 the term of the arrangement is for at least one year, and the  
20 compensation to be paid over the term of the arrangement is set  
21 in advance, does not exceed fair market value, and is not  
22 determined in a manner that takes into account the volume or value  
23 of any referrals or other business generated between parties.

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

27 (4) “Licensee” means a physician as defined in Section 3209.3  
28 of the Labor Code, and a nurse practitioner practicing pursuant to  
29 Section 2837.

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

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

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

38 (6) “Office of a group practice” means an office or offices in  
39 which two or more licensees are legally organized as a partnership,  
40 professional corporation, or not-for-profit corporation, licensed

1 pursuant to subdivision (a) of Section 1204 of the Health and Safety  
2 Code, for which all of the following apply:

3 (A) Each licensee who is a member of the group provides  
4 substantially the full range of services that the licensee routinely  
5 provides, including medical care, consultation, diagnosis, or  
6 treatment through the joint use of shared office space, facilities,  
7 equipment, and personnel.

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

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

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

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

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

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

36 (I) If a referral, billing, or other solicitation is between one or  
37 more licensees who contract with a multispecialty clinic pursuant  
38 to subdivision (I) of Section 1206 of the Health and Safety Code  
39 or who conduct their practice as members of the same professional  
40 corporation or partnership, and the services are rendered on the

1 same physical premises, or under the same professional corporation  
2 or partnership name, the requirements of this subdivision may be  
3 met by posting a conspicuous disclosure statement at the  
4 registration area or by providing a patient with a written disclosure  
5 statement.

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

12 (g) A violation of subdivision (a) shall be a misdemeanor. In  
13 the case of a licensee who is a physician, the Medical Board of  
14 California shall review the facts and circumstances of any  
15 conviction pursuant to subdivision (a) and take appropriate  
16 disciplinary action if the licensee has committed unprofessional  
17 conduct. In the case of a licensee who is a nurse practitioner  
18 functioning pursuant to Section 2837, the Board of Registered  
19 Nursing shall review the facts and circumstances of any conviction  
20 pursuant to subdivision (a) and take appropriate disciplinary action  
21 if the licensee has committed unprofessional conduct. Violations  
22 of this section may also be subject to civil penalties of up to five  
23 thousand dollars (\$5,000) for each offense, which may be enforced  
24 by the Insurance Commissioner, Attorney General, or a district  
25 attorney. A violation of subdivision (c), (d), or (e) is a public  
26 offense and is punishable upon conviction by a fine not exceeding  
27 fifteen thousand dollars (\$15,000) for each violation and  
28 appropriate disciplinary action, including revocation of professional  
29 licensure, by the Medical Board of California, the Board of  
30 Registered Nursing, or other appropriate governmental agency.

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

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

35 SEC. 3. Section 805 of the Business and Professions Code is  
36 amended to read:

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

39 (1) (A) "Peer review" means both of the following:

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

6 (I) Determine whether a licentiate may practice or continue to  
7 practice in a health care facility, clinic, or other setting providing  
8 medical services, and, if so, to determine the parameters of that  
9 practice.

10 (II) Assess and improve the quality of care rendered in a health  
11 care facility, clinic, or other setting providing medical services.

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

14 (B) “Peer review body” includes:

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

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

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

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

35 (2) “Licentiate” means a physician and surgeon, doctor of  
36 podiatric medicine, clinical psychologist, marriage and family  
37 therapist, clinical social worker, professional clinical counselor,  
38 dentist, physician assistant, or nurse practitioner practicing pursuant  
39 to Section 2837. “Licentiate” also includes a person authorized to  
40 practice medicine pursuant to Section 2113 or 2168.

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

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

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

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

20 (7) “805 report” means the written report required under  
21 subdivision (b).

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

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

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

33 (3) Restrictions are imposed, or voluntarily accepted, on staff  
34 privileges, membership, or employment for a cumulative total of  
35 30 days or more for any 12-month period, for a medical disciplinary  
36 cause or reason.

37 (c) If a licentiate takes any action listed in paragraph (1), (2),  
38 or (3) after receiving notice of a pending investigation initiated  
39 for a medical disciplinary cause or reason or after receiving notice  
40 that his or her application for membership or staff privileges is

1 denied or will be denied for a medical disciplinary cause or reason,  
2 the chief of staff of a medical or professional staff or other chief  
3 executive officer, medical director, or administrator of any peer  
4 review body and the chief executive officer or administrator of  
5 any licensed health care facility or clinic where the licentiate is  
6 employed or has staff privileges or membership or where the  
7 licentiate applied for staff privileges or membership, or sought the  
8 renewal thereof, shall file an 805 report with the relevant agency  
9 within 15 days after the licentiate takes the action.

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

12 (2) Withdraws or abandons his or her application for staff  
13 privileges or membership.

14 (3) Withdraws or abandons his or her request for renewal of  
15 staff privileges or membership.

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

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

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

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

36 A supplemental report shall also be made within 30 days  
37 following the date the licentiate is deemed to have satisfied any  
38 terms, conditions, or sanctions imposed as disciplinary action by  
39 the reporting peer review body. In performing its dissemination  
40 functions required by Section 805.5, the agency shall include a

1 copy of a supplemental report, if any, whenever it furnishes a copy  
2 of the original 805 report.

3 If another peer review body is required to file an 805 report, a  
4 health care service plan is not required to file a separate report  
5 with respect to action attributable to the same medical disciplinary  
6 cause or reason. If the Medical Board of California, the Board of  
7 Registered Nursing, or a licensing agency of another state revokes  
8 or suspends, without a stay, the license of a physician and surgeon,  
9 a peer review body is not required to file an 805 report when it  
10 takes an action as a result of the revocation or suspension.

11 (g) The reporting required by this section shall not act as a  
12 waiver of confidentiality of medical records and committee reports.  
13 The information reported or disclosed shall be kept confidential  
14 except as provided in subdivision (c) of Section 800 and Sections  
15 803.1 and 2027, provided that a copy of the report containing the  
16 information required by this section may be disclosed as required  
17 by Section 805.5 with respect to reports received on or after  
18 January 1, 1976.

19 (h) The Medical Board of California, the Osteopathic Medical  
20 Board of California, the Board of Registered Nursing, and the  
21 Dental Board of California shall disclose reports as required by  
22 Section 805.5.

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

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

27 (k) A willful failure to file an 805 report by any person who is  
28 designated or otherwise required by law to file an 805 report is  
29 punishable by a fine not to exceed one hundred thousand dollars  
30 (\$100,000) per violation. The fine may be imposed in any civil or  
31 administrative action or proceeding brought by or on behalf of any  
32 agency having regulatory jurisdiction over the person regarding  
33 whom the report was or should have been filed. If the person who  
34 is designated or otherwise required to file an 805 report is a  
35 licensed physician and surgeon, the action or proceeding shall be  
36 brought by the Medical Board of California. The fine shall be paid  
37 to that agency but not expended until appropriated by the  
38 Legislature. A violation of this subdivision may constitute  
39 unprofessional conduct by the licentiate. A person who is alleged  
40 to have violated this subdivision may assert any defense available

1 at law. As used in this subdivision, “willful” means a voluntary  
2 and intentional violation of a known legal duty.

3 (l) Except as otherwise provided in subdivision (k), any failure  
4 by the administrator of any peer review body, the chief executive  
5 officer or administrator of any health care facility, or any person  
6 who is designated or otherwise required by law to file an 805  
7 report, shall be punishable by a fine that under no circumstances  
8 shall exceed fifty thousand dollars (\$50,000) per violation. The  
9 fine may be imposed in any civil or administrative action or  
10 proceeding brought by or on behalf of any agency having  
11 regulatory jurisdiction over the person regarding whom the report  
12 was or should have been filed. If the person who is designated or  
13 otherwise required to file an 805 report is a licensed physician and  
14 surgeon, the action or proceeding shall be brought by the Medical  
15 Board of California. The fine shall be paid to that agency but not  
16 expended until appropriated by the Legislature. The amount of the  
17 fine imposed, not exceeding fifty thousand dollars (\$50,000) per  
18 violation, shall be proportional to the severity of the failure to  
19 report and shall differ based upon written findings, including  
20 whether the failure to file caused harm to a patient or created a  
21 risk to patient safety; whether the administrator of any peer review  
22 body, the chief executive officer or administrator of any health  
23 care facility, or any person who is designated or otherwise required  
24 by law to file an 805 report exercised due diligence despite the  
25 failure to file or whether they knew or should have known that an  
26 805 report would not be filed; and whether there has been a prior  
27 failure to file an 805 report. The amount of the fine imposed may  
28 also differ based on whether a health care facility is a small or  
29 rural hospital as defined in Section 124840 of the Health and Safety  
30 Code.

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

39 SEC. 4. Section 2837 of the Business and Professions Code is  
40 amended and renumbered to read:

1 2837.5. Nothing in this article shall be construed to limit the  
2 current scope of practice of a registered nurse authorized pursuant  
3 to this chapter.

4 SEC. 5. Section 2837 is added to the Business and Professions  
5 Code, to read:

6 2837. (a) Notwithstanding any other law, a nurse practitioner  
7 who holds a national certification from a national certifying body  
8 recognized by the board may practice under this section without  
9 supervision of a physician and surgeon, if the nurse practitioner  
10 meets all the requirements of this article and practices in one of  
11 the following:

12 (1) A clinic as described in Chapter 1 (commencing with Section  
13 1200) of Division 2 of the Health and Safety Code.

14 (2) A facility as described in Chapter 2 (commencing with  
15 Section 1250) of Division 2 of the Health and Safety Code.

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

18 (4) An accountable care organization, as defined in Section  
19 3022 of the federal Patient Protection and Affordable Care Act  
20 (Public Law 111-148).

21 (5) A group practice, including a professional medical  
22 corporation, as defined in Section 2406, another form of  
23 corporation controlled by physicians and surgeons, a medical  
24 partnership, a medical foundation exempt from licensure, or another  
25 lawfully organized group of physicians that delivers, furnishes, or  
26 otherwise arranges for or provides health care services.

27 (6) A medical group, independent practice association, or any  
28 similar association.

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

33 (c) Notwithstanding any other law, in addition to any other  
34 practice authorized in statute or regulation, a nurse practitioner  
35 who meets the qualifications of subdivision (a) may do any of the  
36 following without physician and surgeon supervision:

37 (1) Order durable medical equipment. Notwithstanding that  
38 authority, this paragraph shall not operate to limit the ability of a  
39 third-party payer to require prior approval.

