

**OSTEOPATHIC MEDICAL
BOARD
OF CALIFORNIA**

**Board Meeting, Thursday, May 5, 2016
10:00 a.m.**

**Western University of Health Sciences
701 E. Second Street
Health Education Center (HEC)
Lecture Hall II (2nd Floor)
Pomona CA 91766**

OMBC Phone (916) 928-8390

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TABLE I



OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
BOARD MEETING

Date: Thursday, May 5, 2016
Time: 10:00 a.m. – 5:00 p.m. (or until the end of business)

Location(s): Western University of Health Sciences
701 E. Second Street
Health Education Center (HEC)
Lecture Hall II (2nd Floor)
Pomona CA 91766
916-928-8390

AGENDA

(Action may be taken on any items listed on the agenda and may be taken out of order, unless noticed for a certain time.) The Board plans to webcast this meeting on its website at <https://thedcapage.wordpress.com/webcasts/>. Webcast availability cannot, however, be guaranteed due to limited resources. The meeting will not be cancelled if webcast is not available. If you wish to participate or to have a guaranteed opportunity to observe, please plan to attend at a physical meeting location. Adjournment, if it is the only item that occurs after a closed session, may not be webcast.

Open Session

1. Call to Order and Roll Call / Establishment of a Quorum
2. Public Comment for Items Not on the Agenda
Note: The Board may not discuss or take action on any matter raised during this public comment section except to decide whether to place the matter on the agenda of a future meeting [Government Code Sections 11125, 11125.7(a)]
3. Introduction of new board member(s)
4. Election of Officers
5. Review and Approval of Minutes – January 21, 2016 Board Meeting
6. President's Report
 - Annual Federation of State Medical Boards (FSMB) Meeting
7. 10:30 a.m. Administrative Hearing
 - Tam Nguyen, D.O. – Petition for Early Termination of Probation

8. Closed Session

- Deliberations on disciplinary or enforcement actions, including the above petition.
(Government Code Section 11126(c)(3).)
- Adjourn Closed Session

Return to Open Session

9. Executive Director's Report – Angie Burton

- Licensing
- Staffing
- Budget
- CURES Update
- Enforcement Report / Discipline
- Proposed Bills – Information and possible discussion
 - **AB 15:** End of Life Option Act
 - **AB 1306:** Certified nurse-midwives - scope of practice
 - **AB 1992:** Physical exams for pupils by chiropractors, NDs, and nurse practitioners
 - **AB 2859:** Retired category – licenses
 - **SB 323:** Nurse practitioners - scope of practice
 - **SB 482:** CURES
 - **SB 1033:** Disclosure of probationary status
 - **SB 1418:** Clinical lab testing without order from health care provider

10. Presentation – Kathleen Creason, Director, Osteopathic Physicians & Surgeons of California (OPSC)

- **AB 1992:** Physical exams for pupils by chiropractors, NDs, and nurse practitioners
- **SB 1033:** Disclosure of probationary status

11. Title 16 California Code of Regulations: Discussion and possible action

- Proposed Amendments to Section 1661.2 (Diversion Evaluation Committee Duties and Responsibilities) and 1663 (Disciplinary Guidelines)
- Proposed Amendments to Section 1610 (Application; Refund of Fee; Expirations; Renewals)
- Discussion on possible Amendments to Section 1636 (Continuing Medical Education Progress Report)

12. Agenda Items for Next Meeting

13. Future Meeting Dates

14. Adjournment

For further information about this meeting, please contact Machiko Chong at 916-928-7636 or in writing 1300 National Drive, Suite 150 Sacramento CA 95834. This notice can be accessed at www.ombc.ca.gov

Government Code section 11125.7 provides the opportunity for the public to address each agenda item during discussion or consideration by the Board prior to the Board taking any action on said item. Members of the public will be provided appropriate opportunities to comment on any issue before the Board, but the Board President may, at his or her discretion, apportion available time among those who wish to speak. Individuals may appear before the Board to discuss items not on the agenda; however, the Board can neither discuss nor take official action on these items at the time of the same meeting. (Gov. Code, sections 11125, 11125.7(a).)

In accordance with the Bagley Keene Open Meeting Act, all meetings of the Board are open to the public and all meeting locations are 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 Machiko Chong, ADA Liaison, at (916) 928-7636 or via e-mail at Machiko.Chong@dca.ca.gov or may send a written request to the Board's office at 1300 National Drive, Suite 150, Sacramento, CA 95834-1991. Providing your request at least five (5) business days before the meeting will help to ensure availability of the requested accommodation.

TABLE 2



OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
Executive Office

Board Member Appointments

Megan Lim Blair of San Diego, was appointed to the Osteopathic Medical Board on March 2, 2016 by Assembly Speaker Toni G. Atkins. Mrs. Blair replaces Keith Higginbotham, Esq. who previously served as Vice President to the Board.

TABLE 3



BOARD MEETING MINUTES

Thursday, January 21, 2016

BOARD MEMBERS PRESENT: Joseph Zammuto, D.O., President
Keith Higginbotham, Esq., Vice President
Cyrus Buhari, D.O., Board Member
Claudia Mercado, Board Member
Alan Howard, Board Member
Cheryl Williams, Board Member
Elizabeth Jensen, D.O., Board Member

STAFF PRESENT: Angelina Burton, Executive Director
Ileana Butu, Esq., Legal Counsel, DCA
Machiko Chong, Executive Analyst
Francine Davies, Assistant Executive Director
Corey Sparks, Lead Enforcement Analyst

BOARD MEMBERS ABSENT: James Lally, D.O., Board Member
Michael Feinstein, D.O., Board Member

The Board meeting of the Osteopathic Medical Board of California (OMBC) was called to order by President, Joseph Zammuto, D.O. at 9:59 a.m. at the Department of Consumer Affairs, 1747 North Market Blvd. (HQ2), Hearing Room, Sacramento, CA 95834.

1. Roll Call

Mr. Higginbotham called roll and determined that a quorum was present.

2. Public Comment for Items Not on the Agenda

The Board received public comment via email from Mr. Joseph Elfelt regarding the Board's regulations, and immunity of Board members from alleged violations of federal antitrust statutes. Dr. Zammuto acknowledged the Board's receipt of Mr. Elfet's public comment and opened the floor to public comment on the issue. With there being no comment received, the discussion was closed.

3. Introduction of new Board member(s)

Dr. Zammuto welcomed Cyrus Buhari, D.O. and Elizabeth Jensen, D.O. to the Board and opened the floor to the members for self-introduction; during which time they provided additional background commentary that had not been included in the Board packet.

4. Election of Officers

Board President

- Dr. Zammuto asked if there were any motions/nominations for election of Board President.
- Joseph Zammuto, D.O. was nominated for President
Motion – K.Higginbotham, **Second** – C. Mercado.
- Dr. Zammuto opened the floor to additional nominations, none were given.
- Roll Call Vote was taken
 - **Aye** – Dr. Buhari, Mr. Higginbotham, Mr. Howard, Dr. Jensen, Ms. Mercado, Mrs. Williams, Dr. Zammuto
 - **Nay** – None
 - **Abstention** – None
 - **Absent** – Dr. Lally, Dr. Feinstein.
- Dr. Zammuto was unanimously elected for Board President.

Vice President

- Dr. Zammuto asked if there were any motions/nominations for election of Vice President.
- Keith Higginbotham, Esq. was nominated for Vice-President
Motion – J. Zammuto, **Second** – E. Jensen.
- Dr. Zammuto opened the floor to any additional nominations, none were given.
- Roll Call Vote was taken
 - **Aye** – Dr. Buhari, Mr. Higginbotham, Mr. Howard, Dr. Jensen, Ms. Mercado, Mrs. Williams, Dr. Zammuto
 - **Nay** – None
 - **Abstention** – None
 - **Absent** – Dr. Lally, Dr. Feinstein.
- Mr. Higginbotham was unanimously elected for Vice President.

Secretary/Treasurer

- Dr. Zammuto asked if there were any motions/nominations for election of Cyrus Buhari, D.O. was nominated for Secretary/Treasurer
Motion – K. Higginbotham, **Second** – C.Mercado.
- Dr. Zammuto opened the floor to any additional nominations, none were given.
- Roll Call Vote was taken
 - **Aye** – Dr. Buhari, Mr. Higginbotham, Mr. Howard, Dr. Jensen, Ms. Mercado, Mrs. Williams, Dr. Zammuto
 - **Nay** – None
 - **Abstention** – None
 - **Absent** – Dr. Lally, Dr. Feinstein.

- Dr. Buhari was unanimously elected as Secretary/Treasurer.

5. Review and Approval of Minutes – September 17, 2015 Board Meeting

Dr. Zammuto called for a motion regarding approval of the Board Meeting minutes of September 17, 2015.

- **Motion to approve the September 17, 2015 Board meeting minutes with no additions or corrections** – K. Higginbotham, **Second** – E. Jensen.
- Roll Call Vote was taken
 - **Aye** – Dr. Buhari, Mr. Higginbotham, Mr. Howard, Dr. Jensen, Ms. Mercado, Mrs. Williams, Dr. Zammuto
 - **Nay** – None
 - **Abstention** – None
 - **Absent** – Dr. Lally, Dr. Feinstein.

Motion carried to approve minutes with no additions or corrections.

6. Review and Approval of Osteopathic Medical Board Strategic Plan - Ted Evans (DCA - SOLID)

Mr. Evans presented the Board with the proposed final draft of the strategic plan compiled during the October 30, 2015 Strategic Planning Session.

Dr. Jensen recommended that revisions be made to the goal areas of footnotes 1 and 2 on page 10, so that they reflect Goal Area 5, Objective 3.

Ms. Butu recommended that editorial revisions be made to page 5, paragraph 3, line 3 removing the period after section 1600 and placing "Et. Seq." in lower case; revisions to paragraph 3 line 5 to read "The Act provides that consumer protection is the Board's highest priority..."; and revisions to page 5, paragraph 4, lines 4 and 5 to reflect "The OMBC is also responsible for enforcing legal and professional standards..."

Dr. Zammuto thanked Mr. Evans, the SOLID team, and the Board for all of the efforts that were put forth in collaborating and finalizing the strategic plan.

He then called for a motion regarding approval of the Strategic Plan with editorial revisions.

- **Motion to approve the Strategic Plan with Corrections** – C. Mercado, **Second** – A. Howard for approval of the Strategic Plan.
- Roll Call Vote was taken
 - **Aye** – Dr. Buhari, Mr. Higginbotham, Mr. Howard, Dr. Jensen, Ms. Mercado, Mrs. Williams, Dr. Zammuto
 - **Nay** – None
 - **Abstention** – None
 - **Absent** – Dr. Lally, Dr. Feinstein.

Motion carried to approve Strategic Plan with corrections.

7. Administrative Hearing

10:30 a.m.

- John Wogec, D.O. - Petition for Reinstatement of Surrendered License

The Office of Administrative Hearing (OAH) Administrative Law Judge (ALJ) Marilyn A. Woollard conducted the above hearing.

8. Closed Session

The Board met in closed session to deliberate on the petition for reinstatement of surrendered license listed above pursuant to Government Code section 11126(c)(3).

Return to Open Session

9. Executive Director's Report

CURES Update - Mike Small, DOJ (Department of Justice) Administrator, Law Enforcement Support Program, provided the Board with an update regarding CURES 2.0. He informed the Board that the CURES 2.0 database launched on January 8, 2016, and stated that the application seemed to be running very well. The database which previously had 13,613 users on the CURES 1.0 system successfully migrated each user to the 2.0 database with no issues. Additionally, they have had roughly 5,000 new applicants register with the program, with 147 of the applicants being osteopathic physician and surgeons.

Dr. Zammuto asked Mrs. Burton if there had been any reported issues from Board licensed physicians regarding logging into and/or completing first time registration on the new site. Mrs. Burton informed him that there had not been any complaints in office, however Mr. Small did make note that the CURES help desk had assisted roughly 16 callers (osteopathic physicians) with registering themselves on the system. Mr. Small noted that security questions and passwords are now a requirement of the database when creating an account; and users will also need to complete a user profile which previously had not been required.

Dr. Zammuto asked Mr. Small if the new retail pharmacies had been added to the database, and was informed that they had been added along with all other clinical users. However, the caveat is that many of the healthcare settings had not been utilizing the contemporary browsers that are required for security purposes. DOJ has since gone in and rebuilt the front end security piece of the system, so that the system is able to discern what level of browser a user is accessing the database. With this change the database would then be able to redirected the facility back to the CURES 1.0 system if an old browser is being used so that they are still able to access prescribing information, but will also give them a six (6) month buffer to update their internet browser so that they are ready to begin using the 2.0 database when the final registration deadline arises.

Dr. Zammuto also questioned how long it would take for prescribing information to appear on the database once it is issued to the patient and fulfilled. Mr. Small stated that the law regarding the reporting requirement was not amended when (SB 809) was legislatively mandated and stated that the law still technically requires dispensation reports as infrequently as once a week. However, most of the larger retailer pharmacies have newer sophisticated software that is actually transmitting the data either daily or up to three (3) times a day. CURES 2.0 was created to have the ability to receive prescribing information real time.

The database will transmit 5 different alerts to physicians based on prescribing information per patient. The analytics engine that runs the database recomputes the whole Terabyte of data in the system nightly and de-duplicates individual person entities and will combine them into one individual person entity (i.e. Bobby Smith; Robby Smith; Robert Smith; etc.) which can be tricky because there are no positive identifiers or patients such as Drivers License Numbers or Social Security Numbers. Once that is completed the system then identifies the prescriptions that are contemporaneous by their days of supply, then those contemporaneous prescriptions are taken and calculated by Morphine Milligram Equivalents (MME) and other markers such as how long the patients has been on the prescription and what combination a patient is using. Alerts will be transmitted for the following prescribing practices:

- If a patient is receiving more than 100 mg of Opioids daily - All contributing physicians will receive an alert
- If patient is receiving more than 40 mg of Methadone
- If patient is receiving both Benzodiazepines and Opioids
- If patient is on Opioids more than 90 days consecutively - All contributing physicians will receive an alert
- (*seeking behavior*) If the patient was seen by: six (6) physicians; six (6) pharmacies; and within six (6) months

Dr. Zammuto questioned if patrons would need to provide identification upon acquiring a controlled substance from a pharmacy as is the case when purchasing behind the counter medications, and was advised by Mr. Small that it is actually not a requirement and those prescriptions could be picked up by anyone (i.e. family members, etc.) and is very informal.

Mr. Higginbotham asked what the interplay between CURES and Law Enforcement is. Mr. Small explained that Law Enforcement users are allowed to access the system after they have completed the registration process. Mr. Small noted that Law Enforcement users are required to submit supportive documentation from their supervisor attesting to the fact that they are members of the agency; that the assignment is relevant to the need to have access and that they work cases involving prescribing practices; accompanied by a photo ID. Once access is granted the applicant is given a case number and a crime code to validate the records accessed. At present the DOJ requires

a search warrant be provided when a Law Enforcement agent is requesting to access data within CURES.

Ms. Mercado questioned whether the CURES database would play a part in the prescribing methods of physicians in accordance with SB 643 - Medical Cannabis, however Mr. Small was unable to provide an answer. Ms. Butu noted that medical marijuana is not a prescription but rather is a recommendation from a physician, and believes that the tracking methods may be different as recommendations would be made as opposed to prescriptions being obtained. Mr. Small added that the way that the medical cannabis is issued varies from that of prescription medication, with cannabis recommendations the individual goes into a shop to purchase it and there is no documented log of daily supply. There would need to be system changes in order to better accommodate cannabis recommendations.

Angie Burton updated the Board on licensing statistics, staffing, Board budget activity, and diversion program statistics. The Board was informed that the vacancy within the administrative staff was filled and the staff hired for the cashier position is in the process of being trained.

Budget – The Board was presented with the current fund condition for the year and was notified that 47% of the budget remained for the final 6 months of the FY 15/16. If the Board is able to maintain expenditures for the remainder of the Fiscal Year, then the final budget should reflect an estimated surplus of 4.5%. Mrs. Burton stated that the FY 16/17 reflects a projected increase of revenue due in part to repayment of the General Fund loan amounting \$1,350,000, and explained that those boards with a presumed weaker fund condition will receive repayment first. As the board's funds are in a healthy state there is a possibility that repayment may not be received next year as expected; however if there is ever a time that the funds need to be pulled from reserve they are available.

Mr. Howard questioned what constituted a "need" that would allow for the Board to request use of the funds that are scheduled to be returned to the reserve, and how the Board would request a change in the FY budget. Mrs. Burton explained that a Budget Change Proposal (BCP) would need to be completed requesting the applicable changes (i.e. staffing, enforcement budget, etc.) and the Board would need to indicate why the change was being requested.

Enforcement/ Discipline - The boards Lead Enforcement Analyst Corey Sparks presented the enforcement report to the board.

10. Interstate Licensing Compact – Jerry Landau, J.D., and Lisa Robins, MLA, Chief Advocacy Officer (FSMB)

Mr. Landau thanked the board for allowing him to attend and participate in the day's board meeting, and gave the board a short introduction of his background. He went on to give an in depth PowerPoint presentation on the mission and vision of the Federation of State Medical Boards (FSMB). A copy of the presentation was also included in the

meeting materials. In addition, Mr. Landau informed the Board of programs and conferences that the FSMB has compiled and will be offering to all state medical board staff and physicians for continued education and knowledge.

Mrs. Robins welcomed the newly appointed Board members and advised them that they were now officially fellows of the FSMB. She discussed some of the information that the FSMB transmits to individual state medical boards, and how it has helped to ensure that there is some facet of board transparency regarding physician disciplinary action by state. She also gave an overview of DocInfo, which is an online physician – lookup database offered to consumers by FSMB which was launched as a free service. The database includes physician specialty certification, any noted sanctions on record, and all jurisdictions where the physician holds a license.

Mrs. Robins provided background information on the Interstate Licensing Compact (Compact) for the newly appointed Board members and explained the anticipated benefits of the Compact upon possible implementation. She explained that the Compact would require that states continue to comply with their state’s renewal rules and regulations. However, the Compact would be more beneficial to individual boards as they would have the ability to share information regarding complaints, disciplinary documents, etc. with participating boards.

Dr. Zammuto inquired whether the 23 states currently involved in the Compact were doing so because they had numerous physicians that were requesting multi – state licensure, or if it was because the Compact was more advantageous in providing an unfettered stream of information between states. Mrs. Robins stated that individual state involvement has been due in part to both instances. Some states are vying to bring more specialty care physicians into their rural and underserved areas, and other states have physicians who are looking to relocate to other jurisdictions while maintaining their primary state license. Administrative streamlining has also played a part in participation as all subsequent states would primarily rely on the attestation of the licensure application in the home state of the physician to ensure that the basic requirements are being met.

11. Public Comment for Items Not on the Agenda

Mr. Frank Cuny, Executive Director, California Citizens for Health Freedom, presented the Board with proposed language for a bill that his organization would like to introduce in next year’s legislation. The bill, entitled “Cancer Medical Treatment Freedom Bill,” would amend Health and Safety Code 109395, to allow physicians and surgeons to offer “integrative treatment” of cancer. The bill is sponsored by California Citizens for Health Freedom & Cancer Control Society, and private practicing physician offices.

Dr. Zammuto thanked Mr. Cuny for his comments and documentation that was made available to the Board, and welcomed further dialog from the organization.

12. Title 16 California Code of Regulations

Ms. Butu provided a brief explanation to the Board regarding how the regulation process works and provided a rough timeframe of completion of the process.

Proposed Language to add Section 1604.10 (Notice to Consumers)

Mrs. Burton introduced the proposed language for Section 1604.10

Proposed Amendments to Section 1610 (Application; Refund of Fee; Expirations; Renewals)

Mrs. Burton re-introduced Section 1610 to the Board which had previously been brought before them and subsequently voted on at the May 2015 Board meeting; legal counsel later recommended changes resulting in the language being brought back to the Board for review.

Upon reading the language Mrs. Burton recommended that additional revisions be made to section (e) subsection (i) striking out “no less than three months”.

Ms. Butu mentioned that Business and Profession Code: Sections 152.5 and 152.6 impact the proposed language. She noted that section 152.5 allows the Board to extend the renewal dates to evenly distribute the renewals throughout the year; and section 152.6 allows the board to establish licensing periods and renewal dates for the licensees in a manner that is best to distribute the renewal work of all boards throughout the year. Ms. Butu advised the Board that they could continue using the renewal method that is currently being utilized, if the Director signed off and approves it. In addition, she noted that the Business and Profession Codes discussed would prevent the need to strike out the language in subdivision (e) subsection (i) previously recommended by Mrs. Burton.

It was decided that the language would remain as is without the strike out, as the Business and Profession Codes discussed allowed for use of the language.

Ms. Butu made note that a parenthesis need to be removed at the end of subdivision (e) subsection (iii).

Proposed Language to add Section 1616 (Sponsored Free Health Care)

Dr. Zammuto inquired on the amount of physicians that have asked if a policy was in place that allowed for temporary issuance of licensure for the health care events. Mrs. Burton stated that two requests had been made thus far and that she did not foresee a down side to implementation of the proposed regulation.

Dr. Zammuto also inquired whether utilizing the Interstate Licensing Compact would benefit the Board. Mrs. Burton stated that the Compact would most likely have no influence on the license as proposed Section 1616 is only valid for a 10 day timeframe.

Ms. Butu added that the proposed language is to implement Business and Professions Code 901, which allows exemptions from licensure for physicians and surgeons licensed in other states to participate in sponsored free health care events in California. Dr. Zammuto asked whether the regulation was sufficient to protect the consumer and was informed by Mrs. Chong that the application process for obtaining Sponsored Free Healthcare licensure would be the same as obtaining a basic unrestricted license through the Board. It would require that the applicant complete the fingerprint process and obtain all required primary source documentation from the proper entities; in addition to the Board running an Federation of State Medical Board (FSMB) report of all subsequent licenses issued in alternate state prior to issuance of licensure in the State of California.

Ms. Butu recommend that 1616.2 (c)(1)(E)(i) be changed to reflect the definition of “good standing” in section 1616. She also recommended that 1616.1 (f)(4) be revised striking out “... Board of that practitioner” and replacing it with “...the out of state license entity of that practitioner” to ensure that there was no confusion had by the licensee. Lastly she recommended that the form number in 1616.2 section (a) subsection (1) and section (c) subsection (1) (A) reflect 2016 instead of 2011.

- Dr. Zammuto called for motion regarding the regulations.

Motion to approve all three regulations with the amendments discussed –
K. Higginbotham, **Second** – C. Buhari.

He then opened the floor for further discussion of the bills.

Dr. Zammuto called for motion of delegation of authority to Mrs. Burton and Ms. Butu to make technical and non-substantive amendments to finalize the regulation packet of the three documents. Ms. Butu clarified that the Board could make that delegation Ms. Burton, and Ms. Butu would be available for any legal questions.

- Roll Call Vote was taken
 - **Aye** – Dr. Buhari, Mr. Higginbotham, Mr. Howard, Dr. Jensen, Ms. Mercado, Mrs. Williams, Dr. Zammuto
 - **Nay** – None
 - **Abstention** – None
 - **Absent** – Dr. Lally, Dr. Feinstein.

Motion carried to delegate authority to Mrs. Burton with legal assistance from Ms. Butu.

13. North Carolina Dental Board v. Federal Trade Commission - Ileana Butu, Esq. (DCA Legal Counsel)

Ms. Butu gave a presentation prepared by the DCA Legal Division regarding *North Carolina Dental Board v. Federal Trade Commission*.

14. Agenda Items for Next Board Meeting

- BreEZe Update - Discussion
- CURES Update (if available)
- Interstate Licensing Compact – Discussion
- CME Regulation - Discussion and possible action

15. Future Meeting Dates

- Thursday, May 5, 2016 @ 10:00 am – Pomona, CA
- Friday, October 7, 2016 @ 10:00 am – Vallejo, CA
- Friday, January 20, 2017 @ 10:00 am - Sacramento, CA

16. Adjournment

There being no further business, the Meeting was adjourned at 4:13 p.m.

- **Motion to adjourn meeting** – K. Higginbotham, **Second** – A. Howard
- Roll Call Vote was taken
 - **Aye** – Dr. Connett, Mr. Higginbotham, Dr. Lally, Ms. Mercado, Dr. Xenos, Dr. Zammuto, Mrs. Williams
 - **Nay** – None
 - **Abstention** – None.

TABLE 4

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TABLE 5

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TABLE 6

Executive Director's Report

Board Meeting – May 5, 2016

This report is to provide the Board Members with an update on licensing, staffing, budget and enforcement functions at the Osteopathic Medical Board of California. No action is needed at this time.

License Statistics

Current number of Osteopathic Physicians and Surgeons holding a California license:

Active Status	7,436
Inactive Status	<u>591</u>
TOTAL	8,027

Number of Osteopathic Physicians and Surgeons currently practicing in California:

6351

Number of Fictitious Name Permits currently registered with the Board:

620

Number of Initial License Applications received in the first quarter 2016 (1/1/16-3/31/16):

203 Initial License Applications received
139 Initial Licenses Issued

Staffing

OMBC's number of staff remains at 11.5. All approved positions are currently filled. We are at 100%. Ms. Francine Davis, our Staff Services Manager, will be retiring after 30 years of State Services at the end of July 2016. We will be advertising this position and hope to conduct interviews in July and make our selection with an anticipate start date of July 31, 2016.

Because we are outgrowing our current office location, after July 1, 2016, we will be requesting DCA Facilities to start looking for a larger office space.

Budget

Attached are our current "Analysis of Fund Condition" report and our current "Expenditure Projection Report".

Our current expenditure projection as of March 2016, indicates that we will be finishing out this fiscal year with a .8% reversion.

CURES (Controlled Substances Utilization Review and Evaluation System) Update

The Board has sent out two e-mail blast notices to our licensees, one in early March and another in April, reminding them that they must register for CURES by July 1, 2016. We have

received numerous telephone calls from licensees who have had difficulties registering. Board staff has been assisting these licensees with their registration. The Board's website also has a link to the Department of Justice CURES 2.0 documents, such as the CURES 2.0 registration, the Frequently Asked Questions, CURES 2.0 Tips and Tricks: CURES 2.0 Registration User Guide and the CURES 2.0 Publications and Training Videos.

According to Department of Justice, presently, there are 1,578 Osteopathic physicians enrolled in CURES 2.0.

There are over 41,000 approved users from CURES 1.0 that have not yet logged onto CURES 2.0. When users log in to CURES 2.0 for the first time, they must update their profile and provide information in order to move over to CURES 2.0. Because CURES 1.0 did not collect "license type" information, Department of Justice cannot identify how many of these users are osteopathic physicians who have not yet moved into CURES 2.0, so there are likely more than 1,578 Osteopathic Physicians enrolled with CURES, just not logged into the new system.

Enforcement

Mr. Corey Sparks, Lead Enforcement Analyst/Probation Monitor will provide the enforcement update report, copy of which is included in this packet.

Legislation

ABX2-15 Chaptered. Approved by the Governor on October 5, 2015, the bill becomes effective June 9, 2016.

This bill established the End of Life Option Act, which will remain in effect until January 1, 2026. This Act gives a mentally competent adult, residing in California, who has a terminal illness, the legal right to ask for and receive a prescription from his/her physician to hasten death, as long as criteria is met.

Provided in your packet is an overview of the Act, written by Nathan Fairman, MD, MPH, and a copy of Assembly Bill 15.

Medical Board of California is working on a website which will include links to all required forms and other resources. Once the website and forms become available, Medical Board has offered to share this information with Osteopathic Medical Board. This will assure that all physicians and surgeons, MD's and DO's, will be provided the same information regarding the requirements associated with this Act.

Budget Report

OSTEOPATHIC MEDICAL BOARD - 0264
BUDGET REPORT
FY 2015-16 EXPENDITURE PROJECTION
Mar-2016

FISCAL MONTH 9

OBJECT DESCRIPTION	FY 2014-15		FY 2015-16				
	ACTUAL EXPENDITURES (MONTH 13)	PRIOR YEAR EXPENDITURES 3/31/2015	BUDGET STONE 2015-16	CURRENT YEAR EXPENDITURES 3/31/2016	PERCENT SPENT	PROJECTIONS TO YEAR END	UNENCUMBERED BALANCE
PERSONNEL SERVICES							
Salary & Wages (Staff)	541,588	415,096	531,000	430,813	81%	562,094	(31,094)
Statutory Exempt (EO)	82,728	61,896	76,000	64,600	85%	86,133	(10,133)
Temp Help Reg (Seasonals)	3,240	3,240	0	500	0%	667	(667)
Board Member Per Diem	500	300	3,000	600	20%	1,000	2,000
Committee Members (DEC)	0	0	0	0		0	0
Overtime	0	0	0	0		0	0
Staff Benefits	299,428	228,982	314,000	243,589	78%	318,726	(4,726)
TOTALS, PERSONNEL SVC	927,484	709,514	924,000	740,102	80%	968,621	(44,621)
OPERATING EXPENSE AND EQUIPMENT							
General Expense	14,474	11,394	112,000	7,074	6%	9,432	102,568
Fingerprint Reports	33,497	22,227	25,000	23,422	94%	31,229	(6,229)
Minor Equipment	0	0	2,000	1,081	54%	0	2,000
Printing	9,917	9,030	5,000	8,701	174%	9,556	(4,556)
Communication	4,901	2,604	16,000	2,990	19%	3,987	12,013
Postage	15,866	15,834	6,000	1,103	18%	1,471	4,529
Travel In State	7,126	7,042	14,000	6,145	44%	6,218	7,782
Travel, Out-of-State	0	0	0	0		0	0
Training	762	762	5,000	0	0%	1,000	4,000
Facilities Operations	69,455	68,015	60,000	61,317	102%	61,317	(1,317)
Utilities	0	0	0	0		0	0
C & P Services - Interdept.	4,000	44,000	7,000	0	0%	0	7,000
C & P Services - External	53,343	81,292	77,000	82,404	107%	82,404	(5,404)
DEPARTMENTAL SERVICES:							
Departmental Pro Rata	98,171	72,060	159,000	119,250	75%	159,000	0
Admin/Exec	96,016	69,288	139,000	104,250	75%	139,000	0
DOI-ProRata Internal	2,686	2,169	4,000	3,000	75%	4,000	0
Public Affairs Office	3,125	2,118	9,000	6,750	75%	9,000	0
PCSD Pro Rata	3,004	2,313	0	0	#DIV/0!	0	0
INTERAGENCY SERVICES:							
Consolidated Data Center	20,214	13,537	1,000	12,277	1228%	16,369	(15,369)
DP Maintenance & Supply	1,583	1,583	4,000	267	7%	356	3,644
Central Admin Svc-ProRata	78,244	58,683	82,000	61,419	75%	82,000	0
EXAM EXPENSES:							
Exam Supplies	0	0	0	0		0	0
Exam Freight	0	0	0	0		0	0
Exam Site Rental	0	0	0	0		0	0
C/P Svcs-External Expert Administrative	0	0	0	0		0	0
C/P Svcs-External Expert Examiners	0	0	0	0		0	0
C/P Svcs-External Subject Matter	0	140	0	0		0	0
ENFORCEMENT:							
Attorney General	280,719	203,702	269,000	189,417	70%	252,556	16,444
Office Admin. Hearings	48,345	15,903	19,000	49,050	258%	65,400	(46,400)
Court Reporters	1,792	625	0	2,450		3,267	(3,267)
Evidence/Witness Fees	73,468	44,862	8,000	42,222	528%	56,296	(48,296)
Invest SVS - MBC ONL	98,332	70,029	94,000	46,984	50%	62,645	31,355
Major Equipment	0	0	0	0		0	0
Special Items of Expense	0	0	0	0		0	0
Other (Vehicle Operations)	0	0	0	0		0	0
TOTALS, OE&E	1,019,040	819,212	1,117,000	831,573	74%	1,056,503	60,497
TOTAL EXPENSE	1,946,524	1,528,726	2,041,000	1,571,675	155%	2,025,124	15,876
Sched. Reimb. - External/Private							0
Sched. Reimb. - Fingerprints	(33,697)	(27,832)	(25,000)	(29,743)	119%	(25,000)	0
Sched. Reimb. - Other	(4,710)	(3,770)	(28,000)	(3,055)		(28,000)	0
Distributed - From Naturopathic			(14,000)			(14,000)	0
Unsched. Reimb. - Other	(122,795)	(97,452)	0	(102,564)			0
NET APPROPRIATION	1,785,322	1,399,672	1,974,000	1,436,313	73%	1,958,124	15,876
SURPLUS/(DEFICIT):							0.8%

0264 Osteopathic Medical Board Analysis of Fund Condition

Prepared 2/22/16

(Dollars in Thousands)