- 1 (2) After performance of a physical examination by the nurse  
2 practitioner and collaboration, if necessary, with a physician and  
3 surgeon, certify disability pursuant to Section 2708 of the  
4 Unemployment Insurance Code.
- 5 (3) For individuals receiving home health services or personal  
6 care services, after consultation, if necessary, with the treating  
7 physician and surgeon, approve, sign, modify, or add to a plan of  
8 treatment or plan of care.
- 9 (4) Assess patients, synthesize and analyze data, and apply  
10 principles of health care.
- 11 (5) Manage the physical and psychosocial health status of  
12 patients.
- 13 (6) Analyze multiple sources of data, identify a differential  
14 diagnosis, and select, implement, and evaluate appropriate  
15 treatment.
- 16 (7) Establish a diagnosis by client history, physical examination,  
17 and other criteria, consistent with this section, for a plan of care.
- 18 (8) Order, furnish, prescribe, or procure drugs or devices.
- 19 (9) Delegate tasks to a medical assistant pursuant to Sections  
20 1206.5, 2069, 2070, and 2071, and Article 2 of Chapter 3 of  
21 Division 13 of Title 16 of the California Code of Regulations.
- 22 (10) Order hospice care, as appropriate.
- 23 (11) Order diagnostic procedures and utilize the findings or  
24 results in treating the patient.
- 25 (12) Perform additional acts that require education and training  
26 and that are recognized by the nursing profession as appropriate  
27 to be performed by a nurse practitioner.
- 28 (d) A nurse practitioner shall refer a patient to a physician and  
29 surgeon or other licensed health care provider if a situation or  
30 condition of the patient is beyond the scope of the education and  
31 training of the nurse practitioner.
- 32 (e) A nurse practitioner practicing under this section shall  
33 maintain professional liability insurance appropriate for the practice  
34 setting.
- 35 SEC. 6. No reimbursement is required by this act pursuant to  
36 Section 6 of Article XIII B of the California Constitution because  
37 the only costs that may be incurred by a local agency or school  
38 district will be incurred because this act creates a new crime or  
39 infraction, eliminates a crime or infraction, or changes the penalty  
40 for a crime or infraction, within the meaning of Section 17556 of

1 the Government Code, or changes the definition of a crime within  
2 the meaning of Section 6 of Article XIII B of the California  
3 Constitution.

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**SB**

**337**

Date of Hearing: July 8, 2015

ASSEMBLY COMMITTEE ON APPROPRIATIONS  
Jimmy Gomez, Chair  
SB 337 (Pavley) – As Amended June 16, 2015

Policy Committee: Business and Professions Vote: 14 - 0

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

**SUMMARY:**

This bill modifies the allowable methods a physician may use to supervise a physician assistant. Specifically, this bill:

- 1) Authorizes a physician supervising a physician assistant (PA) to use two additional mechanisms for the general supervision of a PA, in place of the current-law requirement to review 5% of patient charts, namely, medical review meetings or a physician-approved protocol with minimum standards.
- 2) Authorizes a physician to use one additional mechanism for the supervision of a PA that administers a Schedule II controlled substance in place of the current-law requirement to countersign each prescription, namely, review and countersignature of a 20% sample.
- 3) Requires a PA's patient medical records to identify the PA's supervising physician.

**FISCAL EFFECT:**

Minor and absorbable costs to the Physician Assistant Board (PAB) within the Medical Board of California to conform to the new supervision options (Physician Assistant Fund).

**COMMENTS:**

- 1) **Purpose.** This bill adds different supervision options in an attempt to streamline the physician/PA workflow while still ensuring patient protection. The new options recognize current care delivery models and electronic medical records review. In addition, the bill allows a sample of prescriptions for Schedule II drugs to be reviewed, instead of each prescription. The bill is sponsored by the California Academy of Physician Assistants.
- 2) **Background.** A PA may provide medical services pursuant to a delegation of services agreement with a physician. As of June 2013, there were about 9,000 active PA licenses in California. The recent reclassification of hydrocodone as a Schedule II drug has resulted in significant workload for physicians to review each prescription, and changing care delivery models have prompted a reconsideration of current supervision requirements.
- 3) **Opposition.** The Medical Board of California opposes the reduction in physician supervision of Schedule II drugs, which are prone to abuse.

AMENDED IN ASSEMBLY JUNE 16, 2015

AMENDED IN SENATE APRIL 13, 2015

**SENATE BILL**

**No. 337**

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**Introduced by Senator Pavley**

February 23, 2015

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An act to amend Sections 3501, 3502, and 3502.1 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 337, as amended, Pavley. Physician assistants.

Existing law, the Physician Assistant Practice Act, provides for regulation of physician assistants and authorizes a physician assistant to perform medical services as set forth by regulations when those services are rendered under the supervision of a licensed physician and surgeon, as specified. The act requires the supervising physician and surgeon to review, countersign, and date a sample consisting of, at a minimum, 5% of the medical records of patients treated by the physician assistant functioning under adopted protocols within 30 days of the date of treatment by the physician assistant. The act requires the supervising physician and surgeon to select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient. A violation of those supervision requirements is a misdemeanor.

This bill would require that the medical record for each episode of care for a patient identify the physician and surgeon who is responsible for the supervision of the physician assistant. ~~The bill would require a physician assistant who transmits an oral order to identify the name of the supervising physician and surgeon responsible for the patient. The bill would delete those medical record review provisions, and, instead,~~

require the supervising physician and surgeon to use one or more of described review mechanisms. By adding these new requirements, the violation of which would be a crime, this bill would impose a state-mandated local program by changing the definition of a crime.

The act authorizes a physician assistant, while under prescribed supervision of a physician and surgeon, to administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device. The act prohibits a physician assistant from administering, providing, or issuing a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets approved standards. The act requires that the medical record of any patient cared for by a physician assistant for whom a physician assistant's Schedule II drug order has been issued or carried out to be reviewed, countersigned, and dated by a supervising physician and surgeon within 7 days.

This bill would delete that review and countersignature requirement for a physician assistant's Schedule II drug order, and, instead, require that the supervising physician and surgeon use one of 2 described mechanisms to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances.

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

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

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

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

- 1 SECTION 1. Section 3501 of the Business and Professions
- 2 Code is amended to read:
- 3 3501. (a) As used in this chapter:
- 4 (1) "Board" means the Physician Assistant Board.
- 5 (2) "Approved program" means a program for the education of
- 6 physician assistants that has been formally approved by the board.

1 (3) "Trainee" means a person who is currently enrolled in an  
2 approved program.

3 (4) "Physician assistant" means a person who meets the  
4 requirements of this chapter and is licensed by the board.

5 (5) "Supervising physician" or "supervising physician and  
6 surgeon" means a physician and surgeon licensed by the Medical  
7 Board of California or by the Osteopathic Medical Board of  
8 California who supervises one or more physician assistants, who  
9 possesses a current valid license to practice medicine, and who is  
10 not currently on disciplinary probation for improper use of a  
11 physician assistant.

12 (6) "Supervision" means that a licensed physician and surgeon  
13 oversees the activities of, and accepts responsibility for, the medical  
14 services rendered by a physician assistant.

15 (7) "Regulations" means the rules and regulations as set forth  
16 in Chapter 13.8 (commencing with Section 1399.500) of Title 16  
17 of the California Code of Regulations.

18 (8) "Routine visual screening" means uninvase  
19 nonpharmacological simple testing for visual acuity, visual field  
20 defects, color blindness, and depth perception.

21 (9) "Program manager" means the staff manager of the diversion  
22 program, as designated by the executive officer of the board. The  
23 program manager shall have background experience in dealing  
24 with substance abuse issues.

25 (10) "Delegation of services agreement" means the writing that  
26 delegates to a physician assistant from a supervising physician the  
27 medical services the physician assistant is authorized to perform  
28 consistent with subdivision (a) of Section 1399.540 of Title 16 of  
29 the California Code of Regulations.

30 (11) "Other specified medical services" means tests or  
31 examinations performed or ordered by a physician assistant  
32 practicing in compliance with this chapter or regulations of the  
33 Medical Board of California promulgated under this chapter.

34 (12) "Medical records review meeting" means a meeting  
35 between the supervising physician *and surgeon* and the physician  
36 assistant during which ~~a sample of medical records is~~ *are* reviewed  
37 to ensure adequate supervision of the physician assistant  
38 functioning under protocols. ~~The number of medical records and~~  
39 ~~the specific issues to be reviewed shall be established in the~~

1 ~~delegation of services agreement. Medical records review meetings~~  
2 ~~may occur in person or by electronic communication.~~

3 (b) A physician assistant acts as an agent of the supervising  
4 physician when performing any activity authorized by this chapter  
5 or regulations adopted under this chapter.

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

8 3502. (a) Notwithstanding any other law, a physician assistant  
9 may perform those medical services as set forth by the regulations  
10 adopted under this chapter when the services are rendered under  
11 the supervision of a licensed physician and surgeon who is not  
12 subject to a disciplinary condition imposed by the Medical Board  
13 of California prohibiting that supervision or prohibiting the  
14 employment of a physician assistant. The medical record, for each  
15 episode of care for a patient, shall identify the physician and  
16 surgeon who is responsible for the supervision of the physician  
17 assistant. ~~When a physician assistant transmits an oral order, he~~  
18 ~~or she shall also identify the name of the supervising physician~~  
19 ~~and surgeon responsible for the patient.~~

20 (b) (1) Notwithstanding any other law, a physician assistant  
21 performing medical services under the supervision of a physician  
22 and surgeon may assist a doctor of podiatric medicine who is a  
23 partner, shareholder, or employee in the same medical group as  
24 the supervising physician and surgeon. A physician assistant who  
25 assists a doctor of podiatric medicine pursuant to this subdivision  
26 shall do so only according to patient-specific orders from the  
27 supervising physician and surgeon.

28 (2) The supervising physician and surgeon shall be physically  
29 available to the physician assistant for consultation when that  
30 assistance is rendered. A physician assistant assisting a doctor of  
31 podiatric medicine shall be limited to performing those duties  
32 included within the scope of practice of a doctor of podiatric  
33 medicine.

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

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

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

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

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

15 (2) (A) The supervising physician and surgeon shall use one  
16 or more of the following mechanisms to ensure adequate  
17 supervision of the physician assistant functioning under the  
18 protocols:

19 (i) The supervising physician and surgeon shall review,  
20 countersign, and date a sample consisting of, at a minimum, 5  
21 percent of the medical records of patients treated by the physician  
22 assistant functioning under the protocols within 30 days of the date  
23 of treatment by the physician assistant.

24 (ii) The supervising physician and surgeon and physician  
25 assistant shall ~~conduct at least 10 times annually a medical records~~  
26 ~~review meeting, which may occur in person or by electronic~~  
27 ~~communication.~~ *meeting, at least once a month during at least 10*  
28 *months of the year. During any month in which a medical records*  
29 *review meeting occurs, the supervising physician and surgeon and*  
30 *physician assistant shall review an aggregate of at least 10 medical*  
31 *records of patients treated by the physician assistant functioning*  
32 *under protocols. Documentation of medical records reviewed*  
33 *during the month shall be jointly signed and dated by the*  
34 *supervising physician and surgeon and the physician assistant.*

35 (iii) The supervising physician and surgeon shall supervise the  
36 care provided by the physician assistant through a review of ~~those~~  
37 ~~cases or patients deemed appropriate cases involving treatment by~~  
38 ~~the physician assistant functioning under protocols adopted by~~  
39 the supervising physician and surgeon. The review methods used  
40 shall be identified in the delegation of services ~~agreement, and~~

1 ~~review may occur in person or by electronic communication.~~  
2 *agreement and shall include no less than an aggregate of 10 cases*  
3 *per month for at least 10 months of the year. Documentation of*  
4 *the cases reviewed during the month shall be jointly signed and*  
5 *dated by the supervising physician and surgeon and the physician*  
6 *assistant.*

7 (B) In complying with subparagraph (A), the supervising  
8 physician and surgeon shall select for review those cases that by  
9 diagnosis, problem, treatment, or procedure represent, in his or  
10 her judgment, the most significant risk to the patient.

11 (3) Notwithstanding any other law, the Medical Board of  
12 California or the board may establish other alternative mechanisms  
13 for the adequate supervision of the physician assistant.