2016-17 Governor's Budget		Governor's Budget			
		Actual 2014-15	CY 2015-16	BY 2016-17	BY +1 2017-18
BEGINNING BALANCE		\$ 2,979	\$ 3,153	\$ 3,191	\$ 4,364
Prior Year Adjustment		\$ 3	\$ -	\$ -	\$ -
Adjusted Beginning Balance		\$ 2,982	\$ 3,153	\$ 3,191	\$ 4,364
REVENUES AND TRANSFERS					
Revenues:					
125600	Other regulatory fees	\$ 17	\$ 19	\$ 22	\$ 22
125700	Other regulatory licenses and permits	\$ 323	\$ 325	\$ 346	\$ 346
125800	Renewal fees	\$ 1,591	\$ 1,647	\$ 1,725	\$ 1,725
125900	Delinquent fees	\$ 15	\$ 15	\$ 16	\$ 16
141200	Sales of documents	\$ 3	\$ -	\$ -	\$ -
142500	Miscellaneous services to the public	\$ -	\$ -	\$ -	\$ -
150300	Income from surplus money investments	\$ 9	\$ 9	\$ 8	\$ 12
150500	Interest Income From Interfund Loans	\$ -	\$ -	\$ -	\$ -
160400	Sale of fixed assets	\$ -	\$ -	\$ -	\$ -
161000	Escheat of unclaimed checks and warrants	\$ -	\$ -	\$ -	\$ -
161400	Miscellaneous revenues	\$ -	\$ -	\$ -	\$ -
Totals, Revenues		\$ 1,958	\$ 2,015	\$ 2,117	\$ 2,121
Transfers from Other Funds					
F00001	GF loan repayment per Item 1485-011-0264, BA of 2002	\$ -	\$ -	\$ 1,350	\$ -
Totals, Revenues and Transfers		\$ 1,958	\$ 2,015	\$ 3,467	\$ 2,121
Totals, Resources		\$ 4,940	\$ 5,168	\$ 6,658	\$ 6,485
EXPENDITURES					
Disbursements:					
1110	Program Expenditures (State Operations)	\$ 1,785	\$ 1,974	\$ -	\$ -
1111	Program Expenditures (State Operations)	\$ -	\$ -	\$ 2,291	\$ 2,337
8880	Financial Information System of CA (State Operations)	\$ 2	\$ 3	\$ 3	\$ -
Total Disbursements		\$ 1,787	\$ 1,977	\$ 2,294	\$ 2,337
FUND BALANCE					
Reserve for economic uncertainties		\$ 3,153	\$ 3,191	\$ 4,364	\$ 4,148
Months in Reserve		19.1	16.7	22.4	20.9

Proposed Bills

AB 15

End of Life Option Act

Overview of the California End of Life Option Act

By Nathan Fairman, M.D., M.P.H.

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On October 5, 2015, Governor Jerry Brown signed the End of Life Option Act into law, making California the fourth state in which mentally-competent, terminally-ill patients may request prescriptions from their physicians to hasten death.

The law will take effect 90 days after the special session on health care and financing ends. Already, there are efforts to engage the palliative care and bioethics communities in guiding implementation practices for the new law, to help support institutions in developing policies mindful of the complicated ethical issues that surround aid-in-dying. As well, clinicians are likely to encounter new educational needs – concerning aid-in-dying specifically but also palliative care more generally – as patients inquire about this new option for end-of-life care. To help prepare physicians to respond to patients' inquiries, what follows is an overview of the practice and specific details about the new California law.

The California End of Life Option Act

What does the new California law do?

The law authorizes a California resident adult, who has been determined to be terminally-ill and mentally-competent, to make a request for a drug prescribed for the purpose of ending his or her life.

What safeguards are included in the law?

The Act includes several safeguards, which are aimed at restricting access to patients who are terminally-ill and mentally-competent:

- Two physician assessments are required. The “*attending*” and “*consulting*” physicians must each independently determine that the individual has a terminal disease with a prognosis of six months or less, and is able to provide informed consent. Elements of informed consent, including disclosure of relevant information, assessment of decisional capacity and assurance of voluntariness, are stipulated in the law.
- If either physician is aware of any “*indications of a mental disorder*,” a mental health specialist assessment must be arranged to determine that the individual “*has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.*”

- The attending physician must provide counseling about the importance of the following: *“having another person present when he or she ingests the aid-in-dying drug, not ingesting the aid-in-dying drug in a public place, notifying the next-of-kin of his or her request for the aid-in-dying drug, participating in a hospice program and maintaining the aid-in-dying drug in a safe and secure location.”*
- The attending physician must offer the individual the opportunity to withdraw his or her request for the aid-in-dying drug at any time.
- The individual must make two oral requests, separated by a minimum of fifteen days, and one written request for the aid-in-dying drug.
- The written request must be observed by two adult witnesses, who attest that the patient is *“of sound mind and not under duress, fraud or undue influence.”*
- The patient must make a “final attestation,” forty-eight hours before he or she intends to ingest the medication.
- Only the person diagnosed with the terminal disease may request a prescription for the aid-in-dying drug (i.e., surrogate requests are not permitted).
- The individual must be able to self-administer the medication.

What are the documentation and reporting requirements?

The law explicitly stipulates a number of requirements for documentation in the patient’s medical record, largely corresponding to the safeguards above. In addition, the law creates two reporting obligations:

1. Within 30 days of writing a prescription for an aid-in-dying drug, the attending physician must submit to the California Department of Public Health (CDPH) a copy of the qualifying patient’s written request, an attending physician checklist and compliance form, and a consulting physician’s compliance form.
2. Within 30 days following the individual’s death, the attending physician must submit a follow-up form to CDPH. All forms will be posted on the CDPH and Medical Board websites.

Is participation compulsory?

No. Participation in the law is voluntary for all parties. Individual providers – and institutions as well – may make personal, conscience-based decisions about whether or not to participate.

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California
LEGISLATIVE INFORMATION

AB-15 End of life. (2015-2016)

Assembly Bill No. 15

CHAPTER 1

An act to add and repeal Part 1.85 (commencing with Section 443) of Division 1 of the Health and Safety Code, relating to end of life.

[Approved by Governor October 05, 2015. Filed with Secretary of State
October 05, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 15, Eggman. End of life.

Existing law authorizes an adult to give an individual health care instruction and to appoint an attorney to make health care decisions for that individual in the event of his or her incapacity pursuant to a power of attorney for health care.

This bill, until January 1, 2026, would enact the End of Life Option Act authorizing an adult who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease, as defined, to make a request for a drug prescribed pursuant to these provisions for the purpose of ending his or her life. The bill would establish the procedures for making these requests. The bill would also establish specified forms to request an aid-in-dying drug, under specified circumstances, an interpreter declaration to be signed subject to penalty of perjury, thereby creating a crime and imposing a state-mandated local program, and a final attestation for an aid-in-dying drug. This bill would require specified information to be documented in the individual's medical record, including, among other things, all oral and written requests for an aid-in-dying drug.

This bill would prohibit a provision in a contract, will, or other agreement from being conditioned upon, or affected by, a person making or rescinding a request for the above-described drug. The bill would prohibit the sale, procurement, or issuance of any life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for any policy or plan contract, from being conditioned upon or affected by the request. The bill would prohibit an insurance carrier from providing any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. The bill would also prohibit any communication from containing both the denial of treatment and information as to the availability of aid-in-dying drug coverage.

This bill would provide a person, except as provided, immunity from civil or criminal liability solely because the person was present when the qualified individual self-administered the drug, or the person assisted the qualified individual by preparing the aid-in-dying drug so long as the person did not assist with the ingestion of the drug, and would specify that the immunities and prohibitions on sanctions of a health care provider are solely reserved for conduct of a health care provider provided for by the bill. The bill would make participation in activities authorized pursuant to its provisions voluntary, and would make health care providers immune from liability for refusing to engage in activities authorized pursuant to its provisions. The bill would also authorize a health care provider to prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under the act while on the premises owned or under the management or direct control of that prohibiting health care provider, or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

This bill would make it a felony to knowingly alter or forge a request for drugs to end an individual's life without his or her authorization or to conceal or destroy a withdrawal or rescission of a request for a drug, if it is done with the intent or effect of causing the individual's death. The bill would make it a felony to knowingly coerce or exert undue influence on an individual to request a drug for the purpose of ending his or her life, to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without their knowledge or consent. By creating a new crime, the bill would impose a state-mandated local program. The bill would provide that nothing in its provisions is to be construed to authorize ending a patient's life by lethal injection, mercy killing, or active euthanasia, and would provide that action taken in accordance with the act shall not constitute, among other things, suicide or homicide.

This bill would require physicians to submit specified forms and information to the State Department of Public Health after writing a prescription for an aid-in-dying drug and after the death of an individual who requested an aid-in-dying drug. The bill would authorize the Medical Board of California to update those forms and would require the State Department of Public Health to publish the forms on its Internet Web site. The bill would require the department to annually review a sample of certain information and records, make a statistical report of the information collected, and post that report to its Internet Web site.

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

This bill would make legislative findings to that effect.

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

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

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

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

SECTION 1. Part 1.85 (commencing with Section 443) is added to Division 1 of the Health and Safety Code, to read:

PART 1.85. End of Life Option Act

443. This part shall be known and may be cited as the End of Life Option Act.

443.1. As used in this part, the following definitions shall apply:

- (a) "Adult" means an individual 18 years of age or older.
- (b) "Aid-in-dying drug" means a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease.
- (c) "Attending physician" means the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.
- (d) "Attending physician checklist and compliance form" means a form, as described in Section 443.22, identifying each and every requirement that must be fulfilled by an attending physician to be in good faith compliance with this part should the attending physician choose to participate.
- (e) "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers.
- (f) "Consulting physician" means a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease.
- (g) "Department" means the State Department of Public Health.

(h) "Health care provider" or "provider of health care" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code; any person licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act; any person certified pursuant to Division 2.5 (commencing with Section 1797) of this code; and any clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of this code.

(i) "Informed decision" means a decision by an individual with a terminal disease to request and obtain a prescription for a drug that the individual may self-administer to end the individual's life, that is based on an understanding and acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:

- (1) The individual's medical diagnosis and prognosis.
- (2) The potential risks associated with taking the drug to be prescribed.
- (3) The probable result of taking the drug to be prescribed.
- (4) The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.
- (5) The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

(j) "Medically confirmed" means the medical diagnosis and prognosis of the attending physician has been confirmed by a consulting physician who has examined the individual and the individual's relevant medical records.

(k) "Mental health specialist assessment" means one or more consultations between an individual and a mental health specialist for the purpose of determining that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

(l) "Mental health specialist" means a psychiatrist or a licensed psychologist.

(m) "Physician" means a doctor of medicine or osteopathy currently licensed to practice medicine in this state.

(n) "Public place" means any street, alley, park, public building, any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access.

(o) "Qualified individual" means an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements of this part in order to obtain a prescription for a drug to end his or her life.

(p) "Self-administer" means a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death.

(q) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

443.2. (a) An individual who is an adult with the capacity to make medical decisions and with a terminal disease may make a request to receive a prescription for an aid-in-dying drug if all of the following conditions are satisfied:

- (1) The individual's attending physician has diagnosed the individual with a terminal disease.
- (2) The individual has voluntarily expressed the wish to receive a prescription for an aid-in-dying drug.
- (3) The individual is a resident of California and is able to establish residency through any of the following means:
 - (A) Possession of a California driver license or other identification issued by the State of California.
 - (B) Registration to vote in California.
 - (C) Evidence that the person owns or leases property in California.
 - (D) Filing of a California tax return for the most recent tax year.
- (4) The individual documents his or her request pursuant to the requirements set forth in Section 443.3.

(5) The individual has the physical and mental ability to self-administer the aid-in-dying drug.

(b) A person shall not be considered a "qualified individual" under the provisions of this part solely because of age or disability.

(c) A request for a prescription for an aid-in-dying drug under this part shall be made solely and directly by the individual diagnosed with the terminal disease and shall not be made on behalf of the patient, including, but not limited to, through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decisionmaker.

443.3. (a) An individual seeking to obtain a prescription for an aid-in-dying drug pursuant to this part shall submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician. The attending physician shall directly, and not through a designee, receive all three requests required pursuant to this section.

(b) A valid written request for an aid-in-dying drug under subdivision (a) shall meet all of the following conditions:

(1) The request shall be in the form described in Section 443.11.

(2) The request shall be signed and dated, in the presence of two witnesses, by the individual seeking the aid-in-dying drug.

(3) The request shall be witnessed by at least two other adult persons who, in the presence of the individual, shall attest that to the best of their knowledge and belief the individual is all of the following:

(A) An individual who is personally known to them or has provided proof of identity.

(B) An individual who voluntarily signed this request in their presence.

(C) An individual whom they believe to be of sound mind and not under duress, fraud, or undue influence.

(D) Not an individual for whom either of them is the attending physician, consulting physician, or mental health specialist.

(c) Only one of the two witnesses at the time the written request is signed may:

(1) Be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual's estate upon death.

(2) Own, operate, or be employed at a health care facility where the individual is receiving medical treatment or resides.

(d) The attending physician, consulting physician, or mental health specialist of the individual shall not be one of the witnesses required pursuant to paragraph (3) of subdivision (b).

443.4. (a) An individual may at any time withdraw or rescind his or her request for an aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to the individual's mental state.

(b) A prescription for an aid-in-dying drug provided under this part may not be written without the attending physician directly, and not through a designee, offering the individual an opportunity to withdraw or rescind the request.

443.5. (a) Before prescribing an aid-in-dying drug, the attending physician shall do all of the following:

(1) Make the initial determination of all of the following:

(A) (i) Whether the requesting adult has the capacity to make medical decisions.

(ii) If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment.

(iii) If a mental health specialist assessment referral is made, no aid-in-dying drugs shall be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

(B) Whether the requesting adult has a terminal disease.

- (C) Whether the requesting adult has voluntarily made the request for an aid-in-dying drug pursuant to Sections 443.2 and 443.3.
- (D) Whether the requesting adult is a qualified individual pursuant to subdivision (o) of Section 443.1.
- (2) Confirm that the individual is making an informed decision by discussing with him or her all of the following:
- (A) His or her medical diagnosis and prognosis.
- (B) The potential risks associated with ingesting the requested aid-in-dying drug.
- (C) The probable result of ingesting the aid-in-dying drug.
- (D) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it.
- (E) The feasible alternatives or additional treatment options, including, but not limited to, comfort care, hospice care, palliative care, and pain control.
- (3) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with the provisions of this part.
- (4) Confirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside of the presence of any other persons, except for an interpreter as required pursuant to this part, whether or not the qualified individual is feeling coerced or unduly influenced by another person.
- (5) Counsel the qualified individual about the importance of all of the following:
- (A) Having another person present when he or she ingests the aid-in-dying drug prescribed pursuant to this part.
- (B) Not ingesting the aid-in-dying drug in a public place.
- (C) Notifying the next of kin of his or her request for an aid-in-dying drug. A qualified individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason.
- (D) Participating in a hospice program.
- (E) Maintaining the aid-in-dying drug in a safe and secure location until the time that the qualified individual will ingest it.
- (6) Inform the individual that he or she may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner.
- (7) Offer the individual an opportunity to withdraw or rescind the request for an aid-in-dying drug before prescribing the aid-in-dying drug.
- (8) Verify, immediately before writing the prescription for an aid-in-dying drug, that the qualified individual is making an informed decision.
- (9) Confirm that all requirements are met and all appropriate steps are carried out in accordance with this part before writing a prescription for an aid-in-dying drug.
- (10) Fulfill the record documentation required under Sections 443.8 and 443.19.
- (11) Complete the attending physician checklist and compliance form, as described in Section 443.22, include it and the consulting physician compliance form in the individual's medical record, and submit both forms to the State Department of Public Health.
- (12) Give the qualified individual the final attestation form, with the instruction that the form be filled out and executed by the qualified individual within 48 hours prior to the qualified individual choosing to self-administer the aid-in-dying drug.
- (b) If the conditions set forth in subdivision (a) are satisfied, the attending physician may deliver the aid-in-dying drug in any of the following ways:

(1) Dispensing the aid-in-dying drug directly, including ancillary medication intended to minimize the qualified individual's discomfort, if the attending physician meets all of the following criteria:

- (A) Is authorized to dispense medicine under California law.
- (B) Has a current United States Drug Enforcement Administration (USDEA) certificate.
- (C) Complies with any applicable administrative rule or regulation.

(2) With the qualified individual's written consent, contacting a pharmacist, informing the pharmacist of the prescriptions, and delivering the written prescriptions personally, by mail, or electronically to the pharmacist, who may dispense the drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual and with the designation delivered to the pharmacist in writing or verbally.

(c) Delivery of the dispensed drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual may be made by personal delivery, or, with a signature required on delivery, by United Parcel Service, United States Postal Service, Federal Express, or by messenger service.

443.6. Before a qualified individual obtains an aid-in-dying drug from the attending physician, the consulting physician shall perform all of the following:

- (a) Examine the individual and his or her relevant medical records.
- (b) Confirm in writing the attending physician's diagnosis and prognosis.
- (c) Determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision.
- (d) If there are indications of a mental disorder, refer the individual for a mental health specialist assessment.
- (e) Fulfill the record documentation required under this part.
- (f) Submit the compliance form to the attending physician.

443.7. Upon referral from the attending or consulting physician pursuant to this part, the mental health specialist shall:

- (a) Examine the qualified individual and his or her relevant medical records.
- (b) Determine that the individual has the mental capacity to make medical decisions, act voluntarily, and make an informed decision.
- (c) Determine that the individual is not suffering from impaired judgment due to a mental disorder.
- (d) Fulfill the record documentation requirements of this part.

443.8. All of the following shall be documented in the individual's medical record:

- (a) All oral requests for aid-in-dying drugs.
- (b) All written requests for aid-in-dying drugs.
- (c) The attending physician's diagnosis and prognosis, and the determination that a qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified individual.
- (d) The consulting physician's diagnosis and prognosis, and verification that the qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified individual.
- (e) A report of the outcome and determinations made during a mental health specialist's assessment, if performed.
- (f) The attending physician's offer to the qualified individual to withdraw or rescind his or her request at the time of the individual's second oral request.

(g) A note by the attending physician indicating that all requirements under Sections 443.5 and 443.6 have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.

443.9. (a) Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician shall submit to the State Department of Public Health a copy of the qualifying patient's written request, the attending physician checklist and compliance form, and the consulting physician compliance form.

(b) Within 30 calendar days following the qualified individual's death from ingesting the aid-in-dying drug, or any other cause, the attending physician shall submit the attending physician followup form to the State Department of Public Health.

443.10. A qualified individual may not receive a prescription for an aid-in-dying drug pursuant to this part unless he or she has made an informed decision. Immediately before writing a prescription for an aid-in-dying drug under this part, the attending physician shall verify that the individual is making an informed decision.

443.11. (a) A request for an aid-in-dying drug as authorized by this part shall be in the following form:

REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER I,, am an adult of sound mind and a resident of the State of California.

I am suffering from, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.

I understand that I have the right to withdraw or rescind this request at any time.

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

Signed:.....

Dated:.....

DECLARATION OF WITNESSES

We declare that the person signing this request:

- (a) is personally known to us or has provided proof of identity;
(b) voluntarily signed this request in our presence;
(c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and
(d) is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.

.....Witness 1/Date

.....Witness 2/Date

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident.

(b) (1) The written language of the request shall be written in the same translated language as any conversations, consultations, or interpreted conversations or consultations between a patient and his or her attending or consulting physicians.

(2) Notwithstanding paragraph (1), the written request may be prepared in English even when the conversations or consultations or interpreted conversations or consultations were conducted in a language other than English if the English language form includes an attached interpreter's declaration that is signed under penalty of perjury. The interpreter's declaration shall state words to the effect that:

I, (INSERT NAME OF INTERPRETER), am fluent in English and (INSERT TARGET LANGUAGE).

On (insert date) at approximately (insert time), I read the "Request for an Aid-In-Dying Drug to End My Life" to (insert name of individual/patient) in (insert target language).

Mr./Ms. (insert name of patient/qualified individual) affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.

I declare that I am fluent in English and (insert target language) and further declare under penalty of perjury that the foregoing is true and correct.

Executed at (insert city, county, and state) on this (insert day of month) of (insert month), (insert year).

X _____ Interpreter signature

X _____ Interpreter printed name

X _____ Interpreter address

(3) An interpreter whose services are provided pursuant to paragraph (2) shall not be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the person's estate upon death. An interpreter whose services are provided pursuant to paragraph (2) shall meet the standards promulgated by the California Healthcare Interpreting Association or the National Council on Interpreting in Health Care or other standards deemed acceptable by the department for health care providers in California.

(c) The final attestation form given by the attending physician to the qualified individual at the time the attending physician writes the prescription shall appear in the following form:

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER I, _____, am an adult of sound mind and a resident of the State of California.

I am suffering from _____, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed:.....

Dated:.....

Time:.....

(1) Within 48 hours prior to the individual self-administering the aid-in-dying drug, the individual shall complete the final attestation form. If aid-in-dying medication is not returned or relinquished upon the patient's death as required in Section 443.20, the completed form shall be delivered by the individual's health care provider, family member, or other representative to the attending physician to be included in the patient's medical record.

(2) Upon receiving the final attestation form the attending physician shall add this form to the medical records of the qualified individual.

443.12. (a) A provision in a contract, will, or other agreement executed on or after January 1, 2016, whether written or oral, to the extent the provision would affect whether a person may make, withdraw, or rescind a request for an aid-in-dying drug is not valid.

(b) An obligation owing under any contract executed on or after January 1, 2016, may not be conditioned or affected by a qualified individual making, withdrawing, or rescinding a request for an aid-in-dying drug.

443.13. (a) (1) The sale, procurement, or issuance of a life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for a policy or plan contract may not be conditioned upon or affected by a person making or rescinding a request for an aid-in-dying drug.

(2) Pursuant to Section 443.18, death resulting from the self-administration of an aid-in-dying drug is not suicide, and therefore health and insurance coverage shall not be exempted on that basis.

(b) Notwithstanding any other law, a qualified individual's act of self-administering an aid-in-dying drug shall not have an effect upon a life, health, or annuity policy other than that of a natural death from the underlying disease.

(c) An insurance carrier shall not provide any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. Any communication shall not include both the denial of treatment and information as to the availability of aid-in-dying drug coverage. For the purposes of this subdivision, "insurance carrier" means a health care service plan as defined in Section 1345 of this code or a carrier of health insurance as defined in Section 106 of the Insurance Code.

443.14. (a) Notwithstanding any other law, a person shall not be subject to civil or criminal liability solely because the person was present when the qualified individual self-administers the prescribed aid-in-dying drug. A person who is present may, without civil or criminal liability, assist the qualified individual by preparing the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the aid-in-dying drug.

(b) A health care provider or professional organization or association shall not subject an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating in good faith compliance with this part or for refusing to participate in accordance with subdivision (e).

(c) Notwithstanding any other law, a health care provider shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for participating in this part, including, but not limited to, determining the diagnosis or prognosis of an individual, determining the capacity of an individual for purposes of qualifying for the act, providing information to an individual regarding this part, and providing a referral to a physician who participates in this part. Nothing in this subdivision shall be construed to limit the application of, or provide immunity from, Section 443.16 or 443.17.

(d) (1) A request by a qualified individual to an attending physician to provide an aid-in-dying drug in good faith compliance with the provisions of this part shall not provide the sole basis for the appointment of a guardian or conservator.

(2) No actions taken in compliance with the provisions of this part shall constitute or provide the basis for any claim of neglect or elder abuse for any purpose of law.

(e) (1) Participation in activities authorized pursuant to this part shall be voluntary. Notwithstanding Sections 442 to 442.7, inclusive, a person or entity that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized pursuant to this part is not required to take any action in support of an individual's decision under this part.

(2) Notwithstanding any other law, a health care provider is not subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for refusing to participate in activities authorized under this part, including, but not limited to, refusing to inform a patient regarding his or her rights under this part, and not referring an individual to a physician who participates in activities authorized under this part.

(3) If a health care provider is unable or unwilling to carry out a qualified individual's request under this part and the qualified individual transfers care to a new health care provider, the individual may request a copy of his or her medical records pursuant to law.

443.15. (a) Subject to subdivision (b), notwithstanding any other law, a health care provider may prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under this part while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

(b) A health care provider that elects to prohibit its employees, independent contractors, or other persons or entities, including health care providers, from participating in activities under this part, as described in subdivision (a), shall first give notice of the policy prohibiting participation under this part to the individual or entity. A health care provider that fails to provide notice to an individual or entity in compliance with this subdivision shall not be entitled to enforce such a policy against that individual or entity.

(c) Subject to compliance with subdivision (b), the prohibiting health care provider may take action, including, but not limited to, the following, as applicable, against any individual or entity that violates this policy:

(1) Loss of privileges, loss of membership, or other action authorized by the bylaws or rules and regulations of the medical staff.

(2) Suspension, loss of employment, or other action authorized by the policies and practices of the prohibiting health care provider.

(3) Termination of any lease or other contract between the prohibiting health care provider and the individual or entity that violates the policy.

(4) Imposition of any other nonmonetary remedy provided for in any lease or contract between the prohibiting health care provider and the individual or entity in violation of the policy.

(d) Nothing in this section shall be construed to prevent, or to allow a prohibiting health care provider to prohibit, any other health care provider, employee, independent contractor, or other person or entity from any of the following:

(1) Participating, or entering into an agreement to participate, in activities under this part, while on premises that are not owned or under the management or direct control of the prohibiting provider or while acting outside the course and scope of the participant's duties as an employee of, or an independent contractor for, the prohibiting health care provider.

(2) Participating, or entering into an agreement to participate, in activities under this part as an attending physician or consulting physician while on premises that are not owned or under the management or direct control of the prohibiting provider.

(e) In taking actions pursuant to subdivision (c), a health care provider shall comply with all procedures required by law, its own policies or procedures, and any contract with the individual or entity in violation of the policy, as applicable.

(f) For purposes of this section:

- (1) "Notice" means a separate statement in writing advising of the prohibiting health care provider policy with respect to participating in activities under this part.
- (2) "Participating, or entering into an agreement to participate, in activities under this part" means doing or entering into an agreement to do any one or more of the following:
- (A) Performing the duties of an attending physician as specified in Section 443.5.
 - (B) Performing the duties of a consulting physician as specified in Section 443.6.
 - (C) Performing the duties of a mental health specialist, in the circumstance that a referral to one is made.
 - (D) Delivering the prescription for, dispensing, or delivering the dispensed aid-in-dying drug pursuant to paragraph (2) of subdivision (b) of, and subdivision (c) of, Section 443.5.
 - (E) Being present when the qualified individual takes the aid-in-dying drug prescribed pursuant to this part.
- (3) "Participating, or entering into an agreement to participate, in activities under this part" does not include doing, or entering into an agreement to do, any of the following:
- (A) Diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis, or determining whether a patient has the capacity to make decisions.
 - (B) Providing information to a patient about this part.
 - (C) Providing a patient, upon the patient's request, with a referral to another health care provider for the purposes of participating in the activities authorized by this part.
- (g) Any action taken by a prohibiting provider pursuant to this section shall not be reportable under Sections 800 to 809.9, inclusive, of the Business and Professions Code. The fact that a health care provider participates in activities under this part shall not be the sole basis for a complaint or report by another health care provider of unprofessional or dishonorable conduct under Sections 800 to 809.9, inclusive, of the Business and Professions Code.
- (h) Nothing in this part shall prevent a health care provider from providing an individual with health care services that do not constitute participation in this part.
- 443.16.** (a) A health care provider may not be sanctioned for any of the following:
- (1) Making an initial determination pursuant to the standard of care that an individual has a terminal disease and informing him or her of the medical prognosis.
 - (2) Providing information about the End of Life Option Act to a patient upon the request of the individual.
 - (3) Providing an individual, upon request, with a referral to another physician.
- (b) A health care provider that prohibits activities under this part in accordance with Section 443.15 shall not sanction an individual health care provider for contracting with a qualified individual to engage in activities authorized by this part if the individual health care provider is acting outside of the course and scope of his or her capacity as an employee or independent contractor of the prohibiting health care provider.
- (c) Notwithstanding any contrary provision in this section, the immunities and prohibitions on sanctions of a health care provider are solely reserved for actions of a health care provider taken pursuant to this part. Notwithstanding any contrary provision in this part, health care providers may be sanctioned by their licensing board or agency for conduct and actions constituting unprofessional conduct, including failure to comply in good faith with this part.
- 443.17.** (a) Knowingly altering or forging a request for an aid-in-dying drug to end an individual's life without his or her authorization or concealing or destroying a withdrawal or rescission of a request for an aid-in-dying drug is punishable as a felony if the act is done with the intent or effect of causing the individual's death.
- (b) Knowingly coercing or exerting undue influence on an individual to request or ingest an aid-in-dying drug for the purpose of ending his or her life or to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without his or her knowledge or consent, is punishable as a felony.
- (c) For purposes of this section, "knowingly" has the meaning provided in Section 7 of the Penal Code.

(d) The attending physician, consulting physician, or mental health specialist shall not be related to the individual by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the individual's estate upon death.

(e) Nothing in this section shall be construed to limit civil liability.

(f) The penalties in this section do not preclude criminal penalties applicable under any law for conduct inconsistent with the provisions of this section.

443.18. Nothing in this part may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law.

443.19. (a) The State Department of Public Health shall collect and review the information submitted pursuant to Section 443.9. The information collected shall be confidential and shall be collected in a manner that protects the privacy of the patient, the patient's family, and any medical provider or pharmacist involved with the patient under the provisions of this part. The information shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

(b) On or before July 1, 2017, and each year thereafter, based on the information collected in the previous year, the department shall create a report with the information collected from the attending physician followup form and post that report to its Internet Web site. The report shall include, but not be limited to, all of the following based on the information that is provided to the department and on the department's access to vital statistics:

(1) The number of people for whom an aid-in-dying prescription was written.

(2) The number of known individuals who died each year for whom aid-in-dying prescriptions were written, and the cause of death of those individuals.

(3) For the period commencing January 1, 2016, to and including the previous year, cumulatively, the total number of aid-in-dying prescriptions written, the number of people who died due to use of aid-in-dying drugs, and the number of those people who died who were enrolled in hospice or other palliative care programs at the time of death.

(4) The number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California.

(5) The number of physicians who wrote prescriptions for aid-in-dying drugs.

(6) Of people who died due to using an aid-in-dying drug, demographic percentages organized by the following characteristics:

(A) Age at death.

(B) Education level.

(C) Race.

(D) Sex.

(E) Type of insurance, including whether or not they had insurance.

(F) Underlying illness.

(c) The State Department of Public Health shall make available the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, as described in Section 443.22, by posting them on its Internet Web site.

443.20. A person who has custody or control of any unused aid-in-dying drugs prescribed pursuant to this part after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means in accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program.

443.21. Any governmental entity that incurs costs resulting from a qualified individual terminating his or her life pursuant to the provisions of this part in a public place shall have a claim against the estate of the qualified individual to recover those costs and reasonable attorney fees related to enforcing the claim.

443.215. This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date.

443.22. (a) The Medical Board of California may update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, based on those provided in subdivision (b). Upon completion, the State Department of Public Health shall publish the updated forms on its Internet Web site.

(b) Unless and until updated by the Medical Board of California pursuant to this section, the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form shall be in the following form:

PRINTER PLEASE NOTE: TIP-IN MATERIAL TO BE INSERTED

SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Section 443.19 to the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

(a) Any limitation to public access to personally identifiable patient data collected pursuant to Section 443.19 of the Health and Safety Code as proposed to be added by this act is necessary to protect the privacy rights of the patient and his or her family.

(b) The interests in protecting the privacy rights of the patient and his or her family in this situation strongly outweigh the public interest in having access to personally identifiable data relating to services.

(c) The statistical report to be made available to the public pursuant to subdivision (b) of Section 443.19 of the Health and Safety Code is sufficient to satisfy the public's right to access.

SEC. 3. The provisions of this part are severable. If any provision of this part or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

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

AB 1306

**Certified nurse-midwives-scope of
practice**



California
LEGISLATIVE INFORMATION

AB-1306 Healing arts: certified nurse-midwives: scope of practice. (2015-2016)

AMENDED IN SENATE JULY 01, 2015

AMENDED IN ASSEMBLY MAY 28, 2015

CALIFORNIA LEGISLATURE— 2015–2016 REGULAR SESSION

ASSEMBLY BILL

No. 1306

**Introduced by Assembly Member Burke
(Coauthor: Assembly Member Mark Stone)**

February 27, 2015

An act to amend Sections 650.01, [650.02](#), 2725.1, 2746.2, 2746.5, 2746.51, 2746.52, 4061, 4076, and 4170 of, and to add Section 2746.6 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1306, as amended, Burke. Healing arts: certified nurse-midwives: scope of practice.