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

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

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

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

23 (4) The practice of dentistry or dental hygiene or the work of a  
24 dental auxiliary as defined in Chapter 4 (commencing with Section  
25 1600).

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

29 (f) Compliance by a physician assistant and supervising  
30 physician and surgeon with this section shall be deemed  
31 compliance with Section 1399.546 of Title 16 of the California  
32 Code of Regulations.

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

35 3502.1. (a) In addition to the services authorized in the  
36 regulations adopted by the Medical Board of California, and except  
37 as prohibited by Section 3502, while under the supervision of a  
38 licensed physician and surgeon or physicians and surgeons  
39 authorized by law to supervise a physician assistant, a physician  
40 assistant may administer or provide medication to a patient, or

1 transmit orally, or in writing on a patient's record or in a drug  
2 order, an order to a person who may lawfully furnish the  
3 medication or medical device pursuant to subdivisions (c) and (d).

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

8 (2) Each supervising physician and surgeon who delegates the  
9 authority to issue a drug order to a physician assistant shall first  
10 prepare and adopt, or adopt, a written, practice specific, formulary  
11 and protocols that specify all criteria for the use of a particular  
12 drug or device, and any contraindications for the selection.  
13 Protocols for Schedule II controlled substances shall address the  
14 diagnosis of illness, injury, or condition for which the Schedule II  
15 controlled substance is being administered, provided, or issued.  
16 The drugs listed in the protocols shall constitute the formulary and  
17 shall include only drugs that are appropriate for use in the type of  
18 practice engaged in by the supervising physician and surgeon.  
19 When issuing a drug order, the physician assistant is acting on  
20 behalf of and as an agent for a supervising physician and surgeon.

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

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

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

10 (2) A physician assistant shall not administer, provide, or issue  
11 a drug order to a patient for Schedule II through Schedule V  
12 controlled substances without advance approval by a supervising  
13 physician and surgeon for that particular patient unless the  
14 physician assistant has completed an education course that covers  
15 controlled substances and that meets standards, including  
16 pharmacological content, approved by the board. The education  
17 course shall be provided either by an accredited continuing  
18 education provider or by an approved physician assistant training  
19 program. If the physician assistant will administer, provide, or  
20 issue a drug order for Schedule II controlled substances, the course  
21 shall contain a minimum of three hours exclusively on Schedule  
22 II controlled substances. Completion of the requirements set forth  
23 in this paragraph shall be verified and documented in the manner  
24 established by the board prior to the physician assistant's use of a  
25 registration number issued by the United States Drug Enforcement  
26 Administration to the physician assistant to administer, provide,  
27 or issue a drug order to a patient for a controlled substance without  
28 advance approval by a supervising physician and surgeon for that  
29 particular patient.

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

34 (d) A written drug order issued pursuant to subdivision (a),  
35 except a written drug order in a patient's medical record in a health  
36 facility or medical practice, shall contain the printed name, address,  
37 and telephone number of the supervising physician and surgeon,  
38 the printed or stamped name and license number of the physician  
39 assistant, and the signature of the physician assistant. Further, a  
40 written drug order for a controlled substance, except a written drug

1 order in a patient's medical record in a health facility or a medical  
2 practice, shall include the federal controlled substances registration  
3 number of the physician assistant and shall otherwise comply with  
4 Section 11162.1 of the Health and Safety Code. Except as  
5 otherwise required for written drug orders for controlled substances  
6 under Section 11162.1 of the Health and Safety Code, the  
7 requirements of this subdivision may be met through stamping or  
8 otherwise imprinting on the supervising physician and surgeon's  
9 prescription blank to show the name, license number, and if  
10 applicable, the federal controlled substances registration number  
11 of the physician assistant, and shall be signed by the physician  
12 assistant. When using a drug order, the physician assistant is acting  
13 on behalf of and as the agent of a supervising physician and  
14 surgeon.

15 (e) The supervising physician and surgeon shall use either of  
16 the following mechanisms to ensure adequate supervision of the  
17 administration, provision, or issuance by a physician assistant of  
18 a drug order to a patient for Schedule II controlled substances:

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

24 (2) If the physician assistant has documentation evidencing the  
25 successful completion of an education course that covers controlled  
26 substances, and that controlled substance education course (A)  
27 meets the standards, including pharmacological content, ~~approved~~  
28 ~~by the board, established in Sections 1399.610 and 1399.612 of~~  
29 *Title 16 of the California Code of Regulations*, and (B) is provided  
30 either by an accredited continuing education provider or by an  
31 approved physician assistant training program, ~~and (C) satisfies~~  
32 ~~Sections 1399.610 and 1399.612 of Title 16 of the California Code~~  
33 ~~of Regulations~~, the supervising physician and surgeon shall review,  
34 countersign, and date, within seven days, a sample consisting of  
35 the medical records of at least 20 percent of the patients cared for  
36 by the physician assistant for whom the physician assistant's  
37 Schedule II drug order has been issued or carried out. Completion  
38 of the requirements set forth in this paragraph shall be verified and  
39 documented in the manner established in Section 1399.612 of Title  
40 16 of the California Code of Regulations. Physician assistants who

1 have a certificate of completion of the course described in  
2 paragraph (2) of subdivision (c) shall be deemed to have met the  
3 education course requirement of this subdivision.

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

8 (g) The board shall consult with the Medical Board of California  
9 and report during its sunset review required by Article 7.5  
10 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of  
11 Division 2 of Title 2 of the Government Code the impacts of  
12 exempting Schedule III and Schedule IV drug orders from the  
13 requirement for a physician and surgeon to review and countersign  
14 the affected medical record of a patient.

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

**SB**

**464**

Date of Hearing: July 15, 2015

ASSEMBLY COMMITTEE ON APPROPRIATIONS

Jimmy Gomez, Chair

SB 464 (Hernandez) – As Amended May 22, 2015

Policy Committee: Business and Professions

Vote: 14 - 0

Urgency: No

State Mandated Local Program: No

Reimbursable: No

**SUMMARY:**

This bill clarifies health care practitioners can use patient self-screening tools that will identify patient risk factors for the use of self-administered hormonal contraceptives, for purposes of furnishing self-administered hormonal contraceptives to the patient.

**FISCAL EFFECT:**

Negligible costs to affected professional licensing boards within the Department of Consumer Affairs.

**COMMENTS:**

- 1) **Purpose.** According to the author, hormonal contraception has been proven safe and effective at preventing pregnancy, and the American College of Obstetricians and Gynecologists recently recommended that women should self-screen for contraindications using a checklist, in order to increase their access to hormonal contraceptives. The author further states existing law is unclear as to whether self-screening tools can be used to transmit relevant medical and family history information from a patient to her provider. The author believes enabling the use of self-screening tools will allow healthcare providers to make greater use of existing and developing technology, and will increase access to oral contraception. This bill is sponsored by Planned Parenthood Affiliates of California.
- 2) **Background.** Health care professionals specified in this bill, including a physician, a registered nurse (RN), a certified nurse-midwife (CNM), a nurse practitioner (NP), a physician assistant (PA), or a pharmacist are allowed to furnish self-administered hormonal contraceptives in accordance with existing law for each practitioner. In order to screen patients to ensure hormonal contraceptives are appropriate, certain data elements must be collected. This bill simply clarifies it is acceptable to collect this data from patient self-screening tools, for purposes of furnishing self-administered hormonal contraceptives.
- 3) **Prior Legislation.** SB 493 (Hernandez), Chapter 469, Statutes of 2013, among other things, authorized a pharmacist to furnish self-administered hormonal contraception in accordance with standardized procedures and protocols, which require the patient to use a self-screening tool to identify patient risk factors for contraceptives.

**Analysis Prepared by:** Lisa Murawski / APPR. / (916) 319-2081

AMENDED IN ASSEMBLY MAY 22, 2015

AMENDED IN SENATE APRIL 27, 2015

**SENATE BILL**

**No. 464**

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**Introduced by Senator Hernandez**

February 25, 2015

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An act to ~~amend~~ *add* Section ~~2242.1~~ of 2242.2 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 464, as amended, Hernandez. Healing arts: self-reporting tools.

The Medical Practice Act provides for licensure and regulation of physicians and surgeons by the Medical Board of California, and authorizes a physician and surgeon to, among other things, use drugs or devices in or upon human beings. *The Medical Practice Act makes it unprofessional conduct for a physician and surgeon to prescribe, dispense, or furnish dangerous drugs without an appropriate prior examination and medical indication.* The act prohibits, with specified exceptions, a person or entity from prescribing, dispensing, or furnishing, or causing to be prescribed, dispensed, or furnished, dangerous drugs or dangerous devices on the Internet for delivery to a person in California without an appropriate prior examination and medical indication.

*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 within the Department of Consumer Affairs. The Nursing Practice Act authorizes a registered nurse to dispense self-administered hormonal contraceptives, as specified, in accordance with standardized procedures, including demonstration of competency in providing the*

*appropriate prior examination comprised of checking blood pressure, weight, and patient and family health history, including medications taken by the patient. The Nursing Practice Act also authorizes certified nurse-midwives and nurse practitioners to furnish or order drugs or devices, as specified.*

*The Physician Assistant Practice Act provides for the licensure and regulation of physician assistants by the Physician Assistant Board within the jurisdiction of the Medical Board of California, and authorizes a physician assistant to administer or provide medication to a patient or to transmit a drug order, as specified.*

*The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy within the Department of Consumer Affairs, and authorizes a pharmacist to furnish self-administered hormonal contraceptives in accordance with standardized procedures and protocols. The Pharmacy Law requires the standardized procedures and protocols to require a patient to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives, as specified.*

*This bill, notwithstanding any other law, would authorize the board to consider the use of self-reporting tools by licensees, as that use may be allowed by law: a physician and surgeon, a registered nurse acting in accordance with the authority of the Nursing Practice Act, a certified nurse-midwife acting within the scope of specified existing law relating to nurse-midwives, a nurse practitioner acting within the scope of specified existing law relating to nurse practitioners, a physician assistant acting within the scope of specified existing law relating to physician assistants, or a pharmacist acting within the scope of a specified existing law relating to pharmacists to use a self screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after an appropriate prior examination, prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient. The bill would authorize blood pressure, weight, height, and patient health history to be self-reported using the self-screening tool.*

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

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

1     SECTION 1. Section 2242.2 is added to the Business and  
2     Professions Code, to read:

3     2242.2. Notwithstanding any other law, a physician and  
4     surgeon, a registered nurse acting in accordance with Section  
5     2725.2, a certified nurse-midwife acting within the scope of Section  
6     2746.51, a nurse practitioner acting within the scope of Section  
7     2836.1, a physician assistant acting within the scope of Section  
8     3502.1, and a pharmacist acting within the scope of Section 4052.3  
9     may use a self-screening tool that will identify patient risk factors  
10    for the use of self-administered hormonal contraceptives by a  
11    patient, and, after an appropriate prior examination, prescribe,  
12    furnish, or dispense, as applicable, self-administered hormonal  
13    contraceptives to the patient. Blood pressure, weight, height, and  
14    patient health history may be self-reported using the self-screening  
15    tool that identifies patient risk factors.