(1) Existing law, the Nursing Practice Act, provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing and authorizes the board to issue a certificate to practice nurse-midwifery to a person who meets educational standards established by the board or the equivalent of those educational standards. The act makes the violation of any of its provisions a misdemeanor punishable upon conviction by imprisonment in the county jail for not less than 10 days nor more than one year, or by a fine of not less than \$20 nor more than \$1,000, or by both that fine and imprisonment.

This bill would additionally require an applicant for a certificate to practice nurse-midwifery to provide evidence of current advanced level national certification by a certifying body that meets standards established and approved by the board. This bill would also require the board to create and appoint a Nurse-Midwifery Advisory Council consisting of certified nurse-midwives in good standing with experience in hospital ~~and nonhospital~~ [practice settings, alternative birth settings, and home settings](#), a nurse-midwife educator, as specified, and a consumer of midwifery care. This bill would require [the council to consist of a majority of certified nurse-midwives and would require](#) the council to make recommendations to the board on all matters related to nurse-midwifery practice, education, [disciplinary actions, standards of care](#), and other matters specified by the board, and would require the council to meet regularly, but at least twice a year. This bill would ~~also~~ prohibit corporations and other artificial legal entities from having professional rights, privileges, or powers under the act, except as specified. [The bill would authorize specified entities to employ a certified nurse-midwife and charge for professional services rendered by that certified nurse-midwife, as provided.](#)

(2) The act authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn, and provides that the practice of nurse-

midwifery constitutes the furthering or undertaking by a certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal.

This bill would delete those provisions and would instead authorize a certified nurse-midwife to manage a full range of ~~primary health~~ *gynecological and obstetric* care services for women from adolescence beyond menopause, ~~including, but not limited to, gynecologic and family planning services.~~ *as provided.* The bill would authorize a certified nurse-midwife to practice in ~~all~~ *specified* settings, including, but not limited to, a home *setting.* This bill would declare that the practice of nurse-midwifery within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the client and the resources of the medical personnel available in the setting of care, and would provide that the practice of nurse-midwifery emphasizes informed consent, preventive care, and early detection and referral of complications to a physician and surgeon. ~~This bill would authorize a certified nurse-midwife to provide peripartum care in an out-of-hospital setting to low-risk women with uncomplicated singleton-term pregnancies who are expected to have uncomplicated birth.~~

(3) The act authorizes a certified nurse-midwife to furnish and order drugs or devices incidentally to the provision of family planning services, routine health care or perinatal care, and care rendered consistently with the certified nurse-midwife's educational preparation in specified facilities and clinics, and only in accordance with standardized procedures and protocols, as specified.

This bill would delete the requirement that drugs or devices are furnished or ordered in accordance with standardized procedures and protocols. The bill would authorize a certified nurse-midwife to furnish and order drugs or devices in connection with care rendered in a home, and would authorize a certified nurse-midwife to directly procure supplies and devices, to order, obtain, and administer drugs and diagnostic tests, to order laboratory and diagnostic testing, and to receive reports that are necessary to his or her practice as a certified nurse-midwife and that are consistent with nurse-midwifery education preparation.

(4) The act also authorizes a certified nurse-midwife to perform and repair episiotomies and to repair first-degree and 2nd-degree lacerations of the perineum in a licensed acute care hospital and a licensed alternate birth center, if certain requirements are met, including, but not limited to, that episiotomies are performed pursuant to protocols developed and approved by the supervising physician and surgeon.

This bill would also authorize a certified nurse-midwife to perform and repair episiotomies and to repair first-degree and 2nd-degree lacerations of the perineum in a home, and would delete all requirements that those procedures be performed pursuant to protocols developed and approved by the supervising physician and surgeon. The bill would require a certified nurse-midwife to provide emergency care to a patient during times when a physician and surgeon is unavailable.

This bill would provide that a consultative relationship between a certified nurse-midwife and a physician and surgeon by it self is not a basis for finding the physician and surgeon liable for any acts or omissions on the part of the certified nurse-midwife. The bill would also update cross-references as needed.

(5) Because the act makes a violation of any of its provisions a misdemeanor, this bill would expand the scope of an existing crime and therefore this bill would impose a state-mandated local program.

(6) 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~~ *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. *Existing law provides that, among other exceptions, this prohibition does not apply to a licensee who refers a person to a health facility if specified conditions are met.*

This bill would include a certified nurse-midwife 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 certified nurse-midwife for violating that prohibition, and would require the board to take appropriate disciplinary action if the certified nurse-midwife has committed unprofessional conduct. *The bill would additionally authorize a licensee to refer a person to a licensed alternative birth center, as defined, or a nationally accredited alternative birth center.*

(7) The California Constitution requires the state to reimburse local agencies and school districts for certain

costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

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

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

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

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

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

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

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

(2) A "financial interest" includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the licensee refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect financial relationship between a licensee and the referral recipient including, but not limited to, an arrangement whereby a licensee has an ownership interest in an entity that leases property to the referral recipient. Any financial interest transferred by a licensee to any person or entity or otherwise established in any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the licensee. For purposes of this paragraph, "direct or indirect payment" shall not include a royalty or consulting fee received by a physician and surgeon who has completed a recognized residency training program in orthopedics from a manufacturer or distributor as a result of his or her research and development of medical devices and techniques for that manufacturer or distributor. For purposes of this paragraph, "consulting fees" means those fees paid by the manufacturer or distributor to a physician and surgeon who has completed a recognized residency training program in orthopedics only for his or her ongoing services in making refinements to his or her medical devices or techniques marketed or distributed by the manufacturer or distributor, if the manufacturer or distributor does not own or control the facility to which the physician is referring the patient. A "financial interest" shall not include the receipt of capitation payments or other fixed amounts that are prepaid in exchange for a promise of a licensee to provide specified health care services to specified beneficiaries. A "financial interest" shall not include the receipt of remuneration by a medical director of a hospice, as defined in Section 1746 of the Health and Safety Code, for specified services if the arrangement is set out in writing, and specifies all services to be provided by the medical director, the term of the arrangement is for at least one year, and the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between parties.

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

(4) "Licensee" means a physician as defined in Section 3209.3 of the Labor Code, and a certified nurse-midwife as defined in Article 2.5 (commencing with Section 2746) of Chapter 6 of Division 2 of the Business and Professions Code.

(5) "Licensee's office" means either of the following:

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

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

(6) "Office of a group practice" means an office or offices in which two or more licensees are legally organized as a partnership, professional corporation, or not-for-profit corporation, licensed pursuant to subdivision (a) of

Section 1204 of the Health and Safety Code, for which all of the following apply:

(A) Each licensee who is a member of the group provides substantially the full range of services that the licensee routinely provides, including medical care, consultation, diagnosis, or treatment through the joint use of shared office space, facilities, equipment, and personnel.

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

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

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

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

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

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

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

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

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

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

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

SEC. 2. *Section 650.02 of the Business and Professions Code is amended to read:*

650.02. The prohibition of Section 650.01 shall not apply to or restrict any of the following:

(a) A licensee may refer a patient for a good or service otherwise prohibited by subdivision (a) of Section 650.01 if the licensee's regular practice is located where there is no alternative provider of the service within

either 25 miles or 40 minutes traveling time, via the shortest route on a paved road. If an alternative provider commences furnishing the good or service for which a patient was referred pursuant to this subdivision, the licensee shall cease referrals under this subdivision within six months of the time at which the licensee knew or should have known that the alternative provider is furnishing the good or service. A licensee who refers to or seeks consultation from an organization in which the licensee has a financial interest under this subdivision shall disclose this interest to the patient or the patient's parents or legal guardian in writing at the time of referral.

(b) A licensee, when the licensee or his or her immediate family has one or more of the following arrangements with another licensee, a person, or an entity, is not prohibited from referring a patient to the licensee, person, or entity because of the arrangement:

(1) A loan between a licensee and the recipient of the referral, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, is adequately secured, and the loan terms are not affected by either party's referral of any person or the volume of services provided by either party.

(2) A lease of space or equipment between a licensee and the recipient of the referral, if the lease is written, has commercially reasonable terms, has a fixed periodic rent payment, has a term of one year or more, and the lease payments are not affected by either party's referral of any person or the volume of services provided by either party.

(3) Ownership of corporate investment securities, including shares, bonds, or other debt instruments that may be purchased on terms generally available to the public and that are traded on a licensed securities exchange or NASDAQ, do not base profit distributions or other transfers of value on the licensee's referral of persons to the corporation, do not have a separate class or accounting for any persons or for any licensees who may refer persons to the corporation, and are in a corporation that had, at the end of the corporation's most recent fiscal year, or on average during the previous three fiscal years, stockholder equity exceeding seventy-five million dollars (\$75,000,000).

(4) Ownership of shares in a regulated investment company as defined in Section 851(a) of the federal Internal Revenue Code, if the company had, at the end of the company's most recent fiscal year, or on average during the previous three fiscal years, total assets exceeding seventy-five million dollars (\$75,000,000).

(5) A one-time sale or transfer of a practice or property or other financial interest between a licensee and the recipient of the referral if the sale or transfer is for commercially reasonable terms and the consideration is not affected by either party's referral of any person or the volume of services provided by either party.

(6) A personal services arrangement between a licensee or an immediate family member of the licensee and the recipient of the referral if the arrangement meets all of the following requirements:

(A) It is set out in writing and is signed by the parties.

(B) It specifies all of the services to be provided by the licensee or an immediate family member of the licensee.

(C) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.

(D) A person who is referred by a licensee or an immediate family member of the licensee is informed in writing of the personal services arrangement that includes information on where a person may go to file a complaint against the licensee or the immediate family member of the licensee.

(E) The term of the arrangement is for at least one year.

(F) The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(G) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

(c) (1) A licensee may refer a person to a health facility, as defined in Section 1250 of the Health and Safety Code, *a licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code*, or to any facility, *or nationally accredited alternative birth center*, owned or leased by a health facility, if the recipient of the referral does not compensate the licensee for the patient referral, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of

paragraph (2) of subdivision (b).

(2) Nothing shall preclude this subdivision from applying to a licensee solely because the licensee has an ownership or leasehold interest in an entire health facility or an entity that owns or leases an entire health facility.

(3) A licensee may refer a person to a health facility for any service classified as an emergency under subdivision (a) or (b) of Section 1317.1 of the Health and Safety Code.

(4) A licensee may refer a person to any organization that owns or leases a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code if the licensee is not compensated for the patient referral, the licensee does not receive any payment from the recipient of the referral that is based or determined on the number or value of any patient referrals, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of paragraph (2) of subdivision (b). For purposes of this paragraph, the ownership may be through stock or membership, and may be represented by a parent holding company that solely owns or controls both the health facility organization and the affiliated organization.

(d) A licensee may refer a person to a nonprofit corporation that provides physician services pursuant to subdivision (l) of Section 1206 of the Health and Safety Code if the nonprofit corporation is controlled through membership by one or more health facilities or health facility systems and the amount of compensation or other transfer of funds from the health facility or nonprofit corporation to the licensee is fixed annually, except for adjustments caused by physicians joining or leaving the groups during the year, and is not based on the number of persons utilizing goods or services specified in Section 650.01.

(e) A licensee compensated or employed by a university may refer a person for a physician service, to any facility owned or operated by the university, or to another licensee employed by the university, provided that the facility or university does not compensate the referring licensee for the patient referral. In the case of a facility that is totally or partially owned by an entity other than the university, but that is staffed by university physicians, those physicians may not refer patients to the facility if the facility compensates the referring physicians for those referrals.

(f) The prohibition of Section 650.01 shall not apply to any service for a specific patient that is performed within, or goods that are supplied by, a licensee's office, or the office of a group practice. Further, the provisions of Section 650.01 shall not alter, limit, or expand a licensee's ability to deliver, or to direct or supervise the delivery of, in-office goods or services according to the laws, rules, and regulations governing his or her scope of practice.

(g) The prohibition of Section 650.01 shall not apply to cardiac rehabilitation services provided by a licensee or by a suitably trained individual under the direct or general supervision of a licensee, if the services are provided to patients meeting the criteria for Medicare reimbursement for the services.

(h) The prohibition of Section 650.01 shall not apply if a licensee is in the office of a group practice and refers a person for services or goods specified in Section 650.01 to a multispecialty clinic, as defined in subdivision (l) of Section 1206 of the Health and Safety Code.

(i) The prohibition of Section 650.01 shall not apply to health care services provided to an enrollee of a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(j) The prohibition of Section 650.01 shall not apply to a request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist for diagnostic radiology services, or a request by a radiation oncologist for radiation therapy if those services are furnished by, or under the supervision of, the pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician.

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

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

SEC. 2. SEC. 3. Section 2725.1 of the Business and Professions Code is amended to read:

2725.1. (a) Notwithstanding any other law, a registered nurse may dispense drugs or devices upon an order by a

licensed physician and surgeon or an order by a certified nurse-midwife, nurse practitioner, or physician assistant issued pursuant to Section 2746.51, 2836.1, or 3502.1, respectively, if the registered nurse is functioning within a licensed primary care clinic as defined in subdivision (a) of Section 1204 of, or within a clinic as defined in subdivision (b), (c), (h), or (j) of Section 1206 of, the Health and Safety Code.

(b) No clinic shall employ a registered nurse to perform dispensing duties exclusively. No registered nurse shall dispense drugs in a pharmacy, keep a pharmacy, open shop, or drugstore for the retailing of drugs or poisons. No registered nurse shall compound drugs. Dispensing of drugs by a registered nurse, except a certified nurse-midwife who functions pursuant to Section 2746.51 or a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, shall not include substances included in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code). Nothing in this section shall exempt a clinic from the provisions of Article 13 (commencing with Section 4180) of Chapter 9.

(c) This section shall not be construed to limit any other authority granted to a certified nurse-midwife pursuant to Article 2.5 (commencing with Section 2746), to a nurse practitioner pursuant to Article 8 (commencing with Section 2834), or to a physician assistant pursuant to Chapter 7.7 (commencing with Section 3500).

(d) This section shall not be construed to affect the sites or types of health care facilities at which drugs or devices are authorized to be dispensed pursuant to Chapter 9 (commencing with Section 4000).

SEC. 3. SEC. 4. Section 2746.2 of the Business and Professions Code is amended to read:

2746.2. (a) Each applicant shall show by evidence satisfactory to the board that he or she has met the educational standards established by the board or has at least the equivalent thereof, including evidence of current advanced level national certification by a certifying body that meets standards established and approved by the board.

(b) The board shall create and appoint a Nurse-Midwifery Advisory Council consisting of certified nurse-midwives in good standing with experience in hospital ~~and nonhospital practice settings,~~ *settings, alternative birth center settings, and home settings,* a nurse-midwife educator who has demonstrated familiarity with ~~consumer needs, collegial practice and accompanied liability, and related~~ educational standards in the delivery of maternal-child health care, ~~and a consumer of midwifery care.~~ *care, and at least two qualified physicians appointed by the Medical Board of California, including an obstetrician that has experience working with nurse-midwives.* The council *membership shall consist of a majority of certified nurse-midwives and* shall make recommendations to the board on all matters related to nurse-midwifery practice, education, and other matters as specified by the board. The council shall meet regularly, but at least twice a year.

(c) Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Board of Registered Nursing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic.

(d) Notwithstanding subdivision (c), the following entities may employ a certified nurse-midwife and charge for professional services rendered by a certified nurse-midwife; however, the entity shall not interfere with, control, or otherwise direct the professional judgment of a certified nurse-midwife:

(1) A clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code.

(2) A hospital owned and operated by a health care district pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code.

(3) A clinic operated primarily for the purpose of medical education or nursing education by a public or private nonprofit university medical school, which is approved by the Medical Board or the Osteopathic Medical Board of California, provided the certified nurse-midwife holds an academic appointment on the faculty of the university, including, but not limited to, the University of California medical schools and hospitals.

(4) A licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, or a nationally accredited alternative birth center owned or operated by a nursing corporation, as defined in Section 2775 of the Business and Professions Code.