16    SECTION 1. ~~Section 2242.1 of the Business and Professions~~  
17    Code is amended to read:

18    2242.1. (a) ~~No person or entity may prescribe, dispense, or~~  
19    ~~furnish, or cause to be prescribed, dispensed, or furnished,~~  
20    ~~dangerous drugs or dangerous devices, as defined in Section 4022,~~  
21    ~~on the Internet for delivery to any person in this state, without an~~  
22    ~~appropriate prior examination and medical indication, except as~~  
23    ~~authorized by Section 2242.~~

24    ~~(b) Notwithstanding any other provision of law, a violation of~~  
25    ~~this section may subject the person or entity that has committed~~  
26    ~~the violation to either a fine of up to twenty-five thousand dollars~~  
27    ~~(\$25,000) per occurrence pursuant to a citation issued by the board~~  
28    ~~or a civil penalty of twenty-five thousand dollars (\$25,000) per~~  
29    ~~occurrence.~~

30    ~~(c) The Attorney General may bring an action to enforce this~~  
31    ~~section and to collect the fines or civil penalties authorized by~~  
32    ~~subdivision (b).~~

33    ~~(d) For notifications made on and after January 1, 2002, the~~  
34    ~~Franchise Tax Board, upon notification by the Attorney General~~  
35    ~~or the board of a final judgment in an action brought under this~~  
36    ~~section, shall subtract the amount of the fine or awarded civil~~  
37    ~~penalties from any tax refunds or lottery winnings due to the person~~  
38    ~~who is a defendant in the action using the offset authority under~~

1 ~~Section 12419.5 of the Government Code, as delegated by the~~  
2 ~~Controller, and the processes as established by the Franchise Tax~~  
3 ~~Board for this purpose. That amount shall be forwarded to the~~  
4 ~~board for deposit in the Contingent Fund of the Medical Board of~~  
5 ~~California.~~

6 (e) ~~If the person or entity that is the subject of an action brought~~  
7 ~~pursuant to this section is not a resident of this state, a violation~~  
8 ~~of this section shall, if applicable, be reported to the person's or~~  
9 ~~entity's appropriate professional licensing authority.~~

10 (f) ~~Nothing in this section shall prohibit the board from~~  
11 ~~commencing a disciplinary action against a physician and surgeon~~  
12 ~~pursuant to Section 2242.~~

13 (g) ~~The board may consider the use of self-screening tools by~~  
14 ~~a licensee, as that use may be allowed by law.~~

**SB**

**800**

Date of Hearing: July 7, 2015

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS

Susan Bonilla, Chair

SB 800( Business, Professions & Economic Development) – As Amended June 08, 2015

**SENATE VOTE:** 36-0

**SUBJECT:** Healing arts.

**SUMMARY:** Makes numerous substantive, technical, and minor non-controversial changes to various provisions of the healing arts boards regulated by the Department of Consumer Affairs (DCA).

**EXISTING LAW:**

- 1) Establishes the Dental Practice Act, administered by the Dental Board of California (DBC) within the Department of Consumer Affairs (DCA), to license and regulate the practice of dentistry. (Business and Professions Code (BPC) Section 1600, *et seq.*)
- 2) Specifies that until January 1, 2010, the Dental Hygiene Committee of California (DHCC) may contract with the DBC to carry out specified licensing and enforcement related actions and after January 1, 2010 the DHCC may contract with the DBC to perform investigations of applicants and licensees. (BPC Section 1905.1)
- 3) Requires the DHCC to establish by resolution the amount of the fees that relate to the licensing of a registered dental hygienist, a registered dental hygienist in alternative practice, and a registered dental hygienist in extended functions, as specified. (BPC Section 1944)
- 4) Establishes the Medical Practice Act, administered by the Medical Board of California (MBC) within the DCA, to license and regulate the practice of medicine. (BPC Section 2000, *et seq.*)
- 5) Permits the MBC to deny a physician's and surgeon's certificate to an applicant guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of his or her license; or, the MBC in its sole discretion, may issue a probationary physician's and surgeon's certificate to an applicant subject to terms and conditions, as specified. (BPC Section 2221)
- 6) Authorizes, as part of a pilot program which was repealed January 1, 2011, hospitals owned by health care districts to employ physicians, as specified. (BPC Section 2401(d))
- 7) Requires an applicant for licensure as a Physical Therapist to be a graduate of a professional degree program, as specified, and states that the educational requirements include instruction in the subject prescribed by the Commission on Accreditation in Physical Therapy Education (CAPTE) of the American Physical Therapy Association of Physiotherapy Education Accreditation Canada and include a combination of didactic and clinical experiences which must include at least 18 weeks of full-time experience with a variety of patients. (BPC Section 2650)

- 8) Establishes one of more diversion evaluation committees within the Board of Registered Nursing (BRN), and requires the BRN to establish criteria for the acceptance, denial or termination of registered nurses in the diversion program. (BPC Sections 2770.2, 2770.7)
- 9) Requires a registered nurse (RN) to submit educational, experience and other credentials and information as required by the BRN in order to use the title "nurse practitioner" prior to his or her next licensure renewal. (BPC Section 2835.5)
- 10) Requires an applicant for licensure as a Psychologist to comply with specified education, training and examination requirements. (BPC Section 2914)
- 11) Requires an applicant for licensure as an Optometrist to comply with specified requirements including certain education, training, and examination requirements. (BPC Section 3057)
- 12) Requires the Physician Assistant Board to elect a chairperson and a vice chairperson from among its members. (BPC Section 3509.5)
- 13) Beginning January 1, 2015, authorizes a veterinary assistant to administer a controlled substance pursuant to the order, control, and full professional responsibility of a licensed veterinarian if he or she has been designated by a licensed veterinarian to obtain or administer controlled substances and holds a veterinary assistance controlled substance permit issued by the Veterinary Medical Board (VMB) as specified. (BPC Section 4836.1)
- 14) Requires an applicant for licensure as an Acupuncturist in California to meet specified educational requirements and specifies that an individual who received his or her education and training outside of California to document educational training and clinical experience that meets specified standards. (BPC Section 4938).
- 15) Requires an applicant for licensure as a Licensed Marriage and Family Therapist (LMFT) to take and pass a Board of Behavioral Sciences (BBS) administered California Law and Ethics Examination. (BPC Section 4980.399)
- 16) Requires an applicant for the licensure examination for an LMFT to complete experience including a minimum of 3,000 hours completed in a period of at least 104 weeks, as specified. (BPC Section 4980.43)
- 17) Requires the BBS to establish, by regulation, a procedure for approving providers of continuing education courses, and providers of continuing education must adhere to procedures established by the BBS. (BPC Section 4980.70, 4980.34,)
- 18) Requires an applicant and registrant for licensure as a Licensed Clinical Social Work (LCSW) to take and pass a BBS-administered California Law and Ethics Examination. (BPC Section 4992.09)
- 19) States that registration as an Association Clinical Social Worker (ACSW) expires one year from the last day of the month during which it was issued and to renew a registration, the registrant must complete specified requirements for renewal. (BPC Section 4996.28)

- 20) Requires an applicant for the licensure examination for a Licensed Professional Clinical Counselor (LPCC) must complete clinical mental health experience under the general supervision of an approved supervisor, as specified. (BPC Section 4999.46)
- 21) Requires an application for registration as an in-state or out-of-state telephone medical advice service be made on a form prescribed by the department and contain the signature of the individual owner or of all of the owners of the telephone medical advice service; the name under which the person applying for the in-state or out-of-state telephone medical advice services proposes to do business; the physical address, mailing address, and telephone number of the business entity; the designation, including the name and physical address of an agent for service of process in California; a list of all in-state or out-of-state staff providing telephone medical advice services that are required to be licensed, registered or certified, as specified; and, the department must be notified within 30 days of any change of name, physical location, mailing address, or telephone number of any business, owner, partner, corporate officer, or agent for service of process in California, together with copies of all resolutions or other written communications that substantiate these changes. (BPC Section 4999.1)
- 22) States that every registration issued to a telephone medical advice service expires within 24 months after the initial date of issuance and specifies the requirements to renew that registration. (BPC Section 4999.4)

**THIS BILL:**

- 1) Makes numerous technical, substantive, and conforming changes.

Makes the following changes related to the name of the **Dental Board of California and the Dental Hygiene Committee of California:**

- 1) Replaces the name of the regulatory entity "Board of Dental Examiners" with the "Dental Board of California."
- 2) Repeals the fee for examination provision for third and fourth year dental students for licensure as a registered dental hygienist.
- 3) Adds a feasibility study review in addition to a curriculum review and site evaluation for educational programs for dental hygienists who are not accredited by a DHCC-approved agency, as specified.

Makes the following changes related to the **Medical Board of California and the Medical Practice Act:**

- 4) Deletes an outdated reference to a repealed pilot program.
- 5) Requires an individual to apply for a new license who voluntarily cancels his or her license or who fails to renew his or her license within five years after its expiration.
- 6) Updates the name of the San Diego Psychoanalytic Institute to the San Diego Psychoanalytic Center.

- 7) Deletes the requirement that physical therapist education include at least 18 weeks of full-time experience with a variety of patients.
- 8) Changes the name of the "Diversion Program" to the "Intervention Program" for registered nurses.
- 9) Repeals title act specifications for nurse practitioners.
- 10) Deletes an outdated reference to an educational institution.

Makes the following changes related to the **Board of Optometry (BOO) and the Optometric Practice Act:**

- 11) Deletes the requirement for an applicant for licensure as an optometrist submit proof that he or she has been in active practice in the state in which he or she is licensed for a total of 5,000 hours, as specified.
- 12) Clarifies that the BOO may grant a license to practice optometry to an optometrist that has not had his or her license revoked or suspended in any state where the person holds a license, in addition to meeting other requirements.
- 13) Specifies that an applicant for licensure as an optometrist has no specified drug or mental impairment as determined by a licensed psychologist or licensed psychiatrist instead of a licensed physician.

Makes the following change related to the **Physician Assistant Board:**

- 14) Replaces the titles "Chairperson" and "Vice Chairperson" with "President" and "Vice president."

Makes the following changes related to the **Veterinary Medical Board (VMB):**

- 15) Authorizes the VMB to deny, in addition to revoke or suspend, a controlled substance permit for specified reasons.
- 16) Prohibits a petition from being considered for reinstatement or modification of a penalty by the VMB if the petitioner is under sentence for any criminal offense, as specified.

Makes the following changes related to the **Board of Acupuncture (CAB):**

- 17) Removes Canada as the domestic equivalent to the United States in regard to documenting training and educational experience for applicants for licensure as an acupuncturist in California and includes Canada in the requirement for the CAB to establish standards for the approval of educational training and clinical experience outside of the United States.

Makes the following changes related to the **Board of Behavioral Sciences (BBS):**

- 18) Requires the 12-hour law and ethics course requires for licensure as an LMFT, LEP, LPCC, or LCSW to be taken from a continuing education provider specified by the BBS through regulation.

- 19) Prohibits an applicant for licensure as an LMFT or LPCC from be employed or volunteering in a private practice until registered with the BBS as an intern.
- 20) Repeals a specified list of continuing education providers and instead defines other continuing education providers as those approved by the BBS in regulation.
- 21) States that marriage and family therapist registrant interns, professional clinical counselor, and associate clinical social worker registrants may apply for, and receive, a subsequent registration number instead of a new registration number, as specified.