SEC. 4. SEC. 5. Section 2746.5 of the Business and Professions Code is amended to read:

2746.5. (a) The certificate to practice nurse-midwifery authorizes the holder to manage a full range of primary ~~health gynecological and obstetric~~ care services for women from adolescence to beyond ~~menopause. menopause, consistent with the Core Competencies for Basic Midwifery practice promulgated by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board.~~ These services include, but are not limited to, primary health care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth, and the postpartum period, immediate care of the newborn, and treatment of male partners for sexually transmitted ~~infections. A certified nurse-midwife is authorized to practice in all settings, including, but not limited to, private practice, clinics, hospitals, birth centers, and homes.~~ *infections, utilizing consultation, collaboration, or referral to appropriate levels of health care services, as indicated.*

(b) *A certified nurse-midwife may practice in the following settings:*

(b)

(1) *A licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.*

(2) *A facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.*

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

(4) *A medical group practice, including a professional medical corporation, a medical partnership, a medical foundation exempt from licensure pursuant to Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services.*

(5) *A licensed alternative birth center, as described in Section 1204 of the Health and Safety Code, or nationally accredited birth center.*

(6) *A nursing corporation, as defined in Section 2775 of the Business and Professions Code.*

(7) *A home setting.*

(A) *Except as provided in subparagraph (B) of this paragraph, a certified nurse-midwife shall assist during pregnancy and childbirth in the home setting only when all of the following conditions apply:*

(i) *There is the absence of all of the following:*

(I) *Any preexisting maternal disease or condition likely to complicate the pregnancy.*

(II) *Disease arising from the pregnancy likely to cause significant maternal and/or fetal compromise.*

(III) *Prior caesarean delivery.*

(ii) *There is a singleton fetus.*

(iii) *There is cephalic presentation at the onset of labor.*

(iv) *The gestational age of the fetus is greater than 370/7 weeks and less than 420/7 completed weeks of pregnancy at the onset of labor.*

(v) *Labor is spontaneous or induced in an outpatient setting.*

(B) *If a potential certified nurse-midwife client meets the conditions specified in clauses (ii) to (v), inclusive, of subparagraph (A), but fails to meet the conditions specified in clause (i) of subparagraph (A), and the woman still desires to be a client of the certified nurse-midwife, the certified nurse-midwife shall consult with a physician and surgeon trained in obstetrics and gynecology. A certified nurse-midwife may assist the woman in pregnancy and childbirth only if a physician and surgeon trained in obstetrics and gynecology is consulted and the physician and surgeon who performed the consultation determines that the risk factors presented by her disease or condition are not likely to significantly affect the course of pregnancy and childbirth.*

(c) *As used in this chapter, the practice of nurse-midwifery within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the patient and the resources and*

medical personnel available in the setting of care. ~~When providing peripartum care in out-of-hospital settings, the certified nurse-midwife shall only provide care to low-risk women with uncomplicated singleton-term pregnancies who are expected to have an uncomplicated birth.~~ The practice of nurse-midwifery care emphasizes informed consent, preventive care, and early detection and referral of complications to physicians and surgeons. While practicing in a hospital setting, the certified nurse-midwife shall collaboratively care for women with more complex health needs.

(d) A certified nurse-midwife practicing under subdivision (a) shall be subject to all credentialing and quality standards held by the facility in which he or she practices. The peer review body shall include nurse-midwives as part of the peer review body that reviews nurse-midwives. The peer review body of that facility shall impose standards that assure quality and patient safety in their facility. The standards shall be approved by the relevant governing body unless found by a court to be arbitrary and capricious.

(e)

(e) The practice of nurse-midwifery does not include the assisting of childbirth by any forcible, or mechanical means, nor the performance of any version of those means.

(f) A certified nurse-midwife is not authorized to practice medicine and surgery by the provisions of this chapter.

(d)

(g) Any regulations promulgated by a state department that affect the scope of practice of a certified nurse-midwife shall be developed in consultation with the board and the Nurse-Midwifery Advisory Council.

SEC. 5. SEC. 6. Section 2746.51 of the Business and Professions Code is amended to read:

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

(1) Family planning services, as defined in Section 14503 of the Welfare and Institutions Code.

(2) Routine health care or perinatal care, as defined in subdivision (d) of Section 123485 of the Health and Safety Code.

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

(4) Care rendered in a home pursuant to subdivision (a) of Section 2746.5.

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

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section. The board shall establish the requirements for satisfactory completion of this paragraph.

(3) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of continuing education specific to the use of

Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) when the drugs and devices are furnished or ordered in accordance with requirements referenced in paragraphs (1) to (3), inclusive, of subdivision (b). *In a nonhospital setting, a Schedule II controlled substance shall be furnished by a certified nurse-midwife only during labor and delivery and only after a consultation with a physician and surgeon.*

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient.

(e) "Drug order" or "order" for purposes of this section means an order for medication or for a drug or device that is dispensed to or for an ultimate user, issued by a certified nurse-midwife as an individual practitioner, within the meaning of Section 1306.03 of Title 21 of the Code of Federal Regulations. Notwithstanding any other law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of a physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by certified nurse-midwives; and (3) the signature of a certified nurse-midwife on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(f) A certified nurse-midwife is authorized to directly procure supplies and devices, to order, obtain, and administer drugs and diagnostic tests, to order laboratory and diagnostic testing, and to receive reports that are necessary to his or her practice as a certified nurse-midwife and consistent with nurse-midwifery education preparation.

SEC. 6.~~SEC. 7.~~ Section 2746.52 of the Business and Professions Code is amended to read:

2746.52. (a) Notwithstanding Section 2746.5, the certificate to practice nurse-midwifery authorizes the holder to perform and repair episiotomies, and to repair first-degree and second-degree lacerations of the perineum, in a licensed acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, in a licensed alternate birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, *or a nationally accredited birth center*, and in a home pursuant to ~~subdivision (a)~~ *paragraph (7) of subdivision (b)* of Section 2746.5.

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

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

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

SEC. 7.~~SEC. 8.~~ Section 2746.6 is added to the Business and Professions Code, to read:

2746.6. A consultative relationship between a certified nurse-midwife and a physician and surgeon shall not, by ~~it~~ *self, itself*, provide the basis for finding a physician and surgeon liable for any act or omission of the certified nurse-midwife.

SEC. 8.~~SEC. 9.~~ Section 4061 of the Business and Professions Code is amended to read:

4061. (a) A manufacturer's sales representative shall not distribute any dangerous drug or dangerous device as a complimentary sample without the written request of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. However, a certified nurse-midwife who functions pursuant to Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to a protocol described in Section 3502.1, or a naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, may sign for the request and receipt of complimentary samples of a dangerous drug or dangerous device that has been identified in the standardized procedure, protocol, or practice agreement. Standardized procedures, protocols, and practice agreements shall include specific approval by a physician. A review process, consistent with the requirements of Section 2725, 3502.1, or 3640.5, of the complimentary samples requested and received by a nurse practitioner, certified nurse-midwife, physician

assistant, or naturopathic doctor, shall be defined within the standardized procedure, protocol, or practice agreement.

(b) Each written request shall contain the names and addresses of the supplier and the requester, the name and quantity of the specific dangerous drug desired, the name of the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor, if applicable, receiving the samples pursuant to this section, the date of receipt, and the name and quantity of the dangerous drugs or dangerous devices provided. These records shall be preserved by the supplier with the records required by Section 4059.

(c) Nothing in this section is intended to expand the scope of practice of a certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor.

SEC. 9. SEC. 10. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

SEC. 10. SEC. 11. Section 4170 of the Business and Professions Code is amended to read:

4170. (a) A prescriber shall not dispense drugs or dangerous devices to patients in his or her office or place of practice unless all of the following conditions are met:

(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant.

(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons.

(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph (4).

(6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy.

(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice.

(8) A certified nurse-midwife who functions pursuant to Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to Section 3502.1, or a naturopathic doctor who functions pursuant to Section 3640.5, may hand to a patient of the supervising physician and surgeon, *if applicable*, a properly labeled prescription drug prepackaged by a physician and surgeon, a manufacturer as defined in this chapter, or a pharmacist.

(b) The Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Veterinary Medical Board, and the Physician Assistant Committee shall have authority with the California State Board of Pharmacy to ensure compliance with this section, and those boards are specifically charged with the enforcement of this chapter with respect to their respective licensees.

(c) "Prescriber," as used in this section, means a person, who holds a physician's and surgeon's certificate, a license to practice optometry, a license to practice naturopathic medicine, a license to practice dentistry, a license to practice veterinary medicine, or a certificate to practice podiatry, and who is duly registered by the Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Veterinary Medical Board, or the Board of Osteopathic Examiners of this state.

~~SEC. 11.~~ **SEC. 12.** No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

AB 1992

**Physical exams for pupils by
chiropractors, NDs, and nurse
practitioners**



California
LEGISLATIVE INFORMATION

AB-1992 Pupil health: physical examinations. (2015-2016)

Senate:

Assembly: 1st Cmt Fail

Bill Status	
Measure:	AB-1992
Lead Authors:	Jones (A)
Principal Coauthors:	-
Coauthors:	-
Topic:	Pupil health: physical examinations.
31st Day in Print:	03/18/16
Title:	An act to amend Section 49458 of the Education Code, relating to pupil health.
House Location:	Assembly
Introduced Date:	02/16/16
Committee Location:	Asm Business and Professions
Committee Action Date:	04/26/16
Committee Motion:	Reconsideration.
Committee Vote Result:	(FAIL) »» Ayes: 7; Noes: 7; Abstain: 0;

Type of Measure
Active Bill - Failed Passage in Committee
Majority Vote Required
Non-Appropriation
Non-Fiscal Committee
Non-State-Mandated Local Program
Non-Urgency
Non-Tax levy

Last 5 History Actions	
Date	Action
04/26/16	In committee: Reconsideration refused.
04/26/16	In committee: Set, first hearing. Failed passage.
04/18/16	(pending re-refer to Com. on A., E., S., T., & I.M.)
04/18/16	Assembly Rule 56 suspended.
04/06/16	In committee: Hearing postponed by committee.



California
LEGISLATIVE INFORMATION

AB-1992 Pupil health: physical examinations. (2015-2016)

CALIFORNIA LEGISLATURE— 2015–2016 REGULAR SESSION

ASSEMBLY BILL

No. 1992

Introduced by Assembly Member Jones

February 16, 2016

An act to amend Section 49458 of the Education Code, relating to pupil health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1992, as introduced, Jones. Pupil health: physical examinations.

Existing law authorizes a physician and surgeon or physician assistant to perform a physical examination that is required for participation in an interscholastic athletic program, as specified.

This bill would additionally authorize a doctor of chiropractic, naturopathic doctor, or nurse practitioner practicing in compliance with the respective laws governing their profession.

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

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

SECTION 1. Section 49458 of the Education Code is amended to read:

49458. When a school district or a county superintendent of schools requires a physical examination as a condition of participation in an interscholastic athletic program, the physical examination may be performed by a physician and ~~surgeon or~~ *surgeon*, physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions ~~Code.~~ *Code, doctor of chiropractic practicing in compliance with Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code, naturopathic doctor practicing in compliance with Chapter 8.2 (commencing with Section 3610) of Division 2 of the Business and Professions Code, or nurse practitioner practicing in compliance with Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.*

AB 2859

Retired category - licenses



California
LEGISLATIVE INFORMATION

AB-2859 Professions and vocations: retired category: licenses. (2015-2016)

CALIFORNIA LEGISLATURE— 2015–2016 REGULAR SESSION

ASSEMBLY BILL

No. 2859

Introduced by Assembly Member Low

February 19, 2016

An act to add Section 463 to the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 2859, as introduced, Low. Professions and vocations: retired category: licenses.

Existing law provides for numerous boards, bureaus, commissions, or programs within the Department of Consumer Affairs that administer the licensing and regulation of various businesses and professions. Existing law authorizes any of the boards, bureaus, commissions, or programs within the department, except as specified, to establish by regulation a system for an inactive category of license for persons who are not actively engaged in the practice of their profession or vocation. Under existing law, the holder of an inactive license is prohibited from engaging in any activity for which a license is required. Existing law defines "board" for these purposes to include, unless expressly provided otherwise, a bureau, commission, committee, department, division, examining committee, program, and agency.

This bill would additionally authorize any of the boards, bureaus, commissions, or programs within the department to establish by regulation a system for a retired category of license for persons who are not actively engaged in the practice of their profession or vocation, and would prohibit the holder of a retired license from engaging in any activity for which a license is required, unless regulation specifies the criteria for a retired licensee to practice his or her profession. The bill would authorize a board upon its own determination, and would require a board upon receipt of a complaint from any person, to investigate the actions of any licensee, including, among others, a person with a license that is retired or inactive.

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

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

SECTION 1. Section 463 is added to the Business and Professions Code, to read:

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

(b) The regulation shall contain the following:

(1) The holder of a retired license issued pursuant to this section shall not engage in any activity for which a license is required, unless the board, by regulation, specifies the criteria for a retired licensee to practice his or her profession or vocation.

(2) The holder of a retired license shall not be required to renew that license.

(3) In order for the holder of a retired license issued pursuant to this section to restore his or her license to an active status, the holder of that license shall meet all the following:

(A) Pay a fee established by statute or regulation.

(B) Certify, in a manner satisfactory to the board, that he or she has not committed an act or crime constituting grounds for denial of licensure.

(C) Comply with the fingerprint submission requirements established by regulation.

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

(E) Complete any other requirements as specified by the board by regulation.

(c) A board may upon its own determination, and shall upon receipt of a complaint from any person, investigate the actions of any licensee, including a person with a license that either restricts or prohibits the practice of that person in his or her profession or vocation, including, but not limited to, a license that is retired, inactive, canceled, revoked, or suspended.

SB 323

**Nurse practitioners – scope of
practice**



California
LEGISLATIVE INFORMATION

SB-323 Nurse practitioners: scope of practice. (2015-2016)

AMENDED IN ASSEMBLY JULY 09, 2015

AMENDED IN ASSEMBLY JULY 07, 2015

AMENDED IN ASSEMBLY JUNE 23, 2015

AMENDED IN SENATE APRIL 22, 2015

AMENDED IN SENATE MARCH 26, 2015

CALIFORNIA LEGISLATURE— 2015–2016 REGULAR SESSION

SENATE BILL

No. 323

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

February 23, 2015

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 Local Program: yes

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

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

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

(b) Nurse practitioners will play an especially important part in the implementation of the federal Patient Protection and Affordable Care Act (Public Law 111-148), which will bring an estimated five million more Californians into the health care delivery system, because they will provide for greater access to primary care services in all areas of the state. This is particularly true for patients in medically underserved urban and rural communities.

(c) In the interest of providing patients with comprehensive care and consistent with the spirit of the federal Patient Protection and Affordable Care Act, this measure is supportive of the national health care movement towards integrated and team-based health care models.

(c)

(d) Due to the excellent safety and efficacy record that nurse practitioners have earned, the Institute of Medicine of the National Academies has recommended full practice authority for nurse practitioners. Currently, 20 states allow nurse practitioners to practice to the full extent of their training and education.

(d)

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

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

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

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

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

(2) A "financial interest" includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the licensee refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect financial relationship between a licensee and the referral recipient including, but not limited to, an arrangement whereby a licensee has an ownership interest in an entity that leases property to the referral recipient. Any financial interest transferred by a licensee to any person or entity or otherwise established in any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the licensee. For purposes of this paragraph, "direct or indirect payment" shall not include a royalty or consulting fee received by a physician and surgeon who has completed a recognized residency training program in orthopedics from a manufacturer or distributor as a result of his or her research and development of medical devices and techniques for that manufacturer or distributor. For purposes of this paragraph, "consulting fees" means those fees paid by the manufacturer or distributor to a physician and surgeon who has completed a recognized residency training program in orthopedics only for his or her ongoing services in making refinements to his or her medical devices or techniques marketed or distributed by the manufacturer or distributor, if the manufacturer or distributor does not own or control the facility to which the physician is referring the patient. A "financial interest" shall not include the receipt of capitation payments or other fixed amounts that are prepaid in exchange for a promise of a licensee to provide specified health care services to specified beneficiaries. A "financial interest" shall not include the receipt of remuneration by a medical director of a hospice, as defined in Section 1746 of the Health and Safety Code, for specified services if the arrangement is set out in writing, and specifies all services to be provided by the medical director, the term of the arrangement is for at least one year, and the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between parties.

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

(4) "Licensee" means a physician as defined in Section 3209.3 of the Labor Code, and a nurse practitioner practicing pursuant to Section 2837.

(5) "Licensee's office" means either of the following:

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

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

(6) "Office of a group practice" means an office or offices in which two or more licensees are legally organized as a partnership, professional corporation, or not-for-profit corporation, licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, for which all of the following apply:

(A) Each licensee who is a member of the group provides substantially the full range of services that the licensee routinely provides, including medical care, consultation, diagnosis, or treatment through the joint use of shared office space, facilities, equipment, and personnel.

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

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

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

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

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

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

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

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

(g) A violation of subdivision (a) shall be a misdemeanor. In the case of a licensee who is a physician, the Medical Board of California shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. In the case of a licensee who is a nurse practitioner functioning pursuant to Section 2837, the Board of Registered Nursing shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars (\$5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), or (e) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars (\$15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California, the Board of Registered Nursing, or other appropriate governmental agency.

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

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

SEC. 3. Section 805 of the Business and Professions Code is amended to read:

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

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

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

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

(II) Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.

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

(B) "Peer review body" includes:

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

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

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

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

(2) "Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant, or nurse practitioner practicing pursuant to Section 2837. "Licentiate" also includes a person authorized to practice medicine pursuant to Section 2113 or 2168.

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

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

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

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

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

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

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

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

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

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

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

- (2) Withdraws or abandons his or her application for staff privileges or membership.
- (3) Withdraws or abandons his or her request for renewal of staff privileges or membership.
- (d) For purposes of filing an 805 report, the signature of at least one of the individuals indicated in subdivision (b) or (c) on the completed form shall constitute compliance with the requirement to file the report.
- (e) An 805 report shall also be filed within 15 days following the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.
- (f) A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information, electronically or otherwise, pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report. The notice shall also advise the licentiate that information submitted electronically will be publicly disclosed to those who request the information.

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

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

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

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

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

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

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

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

(l) Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that under no circumstances shall exceed fifty thousand dollars (\$50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The

amount of the fine imposed, not exceeding fifty thousand dollars (\$50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

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

SEC. 4. Section 2837 of the Business and Professions Code is amended and renumbered to read:

2837.5. Nothing in this article shall be construed to limit the current scope of practice of a registered nurse authorized pursuant to this chapter.

SEC. 5. Section 2837 is added to the Business and Professions Code, to read:

2837. (a) Notwithstanding any other law, a nurse practitioner who holds a national certification from a national certifying body recognized by the board may practice under this section without supervision of a physician and surgeon, if the nurse practitioner meets all the requirements of this article and practices in one of the following:

(1) A clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

(2) A facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

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

(4) An accountable care organization, as defined in Section 3022 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(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.

(6) A medical group, independent practice association, or any similar association.

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

(c) Notwithstanding any other law, in addition to any other practice authorized in statute or regulation, a nurse practitioner who meets the qualifications of subdivision (a) may do any of the following without physician and surgeon supervision:

(1) Order durable medical equipment. Notwithstanding that authority, this paragraph shall not operate to limit the ability of a third-party payer to require prior approval.

(2) After performance of a physical examination by the nurse practitioner and collaboration, if necessary, with a physician and surgeon, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(3) For individuals receiving home health services or personal care services, after consultation, if necessary, with the treating physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

(4) Assess patients, synthesize and analyze data, and apply principles of health care.

- (5) Manage the physical and psychosocial health status of patients.
- (6) Analyze multiple sources of data, identify a differential diagnosis, and select, implement, and evaluate appropriate treatment.
- (7) Establish a diagnosis by client history, physical examination, and other criteria, consistent with this section, for a plan of care.
- (8) Order, furnish, prescribe, or procure drugs or devices.
- (9) Delegate tasks to a medical assistant pursuant to Sections 1206.5, 2069, 2070, and 2071, and Article 2 of Chapter 3 of Division 13 of Title 16 of the California Code of Regulations.
- (10) Order hospice care, as appropriate.
- (11) Order diagnostic procedures and utilize the findings or results in treating the patient.
- (12) Perform additional acts that require education and training and that are recognized by the nursing profession as appropriate to be performed by a nurse practitioner.
- (d) A nurse practitioner shall refer a patient to a physician and surgeon or other licensed health care provider if a situation or condition of the patient is beyond the scope of the education and training of the nurse practitioner.
- (e) A nurse practitioner practicing under this section shall maintain professional liability insurance appropriate for the practice setting.

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

SB 482
CURES



California
LEGISLATIVE INFORMATION

SB-482 Controlled substances: CURES database. (2015-2016)

AMENDED IN ASSEMBLY APRIL 07, 2016

AMENDED IN SENATE APRIL 30, 2015

AMENDED IN SENATE APRIL 16, 2015

CALIFORNIA LEGISLATURE— 2015–2016 REGULAR SESSION

SENATE BILL**No. 482****Introduced by Senator Lara****February 26, 2015**

An act to add Section 11165.4 to the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 482, as amended, Lara. Controlled substances: CURES database.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. Existing law requires dispensing pharmacies and clinics to report specified information for each prescription of a Schedule II, Schedule III, or Schedule IV controlled substance to the department.

This bill would require all prescribers, as defined, prescribing a Schedule II or Schedule III controlled substance, to consult a patient's electronic history in the CURES database before prescribing the controlled substance to the patient for the first time. The bill would also require the prescriber to consult the CURES database at least annually when the prescribed controlled substance remains part of the patient's treatment. The bill would prohibit prescribing an additional Schedule II or Schedule III controlled substance to a patient with an existing prescription until the prescriber determines that there is a legitimate need for the controlled substance.

The bill would make the failure to consult a patient's electronic history in the CURES database a cause for disciplinary action by the prescriber's licensing board and would require the licensing boards to notify all prescribers authorized to prescribe controlled substances of these requirements. The bill would provide that a prescriber is not in violation of these requirements ~~during any time that the CURES database is suspended or not accessible, or during any time that the Internet is not operational.~~ *if a specified condition exists, including any time that the CURES database is suspended or not accessible, an inability to access the CURES database in a timely manner because of an emergency, when the controlled substance is prescribed to a patient receiving hospice care, or when the controlled substance is directly administered to the patient by the person prescribing the controlled substance.* The bill would make its provisions operative upon the Department of Justice's certification that the CURES database is ready for statewide use.

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

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

SECTION 1. Section 11165.4 is added to the Health and Safety Code, to read:

11165.4. (a) A prescriber shall access and consult the CURES database for the electronic history of controlled

substances dispensed to a patient under his or her care before prescribing a Schedule II or Schedule III controlled substance for the first time to that patient and at least annually when that prescribed controlled substance remains part of his or her treatment. If the patient has an existing prescription for a Schedule II or Schedule III controlled substance, the prescriber shall not prescribe an additional controlled substance until the prescriber determines that there is a legitimate need for that controlled substance.

(b) Failure to consult a patient's electronic history as required by subdivision (a) is cause for disciplinary action by the prescriber's licensing board. The licensing boards of all prescribers authorized to write or issue prescriptions for controlled substances shall notify these licensees of the requirements of this section.

~~(c) Notwithstanding any other law, a prescriber is not in violation of this section during any period of time in which the CURES database is suspended or not accessible or any period of time in which the Internet is not operational.~~

(c) A prescriber is not liable in a civil action solely for failing to consult the CURES database as required pursuant to subdivision (a).

(d) The requirement in subdivision (a) does not apply, and a prescriber is not in violation of this section, if any of the following conditions are met:

(1) The CURES database is suspended or inaccessible, the Internet is not operational, the data in the CURES database is inaccurate or incomplete, or it is not possible to query the CURES database in a timely manner because of an emergency.

(2) The controlled substance is prescribed to a patient receiving hospice care.

(3) The controlled substance is prescribed to a patient as a part of a surgical procedure that has or will occur in a licensed health care facility and the prescription is nonrefillable.

(4) The controlled substance is directly administered to the patient by the prescriber or another person authorized to prescribe a controlled substance.

~~(d)~~

(e) This section shall not become operative until the Department of Justice certifies that the CURES database is ready for statewide use. The department shall notify the Secretary of State and the Office of Legislative Counsel of the date of that certification.

~~(e)~~

(f) For purposes of this section, "prescriber" means a health care practitioner who is authorized to write or issue prescriptions under Section 11150, excluding veterinarians.

~~(f)~~

(g) A violation of this section shall not be subject to the provisions of Section 11374.

(h) All applicable state and federal privacy laws govern the duties required by this section.

(i) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SB 1033

Disclosure of probationary status



California
LEGISLATIVE INFORMATION

SB-1033 Medical Board: disclosure of probationary status. (2015-2016)

AMENDED IN SENATE MARCH 17, 2016

CALIFORNIA LEGISLATURE— 2015–2016 REGULAR SESSION

SENATE BILL

No. 1033

Introduced by Senator Hill

February 12, 2016

An act to amend Sections 803.1, 2027, ~~and 2228 of~~ 2221, 2221.05, 2228, and 3663 of, and to add Sections 1006 and 4962 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1033, as amended, Hill. Medical Board: disclosure of probationary status.

Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. *Existing law establishes the California Board of Podiatric Medicine within the Medical Board of California for the licensing, regulation, and discipline of podiatrists. Existing law, the Osteopathic Act, enacted by an initiative measure, establishes the Osteopathic Medical Board of California for the licensing and regulation of osteopathic physicians and surgeons and requires the Osteopathic Medical Board of California to enforce the Medical Practice Act with respect to its licensees. Existing law, the Naturopathic Doctors Act, establishes the Naturopathic Medicine Committee in the Osteopathic Medical Board of California for the licensing and regulation of naturopathic doctors. Existing law, the Chiropractic Act, enacted by an initiative measure, establishes the State Board of Chiropractic Examiners for the licensing and regulation of chiropractors. Existing law, the Acupuncture Licensure Act, establishes the Acupuncture Board for the licensing and regulation of acupuncturists.* Existing law authorizes ~~the board~~ each of these regulatory agencies to discipline ~~a physician or a surgeon~~ its licensee by placing her or him on ~~probation, which may include requiring the physician or surgeon to complete specified trainings, examinations, or community service or restricting the extent, scope, or type of practice,~~ probation, as specified.

This bill would require ~~the board~~ these regulatory entities to require a ~~physician or surgeon~~ licensee to disclose on a separate document her or his probationary status to ~~patients before each a patient, the patient's guardian, or the health care surrogate prior to the patient's first visit following the probationary order~~ while the ~~physician or surgeon~~ licensee is on probation under specified circumstances, including ~~the board~~ an accusation alleging, a statement of issues indicating, or an administrative law judge's legal conclusion finding the ~~physician or surgeon~~ licensee committed gross negligence or the ~~physician or surgeon~~ licensee having been on probation ~~repeatedly, more than once,~~ among others. The bill would require the ~~board, by July 1, 2018, to adopt related regulations that include requiring the physician or surgeon~~ licensee to obtain from the patient a signed receipt containing specified information following the disclosure. *The bill would exempt a licensee from disclosing her or his probationary status prior to a visit or treatment if the patient is unable to comprehend the disclosure or sign an*

acknowledgment and a guardian or health care surrogate is unavailable. The bill would require in that instance that the doctor disclose his or her status as soon as either the patient can comprehend and sign the receipt or a guardian or health care surrogate is available to comprehend the disclosure and sign the receipt.

Existing law requires the ~~board~~ *Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine* to disclose to an inquiring member of the public and to post on ~~its~~ *their* Internet Web ~~site~~ *sites* specified information concerning each ~~physician and surgeon,~~ *licensee* including revocations, suspensions, probations, or limitations on practice.

This

The bill would require ~~the board,~~ *the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, the State Board of Chiropractic Examiners, the Naturopathic Medicine Committee, and the Acupuncture Board* by July 1, 2018, to ~~include in each order of probation a written summary containing specified information~~ *develop a standardized format for listing specified information related to the probation* and to ~~include the summary in the disclosure~~ *provide that information* to an inquiring member of the public, on any ~~board~~ documents informing the public of probation orders, and on a specified profile ~~web~~ *Internet Web* page of each ~~physician and surgeon~~ *licensee* subject to ~~probation;~~ *probation, as specified.*

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

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

SECTION 1. Section 803.1 of the Business and Professions Code is amended to read:

803.1. (a) Notwithstanding any other provision of law, the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall disclose to an inquiring member of the public information regarding any enforcement actions taken against a licensee, including a former licensee, by the board or by another state or jurisdiction, including all of the following:

- (1) Temporary restraining orders issued.
- (2) Interim suspension orders issued.
- (3) Revocations, suspensions, probations, or limitations on practice ordered by the board, including those made part of a probationary order or stipulated agreement.
- (4) Public letters of reprimand issued.
- (5) Infractions, citations, or fines imposed.

(b) Notwithstanding any other provision of law, in addition to the information provided in subdivision (a), the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall disclose to an inquiring member of the public all of the following:

(1) Civil judgments in any amount, whether or not vacated by a settlement after entry of the judgment, that were not reversed on appeal and arbitration awards in any amount of a claim or action for damages for death or personal injury caused by the physician and surgeon's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(2) (A) All settlements in the possession, custody, or control of the board shall be disclosed for a licensee in the low-risk category if there are three or more settlements for that licensee within the last 10 years, except for settlements by a licensee regardless of the amount paid where (i) the settlement is made as a part of the settlement of a class claim, (ii) the licensee paid in settlement of the class claim the same amount as the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case where the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action. All settlements in the possession, custody, or control of the board shall be disclosed for a licensee in the high-risk category if there are four or more settlements for that licensee within the last 10 years except for settlements by a licensee regardless of the amount paid where (i) the settlement is made as a part of the settlement of a class claim, (ii) the licensee paid in settlement of the class claim the same amount as the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case where the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action. Classification of a licensee in

either a "high-risk category" or a "low-risk category" depends upon the specialty or subspecialty practiced by the licensee and the designation assigned to that specialty or subspecialty by the Medical Board of California, as described in subdivision (f). For the purposes of this paragraph, "settlement" means a settlement of an action described in paragraph (1) entered into by the licensee on or after January 1, 2003, in an amount of thirty thousand dollars (\$30,000) or more.

(B) The board shall not disclose the actual dollar amount of a settlement but shall put the number and amount of the settlement in context by doing the following:

(i) Comparing the settlement amount to the experience of other licensees within the same specialty or subspecialty, indicating if it is below average, average, or above average for the most recent 10-year period.

(ii) Reporting the number of years the licensee has been in practice.

(iii) Reporting the total number of licensees in that specialty or subspecialty, the number of those who have entered into a settlement agreement, and the percentage that number represents of the total number of licensees in the specialty or subspecialty.

(3) Current American Board of Medical Specialties certification or board equivalent as certified by the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine.

(4) Approved postgraduate training.

(5) Status of the license of a licensee. By January 1, 2004, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall adopt regulations defining the status of a licensee. The board shall employ this definition when disclosing the status of a licensee pursuant to Section 2027. By July 1, 2018, the Medical Board of ~~California~~ *California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine* shall include the ~~summary of each probation order as written pursuant to information described in~~ *subdivision (e) (f)* of Section 2228.

(6) Any summaries of hospital disciplinary actions that result in the termination or revocation of a licensee's staff privileges for medical disciplinary cause or reason, unless a court finds, in a final judgment, that the peer review resulting in the disciplinary action was conducted in bad faith and the licensee notifies the board of that finding. In addition, any exculpatory or explanatory statements submitted by the licensee electronically pursuant to subdivision (f) of that section shall be disclosed. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(c) Notwithstanding any other provision of law, the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall disclose to an inquiring member of the public information received regarding felony convictions of a physician and surgeon or doctor of podiatric medicine.

(d) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board may formulate appropriate disclaimers or explanatory statements to be included with any information released, and may by regulation establish categories of information that need not be disclosed to an inquiring member of the public because that information is unreliable or not sufficiently related to the licensee's professional practice. The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall include the following statement when disclosing information concerning a settlement:

"Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the State of California believes that consumers should have access to malpractice information. In these profiles, the State of California has given you information about both the malpractice settlement history for the doctor's specialty and the doctor's history of settlement payments only if in the last 10 years, the doctor, if in a low-risk specialty, has three or more settlements or the doctor, if in a high-risk specialty, has four or more settlements. The State of California has excluded some class action lawsuits because those cases are commonly related to systems issues such as product liability, rather than questions of individual professional competence and because they are brought on a class basis where the economic incentive for settlement is great. The State of California has placed payment amounts into three statistical categories: below average, average, and above average compared to others in the doctor's specialty. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high-quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make an individual doctor's history more meaningful.

This report reflects data only for settlements made on or after January 1, 2003. Moreover, it includes information concerning those settlements for a 10-year period only. Therefore, you should know that a doctor may have made settlements in the 10 years immediately preceding January 1, 2003, that are not included in this report. After January 1, 2013, for doctors practicing less than 10 years, the data covers their total years of practice. You should take into account the effective date of settlement disclosure as well as how long the doctor has been in practice when considering malpractice averages.

The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to settle. Some doctors work primarily with high-risk patients. These doctors may have malpractice settlement histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the doctor. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information in this report and the general issue of malpractice with your doctor."

(e) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall, by regulation, develop standard terminology that accurately describes the different types of disciplinary filings and actions to take against a licensee as described in paragraphs (1) to (5), inclusive, of subdivision (a). In providing the public with information about a licensee via the Internet pursuant to Section 2027, the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall not use the terms "enforcement," "discipline," or similar language implying a sanction unless the physician and surgeon has been the subject of one of the actions described in paragraphs (1) to (5), inclusive, of subdivision (a).