Makes the following changes related to the **Telephone Medical Advice Services Bureau**:

- 22) Deletes references to in-state and out-of-state registrants.
- 23) Adds Naturopathic Doctors (NDs) and Licensed Professional Clinical Counselors (LPCCs) to the list of qualified medical advice service providers.
- 24) Adds the following to the list of requirements in order to obtain and maintain a registration as a telephone medical advice service:
  - a) Notifying the department within 30 days of any change of name, physical location, mailing address, or telephone number of any business, owner, partner, corporate officer, or agent for service of process in California, together with copies of all resolutions or other written communications that substantiate changes; and,
  - b) Submitting quarterly reports, on a form prescribed by the department, to the department within 30 days of the end of each calendar quarter.
- 25) Makes other minor, technical and updating changes.

**FISCAL EFFECT:** According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, this bill will result in negligible state costs.

**COMMENTS:**

**Purpose.** This bill is the annual Omnibus Committee bill authored by the Business, Professions and Economic Development Committee which consolidates a number of non-controversial provisions related to various regulatory programs and professions governed by the [BPC] within the DCA. Consolidating the provisions in one bill is designed to relieve the various licensing Boards, bureaus and professions from the necessity and burden of having separate measures for a number of non-controversial revisions. As noted by the author, many of the provisions in this bill are minor and technical changes which update outdated references or titles in existing law. Other provisions may be substantive consensus changes which aim to improve the efficacy of the various healing arts entities in administering and enforcing the provisions of their respective licensing laws. This bill is intended to be non-controversial and any opposition or concerns with the consensus provisions will be removed.

**Dental Hygiene Committee of California (DHCC).** The DHCC has the authority over all aspects of the licensing and regulation of dental hygienists, including enforcement and investigation and the approval of educational programs that provide the prerequisite education to

become a licensed dental hygienist. The DHCC also develops and administers written and clinical licensing examinations and conducts occupational analyses of the various professional categories.

The DHCC is responsible for overseeing approximately 19,000 licensed dental hygienists in the state. These dental hygienists include registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions.

This bill updates the BPC to strike outdated references to the Board of Dental Examiners with its current title as the Dental Board of California (DBC). This bill clarifies that the DHCC is a separate entity from the DBC and must separately create and maintain a central file of the names of all persons who hold a license, certificate or similar authority from that "board." This bill also repeals the fee for examination for licensure as a registered dental hygienist for third and fourth year dental students.

**Medical Board of California (MBC).** The MBC is the regulatory entity responsible for regulating physician and surgeons and a number of other allied health professionals. The jurisdiction of the MBC includes issuing licenses and certificates, the administration and hearing of disciplinary actions, and carrying out disciplinary actions as determined by the appropriate panel or ALJ including suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions. This bill would specify that a person who voluntarily cancels his or her license or who fails to renew within five years may not renew the license, but must instead reapply for licensure.

**Board of Optometry (BOO).** The BOO licenses and regulates optometrists in California. In order to become licensed as an optometrist an individual must graduate from an accredited school or college of optometry, take and pass a three-part national board examination and take and pass a California state examination. For those optometrists licensed outside of California who seek licensure in this state, they are required to meet the same provisions above, but also meet other requirements including having a license in good standing in another state, never had his or her license revoked, and submit proof that he or she has been in active practice for at least 5,000 hours in five of the seven consecutive years immediately preceding the date of his or her application.

According to the author, the certification form for identifying the 5,000 hours includes information pertaining to each worksite where the hours were earned, such as worksite addresses, dates, and number of hours worked at each location. The applicant signs this certification under penalty of perjury that the information is true and correct. However, no supporting information is required to substantiate that the information provided is true. When this law was first enacted in 2006, the BOO wanted to ensure that out-of-state practicing optometrists were proficient in treating patients with therapeutic pharmaceutical agents and determined that the 5,000 practice hours of experience would be sufficient to do so. However, this requirement is now considered obsolete by the BOO and inconsistent with the licensing requirements for new graduates. This bill will delete the requirement that out-of-state applicants submit proof of 5,000 hours of experience from outside the state.

**Physician Assistant Board (PAB).** The PAB is responsible for the licensing and regulation of physician assistants. The PAB ensures that licensees and approved programs have met the minimum licensure requirements. The PAB is comprised of nine members, five professional and

four public. This bill revises the current requirement that the PAB appoint a "chairperson" and "vice chairperson" and instead requires the PAB to appoint a "president" and "vice president" respectively.

**Veterinary Medical Board (VMB).** The VMB licenses and regulates veterinarians, RVTs, schools and programs along with veterinary premises and hospitals through the enforcement of the California Veterinary Medicine Practice Act. The VMB develops and enforces the standards for examinations, licensing, and hospital and school inspections. The VMB licenses over 10,000 Veterinarians and 5,000 RVTs. The VMB also requires registration of all premises where veterinary medicine, veterinary dentistry, veterinary surgery, and the various branches thereof, is being practiced, which totals approximately 3,100 veterinary premises. The veterinary medical profession provides health care to a variety of animals including livestock, poultry, and pets from birds, fish, rabbits, hamsters, and snakes to dogs, cats, goats, pigs, horses, and llamas. This bill makes minor and technical changes pertaining to applications for a veterinary controlled substance permit and specifies that a petition for reinstatement or modification of a penalty may not be considered for a petitioner who is under sentence for any criminal offense as specified.

**Board of Acupuncture (CAB).** In order to be licensed as an acupuncturist in California, an applicant must be at least 18 years of age and complete either an educational and training program that includes 3,000 hours of study in the practice of acupuncture, or a supervised tutorial program which is approved by the CAB. An applicant must also pass a California-specific written examination that tests an applicant's knowledge in the practice of acupuncture. Currently, there are over 16,000 acupuncture licensees in California. This bill would allow graduates from Canadian Acupuncture Training programs to apply as foreign applicants to take the California Acupuncture Licensure Examination. Currently, Canada is not included in BPC 4938 (c) as a foreign training location. As a result, Canadian applicants must meet other specified requirements. Currently, the CAB does not extend its school approval to Canadian training programs and none of the Canadian acupuncture training programs would satisfy current requirements.

**Board of Behavioral Sciences (BBS).** The BBS regulates four categories of professionals who perform counseling services including: LMFTs, LCSWs, LPCCs, and LEPs. In addition to providing licensure to qualified candidates the BBS also registers marriage and family therapist interns, associate clinical social workers, professional clinical counselor interns and continuing education providers. The BBS is tasked with developing and administering the written examination for its licensure categories along with administering the continuing education program to ensure professional competency. Currently, the BBS regulates approximately one-hundred thousand licensees, registrants, and interns. This bill will clarify that an LEP or LPCC are registered and subject to regulation by the BBS. In addition, this bill updates the statute to be consistent with the BBS's updated regulations pertaining to continuing education. The BBS no longer approved continuing education providers and the changes in this bill reflect the update to the BBS's continuing education provider regulations.

**Telephone Medical Advice Services Bureau (TMASB).** The TMASB was established by AB 285 (Corbett), Chapter 285, Statutes of 1999. The TMASB is responsible for registering all businesses that employ, contract or, sub-contract with full-time or five or more persons functioning as health care professionals and engage in the business of providing medical advice services over the telephone to a patient at a California address. Those businesses may include health management organizations, physician hospital organizations, practice management

companies, management service organizations, preferred provider organizations, independent practice associations, physicians' groups, hospitals, disability insurers, disease management organizations, demand management services, employee assistance programs, case management services, wellness organizations, among others.

In order to be registered with the TMASB a business must submit an application, a registration fee, a list of staff providing the medical advice services, and each business is required to notify the TMASB within 30 days of any change of name, location, address, business owner, among others. In order to maintain registration, a business must comply with multiple requirements including ensuring that all persons providing services are licensed, as specified, maintain records, and comply with all directions and requests made by the DCA, among others. This bill will also add to the list of requirements to maintain registration that the DCA be notified within 30 days of any changes in address, name, location etcetera, and submit quarterly report as specified.

Currently, Naturopathic Doctors (NDs) and LPCCs are not included in the list of licensed healthcare professionals who can provide medical advice through a TMASB-registered company. According to the author, both of these licensure categories were established after the TMASB was established in California. The TMASB notes at least one professional ND working for a TMASB-registered company.

This bill adds NDs and LPCCs to the list of health care professionals that may provide medical advice services through a Bureau-registered company. In addition, this bill will delete a reference to in-state and out-of-state licensed providers because the Bureau does not make a distinction for in-state or out-of-state registrants.

**Current Related Legislation.** SB 799 (Committee on Business, Professions and Economic Development) of the current legislative session is the non-health committee omnibus bill which makes several non-controversial, minor, non-substantive or technical changes to various provisions pertaining to the non-health regulatory programs under the DCA. *STATUS: This bill is pending in the Assembly Business and Professions Committee.*

**Prior Related Legislation.** SB 1466 (Committee on Business, Professions and Economic Development), Chapter 316, Statutes of 2014, made several non-controversial, minor, non-substantive or technical changes to various provisions pertaining to the health regulatory programs under the BPC.

SB 1575 (Committee on Business, Professions and Economic Development), Chapter 799, Statutes of 2012, made numerous minor and technical changes to various provisions pertaining to the health-related regulatory boards within the DCA.

**TECHNICAL AMENDMENT:**

On page, 69, in line 9, after "the" strike: ~~in-state~~

On page 69, in line 10, strike: ~~or out-of-state~~

**REGISTERED SUPPORT:**

Medical Board of California

**REGISTERED OPPOSITION:**

None on file.

Analysis Prepared by: Elissa Silva / B. & P. / (916) 319-3301

AMENDED IN ASSEMBLY JULY 16, 2015

AMENDED IN ASSEMBLY JULY 13, 2015

AMENDED IN ASSEMBLY JUNE 8, 2015

AMENDED IN SENATE APRIL 20, 2015

**SENATE BILL**

**No. 800**

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**Introduced by Committee on Business, Professions and Economic  
Development (Senators Hill (Chair), Bates, Berryhill, Block,  
Galgiani, Hernandez, Jackson, Mendoza, and Wieckowski)**

March 18, 2015

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An act to amend Sections 28, 146, 500, 650.2, 800, 1603a, 1618.5, 1640.1, 1648.10, 1650, 1695, 1695.1, 1905.1, 1944, 2054, 2401, 2428, 2529, 2650, 2770, 2770.1, 2770.2, 2770.7, 2770.8, 2770.10, 2770.11, 2770.12, 2770.13, 2835.5, ~~2914~~, 3057, 3509.5, 4836.2, 4887, 4938, 4939, 4980.399, 4980.43, 4980.54, 4984.01, 4989.34, 4992.09, 4996.2, 4996.22, 4996.28, 4999.1, 4999.2, 4999.3, 4999.4, 4999.5, 4999.7, 4999.45, 4999.46, 4999.55, 4999.76, and 4999.100 of, to amend the heading of Article 3.1 (commencing with Section 2770) of Chapter 6 of Division 2 of, and to repeal Section 1917.2 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 800, as amended, Committee on Business, Professions and Economic Development. Healing arts.

Under existing law, the Department of Consumer Affairs is comprised of various boards, bureaus, commissions, committees, and similarly constituted agencies that license and regulate the practice of various professions and vocations, including those relating to the healing arts:

1 (12) Pays an application fee in an amount equal to the  
2 application fee prescribed pursuant to subdivision (a) of Section  
3 3152.

4 (13) Has successfully passed the board's jurisprudence  
5 examination.

6 (b) If the board finds that the competency of a candidate for  
7 licensure pursuant to this section is in question, the board may  
8 require the passage of a written, practical, or clinical examination  
9 or completion of additional continuing education or coursework.

10 (c) In cases where the person establishes, to the board's  
11 satisfaction, that he or she has been displaced by a federally  
12 declared emergency and cannot relocate to his or her state of  
13 practice within a reasonable time without economic hardship, the  
14 board may reduce or waive the fees required by paragraph (12) of  
15 subdivision (a).

16 (d) Any license issued pursuant to this section shall expire as  
17 provided in Section 3146, and may be renewed as provided in this  
18 chapter, subject to the same conditions as other licenses issued  
19 under this chapter.

20 (e) The term "in good standing," as used in this section, means  
21 that a person under this section:

22 (1) Is not currently under investigation nor has been charged  
23 with an offense for any act substantially related to the practice of  
24 optometry by any public agency, nor entered into any consent  
25 agreement or subject to an administrative decision that contains  
26 conditions placed by an agency upon a person's professional  
27 conduct or practice, including any voluntary surrender of license,  
28 nor been the subject of an adverse judgment resulting from the  
29 practice of optometry that the board determines constitutes  
30 evidence of a pattern of incompetence or negligence.

31 (2) Has no physical or mental impairment related to drugs or  
32 alcohol, and has not been found mentally incompetent by a licensed  
33 psychologist or licensed psychiatrist so that the person is unable  
34 to undertake the practice of optometry in a manner consistent with  
35 the safety of a patient or the public.

36 ~~SEC. 34.~~

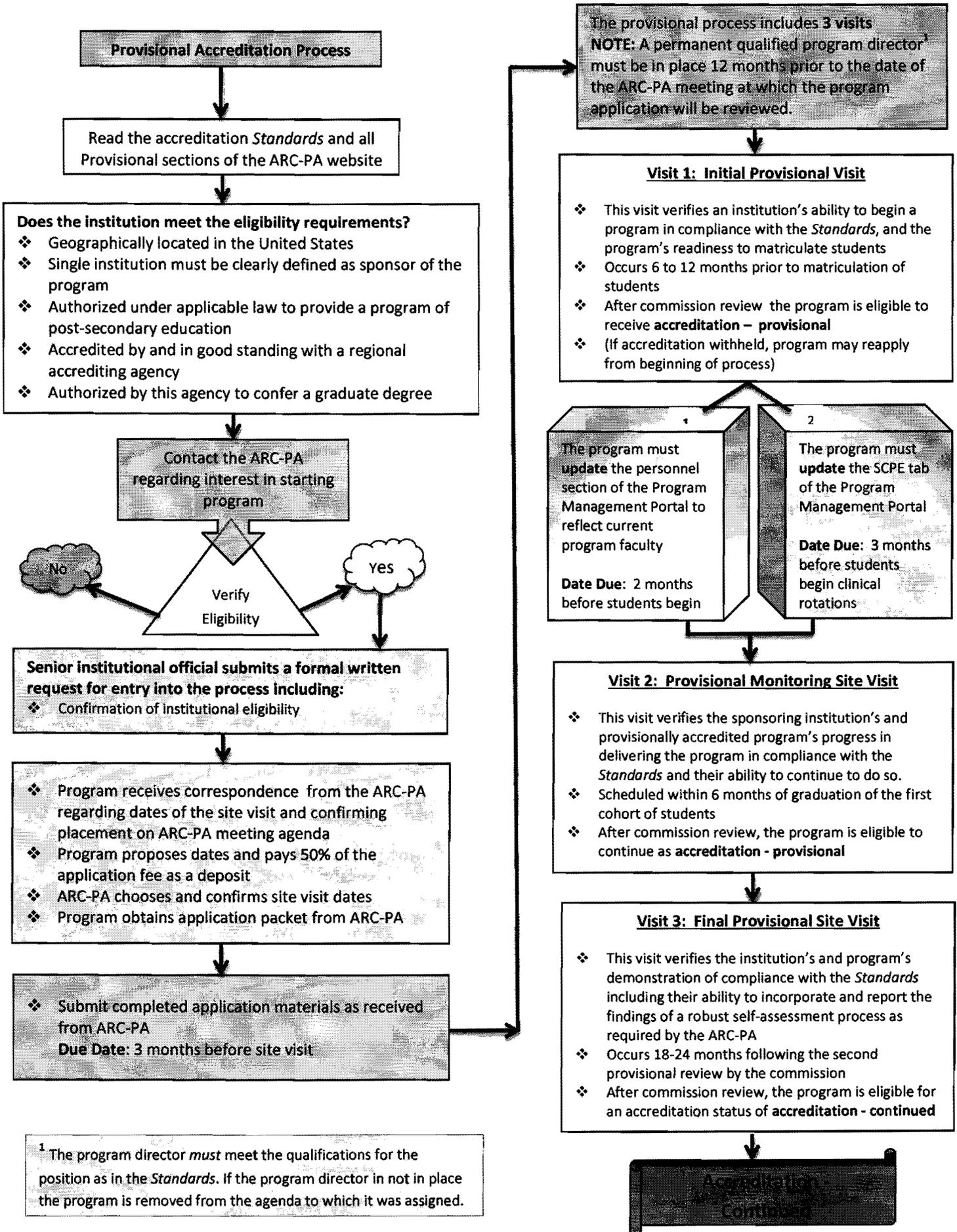
37 *SEC. 33.* Section 3509.5 of the Business and Professions Code  
38 is amended to read:

39 3509.5. The board shall elect annually a president and a vice  
40 president from among its members.

Agenda

Item

12



Agenda

Item

14

**PHYSICIAN ASSISTANT BOARD - FUND 0280  
BUDGET REPORT  
FY 2014-15 EXPENDITURE PROJECTION**

FM 12

OBJECT DESCRIPTION	FY 2013-14		FY 2014-15				
	ACTUAL EXPENDITURES (MONTH 13)	PRIOR YEAR EXPENDITURES 6/30/2014	BUDGET STONE 2014-15	CURRENT YEAR EXPENDITURES 6/30/2015	PERCENT SPENT	PROJECTIONS TO YEAR END	UNENCUMBERED BALANCE
<b>PERSONNEL SERVICES</b>							
Civil Service-Perm	142,342	142,175	193,094	179,755	93%	181,150	11,944
Statutory Exempt (EO)	77,454	77,454	79,344	85,908	108%	85,908	(6,564)
Temp Help - Expert Examiner (903)			0				0
Temp Help Reg (907)	34,475	31,305	30,000	32,099	107%	36,189	(6,189)
Bd / Commsn (901, 920)			0			0	0
Comm Member (911)	6,100	6,100	1,530	7,300	477%	7,300	(5,770)
Overtime	0		0	1,702		1,702	(1,702)
Staff Benefits	88,051	87,951	129,966	116,885	90%	117,026	12,940
<b>TOTALS, PERSONNEL SVC</b>	<b>348,422</b>	<b>344,985</b>	<b>433,934</b>	<b>423,649</b>	<b>98%</b>	<b>429,275</b>	<b>4,659</b>
<b>OPERATING EXPENSE AND EQUIPMENT</b>							
General Expense	15,280	14,983	14,556	16,046	110%	17,000	(2,444)
Fingerprint Reports	9,867	9,867	14,890	14,357	96%	15,000	(110)
Minor Equipment	2,361	2,361	2,500	323		323	2,177
Printing	6,559	6,559	6,890	6,084	88%	6,600	290
Communication	2,564	2,539	5,669	1,802	32%	2,000	3,669
Postage	4,882	4,882	8,187	3,848	47%	4,200	3,987
Insurance			0			0	0
Travel In State	12,768	10,374	20,957	13,184	63%	14,000	6,957
Travel, Out-of-State			0			0	0
Training	1,200	1,200	1,034	0	0%	0	1,034
Facilities Operations	42,473	42,473	55,958	45,266	81%	45,266	10,692
Utilities			0			0	0
C & P Services - Interdept.	63,000	63,000	1,899	0	0%	0	1,899
C & P Services - External	75,110	75,110	50,129	105,130	210%	105,130	(55,001)
<b>DEPARTMENTAL SERVICES:</b>							
OIS Pro Rata	79,865	80,707	80,839	80,416	99%	80,416	423
Administration Pro Rata	46,017	46,293	51,311	51,821	101%	51,821	(510)
Interagency Services	0	0	7,717	0	0%	0	7,717
Shared Svcs - MBC Only	93,326	93,326	93,326	90,112	97%	93,326	0
DOI - Pro Rata	1,466	1,473	1,604	1,055	66%	1,604	0
Public Affairs Pro Rata	1,693	2,069	1,569	2,057	131%	2,057	(488)
PCSD Pro Rata	1,673	1,775	1,704	2,051	120%	2,051	(347)
<b>INTERAGENCY SERVICES:</b>							
Consolidated Data Center	639	639	4,810	0	0%	700	4,110
DP Maintenance & Supply	9	9	3,019	160	5%	160	2,859
Statewide - Pro Rata	61,708	61,708	69,681	69,681	100%	69,681	0
<b>EXAMS EXPENSES:</b>							
Exam Supplies			0			0	0
<b>OTHER ITEMS OF EXPENSE:</b>							
<b>ENFORCEMENT:</b>							
Attorney General	313,066	313,066	382,418	363,002	95%	381,934	484
Office Admin. Hearings	43,906	43,906	81,251	57,102	70%	58,000	23,251
Court Reporters	1,843	1,343		3,317		3,317	(3,317)
Evidence/Witness Fees	47,198	43,323	492	42,713	8682%	46,600	(46,108)
Investigative Svcs - MBC Only	133,542	108,942	218,870	155,327	71%	165,000	53,870
Vehicle Operations						0	0
Major Equipment						0	0
<b>TOTALS, OE&amp;E</b>	<b>1,062,015</b>	<b>1,031,927</b>	<b>1,181,280</b>	<b>1,124,854</b>	<b>95%</b>	<b>1,166,186</b>	<b>15,094</b>
<b>TOTAL EXPENSE</b>	<b>1,410,437</b>	<b>1,376,912</b>	<b>1,615,214</b>	<b>1,548,503</b>	<b>193%</b>	<b>1,595,461</b>	<b>19,753</b>
Sched. Reimb. - Fingerprints	(4,889)	(4,889)	(25,000)	(11,493)	46%	(25,000)	0
Sched. Reimb. - Other	(2,680)	(2,680)	(25,000)	(940)	4%	(25,000)	0
Unsched. Reimb. - ICR	(46,525)	(46,525)		(50,421)			0
Unsched. Reimb. - ICR - Prob Monitor	(22,723)	(22,723)		(6,750)			0
<b>NET APPROPRIATION</b>	<b>1,333,620</b>	<b>1,300,095</b>	<b>1,565,214</b>	<b>1,478,899</b>	<b>94%</b>	<b>1,545,461</b>	<b>19,753</b>
<b>SURPLUS/(DEFICIT):</b>							<b>1.3%</b>

# 0280 - Physician Assistant Board Analysis of Fund Condition

(Dollars in Thousands)

NOTE: \$1.5 Million General Fund Repayment Outstanding

2015-16 Governor's Budget w/ BreEZe SPR 3.1 (Assembly) +  
Project Extension (\$1.95 million one-time)

	ACTUAL 2013-14	CY 2014-15	BY 2015-16	BY + 1 2016-17
<b>BEGINNING BALANCE</b>	\$ 1,240	\$ 1,531	\$ 1,449	\$ 1,517
Prior Year Adjustment	\$ 56	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 1,296	\$ 1,531	\$ 1,449	\$ 1,517
<b>REVENUES AND TRANSFERS</b>				
Revenues:				
125600 Other regulatory fees	\$ 11	\$ 11	\$ 11	\$ 11
125700 Other regulatory licenses and permits	\$ 212	\$ 177	\$ 178	\$ 178
125800 Renewal fees	\$ 1,336	\$ 1,350	\$ 1,395	\$ 1,395
125900 Delinquent fees	\$ 3	\$ 3	\$ 3	\$ 3
141200 Sales of documents	\$ 1	\$ -	\$ -	\$ -
142500 Miscellaneous services to the public	\$ -	\$ -	\$ -	\$ -
150300 Income from surplus money investments	\$ 4	\$ 5	\$ 5	\$ 5
160400 Sale of fixed assets	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 1	\$ -	\$ -	\$ -
161400 Miscellaneous revenues	\$ -	\$ -	\$ -	\$ -
164300 Penalty Assessments	\$ -	\$ -	\$ -	\$ -
Totals, Revenues	\$ 1,569	\$ 1,546	\$ 1,592	\$ 1,592
Totals, Revenues and Transfers	\$ 1,569	\$ 1,546	\$ 1,592	\$ 1,592
Totals, Resources	\$ 2,865	\$ 3,077	\$ 3,041	\$ 3,109
<b>EXPENDITURES</b>				
Disbursements:				
0840 State Controllers	\$ -	\$ -	\$ -	\$ -
1110 Program Expenditures (State Operations)	\$ 1,334	\$ 1,504	\$ 1,405	\$ 1,433
Pending AG/OAH Augmentation	\$ -	\$ 117	\$ -	\$ -
2014-15 BreEZe CY Adj	\$ -	\$ 5	\$ -	\$ -
2015-16 BreEZe SFL (Assembly)	\$ -	\$ -	\$ 107	\$ 113
2015-16 BreEZe Project Extension	\$ -	\$ -	\$ 9	\$ -
8880 FISCAL (State Operations)	\$ -	\$ 1	\$ 3	\$ -
Total Disbursements	\$ 1,334	\$ 1,627	\$ 1,524	\$ 1,546
<b>FUND BALANCE</b>				
Reserve for economic uncertainties	\$ 1,531	\$ 1,449	\$ 1,517	\$ 1,563
<b>Months in Reserve</b>	11.3	11.4	11.8	12.8

## NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED IN BY+1 AND ON-GOING.
- B. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR BEGINNING IN BY+1.
- C. ASSUMES INTEREST RATE AT 0.3%.

# DEPARTMENT OF CONSUMER AFFAIRS

PHYSICIAN ASSISTANT COMMITTEE

## BUDGET REPORT AS OF 6/30/2015

RUN DATE 7/11/2015

PAGE 1

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PHYSICIAN ASSISTANT BOARD

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
<b>PERSONAL SERVICES</b>							
<b>SALARIES AND WAGES</b>							
003 00 CIVIL SERVICE-PERM	193,094	10,464	179,755	0	179,755	13,339	
033 04 TEMP HELP (907)	30,000	2,148	32,099	0	32,099	(2,099)	
063 00 STATUTORY-EXEMPT	79,344	7,370	85,908	0	85,908	(6,564)	
063 03 COMM MEMBER (911)	1,530	1,800	7,300	0	7,300	(5,770)	
083 00 OVERTIME	0	0	1,702	0	1,702	(1,702)	
<b>TOTAL SALARIES AND WAGES</b>	<b>303,968</b>	<b>21,781</b>	<b>306,763</b>	<b>0</b>	<b>306,763</b>	<b>(2,795)</b>	<b>-0.92%</b>
<b>STAFF BENEFITS</b>							
103 00 OASDI	16,290	1,081	16,205	0	16,205	85	
104 00 DENTAL INSURANCE	1,659	164	2,050	0	2,050	(391)	
105 00 HEALTH/WELFARE INS	39,901	1,902	25,135	0	25,135	14,766	
106 01 RETIREMENT	67,014	4,330	57,808	0	57,808	9,206	
125 00 WORKERS' COMPENSAT	4,266	0	0	0	0	4,266	
125 15 SCIF ALLOCATION CO	0	381	1,845	0	1,845	(1,845)	
134 00 OTHER-STAFF BENEFI	0	778	9,043	0	9,043	(9,043)	
135 00 LIFE INSURANCE	0	7	83	0	83	(83)	
136 00 VISION CARE	445	26	354	0	354	91	
137 00 MEDICARE TAXATION	391	310	4,361	0	4,361	(3,970)	
<b>TOTAL STAFF BENEFITS</b>	<b>129,966</b>	<b>8,978</b>	<b>116,885</b>	<b>0</b>	<b>116,885</b>	<b>13,081</b>	<b>10.07%</b>
<b>TOTAL PERSONAL SERVICES</b>	<b>433,934</b>	<b>30,759</b>	<b>423,648</b>	<b>0</b>	<b>423,648</b>	<b>10,286</b>	<b>2.37%</b>
<b>OPERATING EXPENSES &amp; EQUIPMENT</b>							
<b>FINGERPRINTS</b>							
213 04 FINGERPRINT REPORT	14,890	1,813	14,357	0	14,357	533	
<b>TOTAL FINGERPRINTS</b>	<b>14,890</b>	<b>1,813</b>	<b>14,357</b>	<b>0</b>	<b>14,357</b>	<b>533</b>	<b>3.58%</b>
<b>GENERAL EXPENSE</b>							
201 00 GENERAL EXPENSE	14,556	0	0	0	0	14,556	
206 00 MISC OFFICE SUPPLI	0	50	3,521	0	3,521	(3,521)	
207 00 FREIGHT & DRAYAGE	0	42	877	0	877	(877)	
213 02 ADMIN OVERHEAD-OTH	0	4	2,148	0	2,148	(2,148)	
217 00 MTG/CONF/EXHIBIT/S	0	630	7,309	2,190	9,499	(9,499)	
<b>TOTAL GENERAL EXPENSE</b>	<b>14,556</b>	<b>727</b>	<b>13,855</b>	<b>2,190</b>	<b>16,046</b>	<b>(1,490)</b>	<b>-10.23%</b>

**DEPARTMENT OF CONSUMER AFFAIRS**

**BUDGET REPORT**

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PHYSICIAN ASSISTANT COMMITTEE

PHYSICIAN ASSISTANT BOARD

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
<b>PRINTING</b>							
241 00 PRINTING	6,890	0	0	0	0	6,890	
242 03 COPY COSTS ALLO	0	0	430	0	430	(430)	
242 05 METRO PRINT/MAIL	0	0	4,334	0	4,334	(4,334)	
244 00 OFFICE COPIER EXP	0	309	927	393	1,320	(1,320)	
<b>TOTAL PRINTING</b>	<b>6,890</b>	<b>309</b>	<b>5,690</b>	<b>393</b>	<b>6,084</b>	<b>806</b>	<b>11.70%</b>
<b>COMMUNICATIONS</b>							
251 00 COMMUNICATIONS	5,669	0	0	0	0	5,669	
252 00 CELL PHONES,PDA,PA	0	40	528	0	528	(528)	
257 01 TELEPHONE EXCHANGE	0	230	1,274	0	1,274	(1,274)	
<b>TOTAL COMMUNICATIONS</b>	<b>5,669</b>	<b>270</b>	<b>1,802</b>	<b>0</b>	<b>1,802</b>	<b>3,867</b>	<b>68.21%</b>
<b>POSTAGE</b>							
261 00 POSTAGE	8,187	0	0	0	0	8,187	
262 00 STAMPS, STAMP ENVE	0	284	1,641	0	1,641	(1,641)	
263 05 DCA POSTAGE ALLO	0	193	2,207	0	2,207	(2,207)	
<b>TOTAL POSTAGE</b>	<b>8,187</b>	<b>477</b>	<b>3,848</b>	<b>0</b>	<b>3,848</b>	<b>4,339</b>	<b>53.00%</b>
<b>TRAVEL: IN-STATE</b>							
291 00 TRAVEL: IN-STATE	20,957	0	0	0	0	20,957	
292 00 PER DIEM-I/S	0	0	4,123	0	4,123	(4,123)	
294 00 COMMERCIAL AIR-I/S	0	0	4,312	0	4,312	(4,312)	
296 00 PRIVATE CAR-I/S	0	143	2,509	0	2,509	(2,509)	
297 00 RENTAL CAR-I/S	0	412	1,811	0	1,811	(1,811)	
301 00 TAXI & SHUTTLE SER	0	0	39	0	39	(39)	
305 00 MGMT/TRANS FEE-I/S	0	27	167	0	167	(167)	
305 01 CALATERS SERVICE F	0	56	224	0	224	(224)	
<b>TOTAL TRAVEL: IN-STATE</b>	<b>20,957</b>	<b>638</b>	<b>13,184</b>	<b>0</b>	<b>13,184</b>	<b>7,773</b>	<b>37.09%</b>
<b>TRAINING</b>							
331 00 TRAINING	1,034	0	0	0	0	1,034	
<b>TOTAL TRAINING</b>	<b>1,034</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,034</b>	<b>100.00%</b>
<b>FACILITIES OPERATIONS</b>							
341 00 FACILITIES OPERATI	55,958	0	0	0	0	55,958	
343 00 RENT-BLDG/GRND(NON	0	3,694	44,230	0	44,230	(44,230)	
346 00 RECURRING MAINT SV	0	0	120	0	120	(120)	
347 00 FACILITY PLNG-DGS	0	153	916	0	916	(916)	
<b>TOTAL FACILITIES OPERATIONS</b>	<b>55,958</b>	<b>3,847</b>	<b>45,266</b>	<b>0</b>	<b>45,266</b>	<b>10,692</b>	<b>19.11%</b>

**DEPARTMENT OF CONSUMER AFFAIRS**

PHYSICIAN ASSISTANT COMMITTEE

**BUDGET REPORT  
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PHYSICIAN ASSISTANT BOARD

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
<b>C/P SVS - INTERDEPARTMENTAL</b>							
382 00 CONSULT/PROF-INTER	1,900	0	0	59,000	59,000	(57,100)	
<b>TOTAL C/P SVS - INTERDEPARTMENTAL</b>	<b>1,900</b>	<b>0</b>	<b>0</b>	<b>59,000</b>	<b>59,000</b>	<b>(57,100)</b>	<b>-3005.26%</b>
<b>C/P SVS - EXTERNAL</b>							
402 00 CONSULT/PROF SERV-	33,561	0	0	0	0	33,561	
404 05 C&P EXT ADMIN CR C	16,568	267	789	23,211	24,000	(7,432)	
409 00 INFO TECHNOLOGY-EX	0	0	1,514	0	1,514	(1,514)	
418 02 CONS/PROF SVS-EXTR	0	1,268	18,651	60,965	79,616	(79,616)	
<b>TOTAL C/P SVS - EXTERNAL</b>	<b>50,129</b>	<b>1,535</b>	<b>20,954</b>	<b>84,176</b>	<b>105,130</b>	<b>(55,001)</b>	<b>-109.72%</b>
<b>DEPARTMENTAL SERVICES</b>							
424 03 OIS PRO RATA	80,839	0	80,416	0	80,416	423	
427 00 INDIRECT DISTRB CO	51,311	0	51,821	0	51,821	(510)	
427 01 INTERAGENCY SERVS	7,717	0	0	0	0	7,717	
427 02 SHARED SVS-MBC ONL	93,326	22,528	90,112	0	90,112	3,214	
427 30 DOI - ISU PRO RATA	1,604	0	1,055	0	1,055	549	
427 34 PUBLIC AFFAIRS PRO	1,569	0	2,057	0	2,057	(488)	
427 35 PCSD PRO RATA	1,704	0	2,051	0	2,051	(347)	
<b>TOTAL DEPARTMENTAL SERVICES</b>	<b>238,070</b>	<b>22,528</b>	<b>227,512</b>	<b>0</b>	<b>227,512</b>	<b>10,558</b>	<b>4.43%</b>
<b>CONSOLIDATED DATA CENTERS</b>							
428 00 CONSOLIDATED DATA	4,810	0	0	0	0	4,810	
<b>TOTAL CONSOLIDATED DATA CENTERS</b>	<b>4,810</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,810</b>	<b>99.99%</b>
<b>DATA PROCESSING</b>							
431 00 INFORMATION TECHNO	3,019	0	0	0	0	3,019	
436 00 SUPPLIES-IT (PAPER	0	0	160	0	160	(160)	
<b>TOTAL DATA PROCESSING</b>	<b>3,019</b>	<b>0</b>	<b>160</b>	<b>0</b>	<b>160</b>	<b>2,859</b>	<b>94.70%</b>
<b>CENTRAL ADMINISTRATIVE SERVICES</b>							
438 00 PRO RATA	69,681	0	69,681	0	69,681	0	
<b>TOTAL CENTRAL ADMINISTRATIVE SERVICES</b>	<b>69,681</b>	<b>0</b>	<b>69,681</b>	<b>0</b>	<b>69,681</b>	<b>0</b>	<b>0.00%</b>
<b>ENFORCEMENT</b>							
396 00 ATTORNEY GENL-INTE	382,418	33,024	336,513	0	336,513	45,905	
397 00 OFC ADMIN HEARNG-I	81,251	11,525	53,424	0	53,424	27,827	
414 31 EVIDENCE/WITNESS F	492	5,363	42,713	0	42,713	(42,221)	
418 97 COURT REPORTER SER	0	79	3,317	0	3,317	(3,317)	
427 32 INVEST SVS-MBC ONL	218,870	18,166	155,327	0	155,327	63,543	

DEPARTMENT OF CONSUMER AFFAIRS

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PHYSICIAN ASSISTANT COMMITTEE

PHYSICIAN ASSISTANT BOARD

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
<u>TOTAL</u> ENFORCEMENT	683,031	68,156	591,294	0	591,294	91,737	13.43%
MINOR EQUIPMENT							
226 00 MINOR EQUIPMENT	2,500	0	0	0	0	2,500	
226 55 MIN EQPMT-PHONE-RE	0	0	323	0	323	(323)	
<u>TOTAL</u> MINOR EQUIPMENT	2,500	0	323	0	323	2,177	87.07%
<u>TOTAL</u> OPERATING EXPENSES & EQUIPMEN	1,181,281	100,299	1,007,927	145,760	1,153,687	27,594	2.34%
<b>PHYSICIAN ASSISTANT BOARD</b>	<b>1,615,215</b>	<b>131,058</b>	<b>1,431,575</b>	<b>145,760</b>	<b>1,577,335</b>	<b>37,880</b>	<b>2.35%</b>
	1,615,215	131,058	1,431,575	145,760	1,577,335	37,880	2.35%

Agenda

Item

15

**DISCUSSION OF COMPLIANCE WITH TITLE 16 OF THE CALIFORNIA CODE OF REGULATIONS SECTION 1399.546 – REPORTING OF PHYSICIAN ASSISTANT SUPERVISOR; ELECTRONIC RECORDS AND SIGNATURES**

**INFORMAL SURVEY OF OTHER STATE SUPERVISION REQUIREMENTS**

As requested by the Board, staff conducted an informal survey to determine the supervision reporting requirements in other States. We reviewed physician assistant licensing websites in 35 states.

Our survey revealed that of the 35 states reviewed almost 30 require that, as a condition of initial licensure, applicants submit to the licensing board the name or names of their supervising physicians. Some states also require that the applicant provide a “practice plan” or supervision document with their application. Licensure is granted upon the licensing board’s approval of the physician assistant/supervising physician arrangement.

Again, almost 30 of the states surveyed required that the physician assistant licensees report and obtain approval from the licensing board when they add or delete supervising physicians. A few states also require that the licensee submit their “practice plan” or supervision document at the time of their renewal.

**BACKGROUND OF THE ADOPTION OF CCR SECTION 1399.546**

On December 16, 1986, the Board of Medical Quality Assurance (now Medical Board of California), Division of Allied Health Professions submitted the Office of Administrative Law (OAL) the adoption of section 1399.510 of Article 1, Chapter 13.8, Title 16 of the California Code of Regulations.

Initially, the proposed section would require physician assistants to identify the name of his or her approved supervising physician each time the physician assistant provided care to a patient by written or oral order.

During the period of review, the Board submitted new regulatory text to OAL that renumbered the regulation as section 1399.546 and placed it in Article 4, Chapter 13.8, Title 16 of the California Code of Regulations.

OAL approved the rulemaking file on January 14, 1987.

Attached you will find a copy of the Initial Statement of Reasons (ISR) for the rulemaking file that adopted Title 16, California Code of Regulations Section 1399.546. The ISR describes the problem addressed, specific propose of the proposed regulatory action, and factual basis.

The regulation has not been amended since it was adopted with the exception of deleting the “s” from physician assistant.

**CCR SECTION 1399.546 AND SB 337 AMENDMENTS TO BPC SECTION 3502(A)**

SB 337 includes an amendment to BPC Section 3502(a) adding:

The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

SB 337 also seeks to amend BPC 3502 by adding (f) which states:

Compliance by a physician assistant and supervising physician and surgeon with this section shall be deemed compliance with Section 1399.546 of Title 16 of the California Code of Regulations.

BOARD OF MEDICAL QUALITY ASSURANCE  
DIVISION OF ALLIED HEALTH PROFESSIONS

## INITIAL STATEMENT OF REASONS

Hearing Date: Thursday, July 24, 1986

Subject Matter of Proposed Regulations:

(1) Sections Affected: 1399.510 and 1399.522 of Article I  
of Chapter 13.8, California Administrative Code

Problem Addressed:

Section 3502, Business and Professions Code requires supervision of physician's assistants by physicians who are approved by the Board to supervise. Current regulations do not require supervisors or physician's assistants to notify the Board of their supervisors/supervisees. The Board must individually investigate in order to ascertain if a physician's assistant is being appropriately supervised, by whom and where each is working.

Many physician's assistants are supervised by more than one physician. Current regulations do not require a physician's assistant to identify which supervisor is assuming supervisory responsibility for the care given to a particular patient by the physician's assistant.

Specific Purpose of the Regulation:

This regulation would permit the Board to create a record of the supervisor/supervisee pairs and their practice locations, to assure compliance with Section 3502. It also would assure that whenever a physician's assistant attends a patient the patient record will clearly indicate which physician supervisor is responsible for supervision of that physician's assistant with respect to that particular patient encounter.

Factual Basis:

The Board investigates complaints relating to the practice and supervision of physician's assistants. It also receives public inquiries regarding who is the approved supervisor of a physician's assistant. At present the Board is unable to determine from its own records where a physician's assistant is currently practicing or who is his or her supervisor.

It is necessary to investigate each inquiry or complaint in order to determine if the licensees are complying with Section 3502. This may require nothing more than a phone call

to the physician's assistant in some instances; in other cases a formal investigation may be required to locate the physician's assistant, establish who is supervising and determine where each is practicing. (Note: current law and regulations permit supervision by electronic means including telephone or radio. The physician's assistant is not required to practice in the same physical location as the physician.)

Statements made by the Physician's Assistant Examining Committee to the Division of Allied Health Professions in the past establish that neither the Committee, its staff nor the Division of Allied Health Professions currently maintains records of which physicians are supervising which physician's assistants or where they are practicing. Statements made to the Division of Allied Health Professions by the Board of Medical Quality Assurance Enforcement Program establish that the Enforcement Program is unable to determine from Board or Committee records whether a physician's assistant is being supervised and by whom. It is necessary to investigate in order to make such determinations.

Underlying Data:

Annual reports of the Board of Medical Quality Assurance show that 33 complaints were filed against physician's assistants in 1982, 50 in 1983 and 48 in fiscal 1984. The Board and the Physician's Assistant Examining Committee also receive periodic oral inquiries from patients and licensees requesting information about specific physician's assistants and supervisors. Written records of such inquiries are not routinely maintained, so there is no written record for inclusion in this rulemaking file.

Small Business Impact:

This regulation will not have a significant adverse economic impact on small businesses.

Cost Impact:

This regulation will not have a significant cost impact on any public agency.

This regulation will not have a significant cost impact on affected private persons or entities.

Specific Technologies or Equipment:

This regulation does not mandate the use of specific technologies or equipment.

Alternatives Considered:

1. Requiring physician's assistants to report the names of their supervisors and their practice locations.

Rejected because the Division of Allied Health Professions does not have direct jurisdiction over the physician's assistants. Only the Physician's Assistant Examining Committee can promulgate such a requirement for physician's assistants.

2. Promulgate a regulation limiting the distance between the practice locations of physician's assistants and their supervisors, as well as identifying who supervises whom.

Rejected because any such limitation would be based on an arbitrary determination of what constitutes a "reasonable" distance between the supervisor and physician's assistant. Arbitrary limits could adversely impact medical care in certain remote parts of the state.

**TITLE 16, CCR SECTION 1399.546**

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.

**SB 337 (As amended June 16, 2015): PROPOSED AMENDMENTS TO BPC 3502; SUPERVISION REPORTING REQUIREMENTS (HIGHLIGHTED/BOLD SECTIONS)**

**3502.**

(a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. **The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.** ~~When a physician assistant transmits an oral order, he or she shall also identify the name of the supervising physician and surgeon responsible for the patient.~~

(b) (1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon.

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

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

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

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

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

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

(2) (A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

(ii) The supervising physician and surgeon and physician assistant shall ~~conduct at least 10 times annually a medical records review meeting, which may occur in person or by electronic communication.~~ *meeting, at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.*

(iii) The supervising physician and surgeon shall supervise the care provided by the physician assistant through a review of ~~those cases or patients deemed appropriate cases involving treatment by the physician assistant functioning under protocols adopted by the supervising physician and surgeon.~~ *The review methods used shall be identified in the delegation of services agreement, and review may occur in person or by electronic communication.* *agreement and shall include no less than an aggregate of 10 cases per month for at least 10 months of the year. Documentation of the cases reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.*

(B) In complying with subparagraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

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

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

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

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

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

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

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

**(f) Compliance by a physician assistant and supervising physician and surgeon with this section shall be deemed compliance with Section 1399.546 of Title 16 of the California Code of Regulations.**

Agenda

Item

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**FOURTH QUARTER 2015**

**SEPTEMBER**

SUN	MON	TUE	WED	THU	FRI	SAT
		1	2	3	4	5
6	H	7	8	9	10	11
12		13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

**OCTOBER**

SUN	MON	TUE	WED	THU	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

**NOVEMBER**

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	H	11	12	13
14	PAB MTG	15	16	17	18	19
20	21	22	23	24	H	25
26	27	28	29	30		

**DECEMBER**

SUN	MON	TUE	WED	THU	FRI	SAT
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	H	25
26	27	28	29	30	31	