(f) The Medical Board of California shall adopt regulations no later than July 1, 2003, designating each specialty and subspecialty practice area as either high risk or low risk. In promulgating these regulations, the board shall consult with commercial underwriters of medical malpractice insurance companies, health care systems that self-insure physicians and surgeons, and representatives of the California medical specialty societies. The board shall utilize the carriers' statewide data to establish the two risk categories and the averages required by subparagraph (B) of paragraph (2) of subdivision (b). Prior to issuing regulations, the board shall convene public meetings with the medical malpractice carriers, self-insurers, and specialty representatives.

(g) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, *and* the Physician Assistant Board shall provide each licensee, including a former licensee under subdivision (a), with a copy of the text of any proposed public disclosure authorized by this section prior to release of the disclosure to the public. The licensee shall have 10 working days from the date the board provides the copy of the proposed public disclosure to propose corrections of factual inaccuracies. Nothing in this section shall prevent the board from disclosing information to the public prior to the expiration of the 10-day period.

(h) Pursuant to subparagraph (A) of paragraph (2) of subdivision (b), the specialty or subspecialty information required by this section shall group physicians by specialty board recognized pursuant to paragraph (5) of subdivision (h) of Section 651 unless a different grouping would be more valid and the board, in its statement of reasons for its regulations, explains why the validity of the grouping would be more valid.

(i) By July 1, 2018, the ~~board~~ *Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine* shall include ~~each licensee's probation summary written pursuant to subdivision (e) the information listed in subdivision (f)~~ of Section 2228 on any board documents informing the public of probation ~~orders, orders and probationary licenses~~, including, but not limited to, newsletters.

SEC. 2. *Section 1006 is added to the Business and Professions Code, to read:*

1006. *(a) Except as provided by subdivision (c), the State Board of Chiropractic Examiners shall require a licensee to disclose on a separate document her or his probationary status to a patient, the patient's guardian, or health care surrogate prior to the patient's first visit following the probationary order while the licensee is on probation in any of the following circumstances:*

(1) The accusation alleges, the statement of issues indicates, or the legal conclusions of an administrative law judge find that the licensee is implicated in any of the following:

(A) Gross negligence.

(B) Repeated negligent acts involving a departure from the standard of care with multiple patients.

(C) Repeated acts of inappropriate and excessive prescribing of controlled substances, including, but not limited to, prescribing controlled substances without appropriate prior examination or without medical reason documented in medical records.

(D) Drug or alcohol abuse that threatens to impair a licensee's ability to practice medicine safely, including practicing under the influence of drugs or alcohol.

(E) Felony conviction arising from or occurring during patient care or treatment.

(F) Mental illness or other cognitive impairment that impedes a licensee's ability to safely practice medicine.

(2) The board ordered any of the following in conjunction with placing the licensee on probation:

(A) That a third-party chaperone be present when the licensee examines patients as a result of sexual misconduct.

(B) That the licensee submit to drug testing as a result of drug or alcohol abuse.

(C) That the licensee have a monitor.

(D) Restricting the licensee totally or partially from prescribing controlled substances.

(3) The licensee has not successfully completed a clinical training program or any associated examinations required by the board as a condition of probation.

(4) The licensee has been on probation more than once.

(b) The licensee shall obtain from each patient a signed receipt following the disclosure that includes a written explanation of how the patient can find further information on the licensee's probation on the board's Internet Web site.

(c) The licensee shall not be required to provide the disclosure prior to the visit as required by subdivision (a) if the patient is unconscious or otherwise unable to comprehend the disclosure and sign the receipt pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the receipt. In that instance, the licensee shall disclose her or his status as soon as either the patient can comprehend the disclosure and sign the receipt or a guardian or health care surrogate is available to comprehend the disclosure and sign the receipt.

(d) By July 1, 2018, the board shall develop a standardized format for listing the following information pursuant to subdivision (e):

(1) The listing of the causes for probation alleged in the accusation, the statement of issues, or the legal conclusions of an administrative law judge.

(2) The length of the probation and the end date.

(3) All practice restrictions placed on the licensee by the committee.

(e) By July 1, 2018, the board shall provide the information listed in subdivision (d) as follows:

(1) To an inquiring member of the public.

(2) On any board documents informing the public of probation orders and probationary licenses, including, but not limited to, newsletters.

(3) Upon availability of a licensee's BreEZe profile Internet Web page on the BreEZe system pursuant to Section 210, in plain view on the BreEZe profile Internet Web page of a licensee subject to probation or a probationary license.

SEC. 2. SEC. 3. Section 2027 of the Business and Professions Code is amended to read:

2027. (a) The board shall post on its Internet Web site the following information on the current status of the license for all current and former licensees:

(1) Whether or not the licensee is presently in good standing.

(2) Current American Board of Medical Specialties certification or board equivalent as certified by the board.

(3) Any of the following enforcement actions or proceedings to which the licensee is actively subjected:

(A) Temporary restraining orders.

(B) Interim suspension orders.

(C) (i) Revocations, suspensions, probations, or limitations on practice ordered by the board or the board of another state or jurisdiction, including those made part of a probationary order or stipulated agreement.

(ii) By July 1, 2018, the ~~board~~ *board, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine* shall include, in plain view on the BreEZe profile ~~web Internet Web~~ page of each licensee subject to ~~probation, the summary of each probation order as written pursuant to~~ *probation or a probationary license, the information described in* subdivision ~~(e)~~ (f) of Section 2228. For purposes of this subparagraph, a BreEZe profile ~~web Internet Web~~ page is a profile ~~web Internet Web~~ page on the BreEZe system pursuant to Section 210.

(D) Current accusations filed by the Attorney General, including those accusations that are on appeal. For purposes of this paragraph, "current accusation" means an accusation that has not been dismissed, withdrawn, or settled, and has not been finally decided upon by an administrative law judge and the board unless an appeal of that decision is pending.

(E) Citations issued that have not been resolved or appealed within 30 days.

(b) The board shall post on its Internet Web site all of the following historical information in its possession, custody, or control regarding all current and former licensees:

(1) Approved postgraduate training.

(2) Any final revocations and suspensions, or other equivalent actions, taken against the licensee by the board or the board of another state or jurisdiction or the surrender of a license by the licensee in relation to a disciplinary action or investigation, including the operative accusation resulting in the license surrender or discipline by the board.

(3) Probation or other equivalent action ordered by the board, or the board of another state or jurisdiction, completed or terminated, including the operative accusation resulting in the discipline by the board.

(4) Any felony convictions. Upon receipt of a certified copy of an expungement order granted pursuant to Section 1203.4 of the Penal Code from a licensee, the board shall, within six months of receipt of the expungement order, post notification of the expungement order and the date thereof on its Internet Web site.

(5) Misdemeanor convictions resulting in a disciplinary action or accusation that is not subsequently withdrawn or dismissed. Upon receipt of a certified copy of an expungement order granted pursuant to Section 1203.4 of the Penal Code from a licensee, the board shall, within six months of receipt of the expungement order, post notification of the expungement order and the date thereof on its Internet Web site.

(6) Civil judgments issued in any amount, whether or not vacated by a settlement after entry of the judgment, that were not reversed on appeal, and arbitration awards issued in any amount, for a claim or action for damages for death or personal injury caused by the physician and surgeon's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(7) Except as provided in subparagraphs (A) and (B), a summary of any final hospital disciplinary actions that resulted in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason. The posting shall provide any additional explanatory or exculpatory information submitted by the licensee pursuant to subdivision (f) of Section 805. The board shall also post on its Internet Web site a factsheet that explains and provides information on the reporting requirements under Section 805.

(A) If a licensee's hospital staff privileges are restored and the licensee notifies the board of the restoration, the information pertaining to the termination or revocation of those privileges shall remain posted on the Internet Web site for a period of 10 years from the restoration date of the privileges, and at the end of that period shall

be removed.

(B) If a court finds, in a final judgment, that peer review resulting in a hospital disciplinary action was conducted in bad faith and the licensee notifies the board of that finding, the information concerning that hospital disciplinary action posted on the Internet Web site shall be immediately removed. For purposes of this subparagraph, "peer review" has the same meaning as defined in Section 805.

(8) Public letters of reprimand issued within the past 10 years by the board or the board of another state or jurisdiction, including the operative accusation, if any, resulting in discipline by the board.

(9) Citations issued within the last three years that have been resolved by payment of the administrative fine or compliance with the order of abatement.

(10) All settlements within the last five years in the possession, custody, or control of the board shall be disclosed for a licensee in the low-risk category if there are three or more settlements for that licensee within the last five years, and for a licensee in the high-risk category if there are four or more settlements for that licensee within the last five years. Classification of a licensee in either a "high-risk category" or a "low-risk" category depends upon the specialty or subspecialty practiced by the licensee and the designation assigned to that specialty or subspecialty by the board pursuant to subdivision (f) of Section 803.1.

(A) For the purposes of this paragraph, "settlement" means a settlement in an amount of thirty thousand dollars (\$30,000) or more of any claim or action for damages for death or personal injury caused by the physician and surgeon's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(B) For the purposes of this paragraph, "settlement" does not include a settlement by a licensee, regardless of the amount paid, when (i) the settlement is made as a part of the settlement of a class claim, (ii) the amount paid in settlement of the class claim is the same amount paid by the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case for which the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action.

(C) The board shall not disclose the actual dollar amount of a settlement, but shall disclose settlement information in the same manner and with the same disclosures required under subparagraph (B) of paragraph (2) of subdivision (b) of Section 803.1.

(11) Appropriate disclaimers and explanatory statements to accompany the information described in paragraphs (1) to (10), inclusive, including an explanation of what types of information are not disclosed. These disclaimers and statements shall be developed by the board and shall be adopted by regulation.

(c) The board shall provide links to other Internet Web sites that provide information on board certifications that meet the requirements of subdivision (h) of Section 651. The board may also provide links to any other Internet Web sites that provide information on the affiliations of licensed physicians and surgeons. The board may provide links to other Internet Web sites on the Internet that provide information on health care service plans, health insurers, hospitals, or other facilities.

SEC. 4. Section 2221 of the Business and Professions Code is amended to read:

2221. (a) The board may 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~~ *license.*

(b) The board in its sole discretion, may issue a probationary physician's and surgeon's certificate to an applicant subject to terms and conditions, including, but not limited to, any of the following conditions of probation:

(1) Practice limited to a supervised, structured environment where the licensee's activities shall be supervised by another physician and surgeon.

(2) Total or partial restrictions on drug prescribing privileges for controlled substances.

(3) Continuing medical or psychiatric treatment.

(4) Ongoing participation in a specified rehabilitation program.

- (5) Enrollment and successful completion of a clinical training program.
- (6) Abstention from the use of alcohol or drugs.
- (7) Restrictions against engaging in certain types of medical practice.
- (8) Compliance with all provisions of this chapter.
- (9) Payment of the cost of probation monitoring.

(10) Disclosing probationary license status to patients, pursuant to subdivision (b) of Section 2228.

(b)

(c) The board may modify or terminate the terms and conditions imposed on the probationary certificate upon receipt of a petition from the *licensee; however, the provisions of subdivision (b) of Section 2228 are mandatory with any probationary* licensee. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board.

(c)

(d) The board shall deny a physician's and surgeon's certificate to an applicant who is required to register pursuant to Section 290 of the Penal Code. This subdivision does not apply to an applicant who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(d)

(e) An applicant shall not be eligible to reapply for a physician's and surgeon's certificate for a minimum of three years from the effective date of the denial of his or her application, except that the board may, in its discretion and for good cause demonstrated, permit reapplication after not less than one year has elapsed from the effective date of the denial.

SEC. 5. *Section 2221.05 of the Business and Professions Code is amended to read:*

2221.05. (a) Notwithstanding ~~subdivision~~ *subdivisions* (a) and (b) of Section 2221, the board may issue a physician's and surgeon's certificate to an applicant who has committed minor violations that the board deems, in its discretion, do not merit the denial of a certificate or require probationary status under Section 2221, and may concurrently issue a public letter of reprimand.

(b) A public letter of reprimand issued concurrently with a physician's and surgeon's certificate shall be purged three years from the date of issuance.

(c) A public letter of reprimand issued pursuant to this section shall be disclosed to an inquiring member of the public and shall be posted on the board's Internet Web site.

(d) Nothing in this section shall be construed to affect the board's authority to issue an unrestricted license.

SEC. 3. **SEC. 6.** Section 2228 of the Business and Professions Code is amended to read:

2228. (a) The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(1) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(2) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(3) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(4) Providing the option of alternative community service in cases other than violations relating to quality of care.

(b) The ~~board~~ *board or the California Board of Podiatric Medicine* shall require a licensee to disclose *on a separate document* her or his probationary status to ~~patients before each visit a patient, the patient's guardian, or health care surrogate prior to the patient's first visit following the probationary order~~ while the licensee is on probation in any of the following circumstances:

(1) The ~~board made a finding in the probation order~~ *accusation alleges, the statement of issues indicates, or the legal conclusions of an administrative law judge finds* that the licensee ~~committed~~ *is implicated in* any of the following:

(A) Gross negligence.

(B) Repeated negligent acts involving a departure from the standard of care with multiple patients.

(C) Repeated acts of inappropriate and excessive prescribing of controlled substances, including, but not limited to, prescribing controlled substances without appropriate prior examination or without medical reason documented in medical records.

(D) Drug or alcohol abuse that threatens to impair a licensee's ability to practice medicine safely, including practicing under the influence of drugs or alcohol.

(E) Felony conviction arising from or occurring during patient care or treatment.

(F) Mental illness or other cognitive impairment that impedes a licensee's ability to safely practice medicine.

(2) The board ordered any of the following in conjunction with placing the licensee on probation:

(A) That a ~~third-party~~ *third-party* chaperone be present when the licensee examines patients as a result of sexual misconduct.

(B) That the licensee submit to drug testing as a result of drug or alcohol abuse.

(C) That the licensee have a monitor.

(D) Restricting totally or partially the licensee from prescribing controlled substances.

~~(E) Suspending the licensee from practice in cases related to quality of care.~~

(3) The licensee has not successfully completed a clinical training program or any associated examinations required by the board as a condition of probation.

(4) The licensee has been on probation ~~repeatedly.~~ *more than once.*

(c) The ~~board shall adopt regulations by July 1, 2018, to implement subdivision (b). The board shall include in these regulations a requirement that the~~ licensee *shall* obtain from each patient a signed receipt following the disclosure that includes a written explanation of how the patient can find further information on the licensee's ~~discipline~~ *probation* on the board's Internet Web site.

(d) A licensee shall not be required to provide the disclosure prior to a visit as required by subdivision (b) if the patient is unconscious or otherwise unable to comprehend the disclosure and sign the receipt pursuant to subdivision (c) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the receipt. In that instance, the licensee shall disclose her or his status as soon as either the patient can comprehend the disclosure and sign the receipt or a guardian or health care surrogate is available to comprehend the disclosure and sign the receipt.

~~(d)~~

~~(e) Section 2314 shall not apply to subdivision (b) or (c). (b), (c), or (d).~~

~~(e)~~

(f) By July 1, 2018, the board shall include, in the first section of each order of probation, a standardized, single paragraph, plain language summary that contains the accusations that led to the licensee's probation, the develop a standardized format for listing the following information pursuant to paragraph (5) of subdivision (b) of Section 803.1, subdivision (i) of Section 803.1, and clause (ii) of subparagraph (C) of paragraph (1) of

subdivision (a) of Section 2027:

(1) The listing of the causes for probation alleged in the accusation, the statement of issues, or the legal conclusions of an administrative law judge.

(2) The length of the probation and the end ~~date, and all~~ date.

(3) All practice restrictions placed on the licensee by the board.

SEC. 7. *Section 3663 of the Business and Professions Code is amended to read:*

3663. (a) The committee shall have the responsibility for reviewing the quality of the practice of naturopathic medicine carried out by persons licensed as naturopathic doctors pursuant to this chapter.

(b) The committee may discipline a naturopathic doctor for unprofessional conduct. After a hearing conducted in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), the committee may deny, suspend, revoke, or place on probation the license of, or reprimand, censure, or otherwise discipline a naturopathic doctor in accordance with Division 1.5 (commencing with Section 475).

(c) Except as provided by subdivision (e), the committee shall require a naturopathic doctor to disclose on a separate document her or his probationary status to a patient, the patient's guardian, or health care surrogate prior to the patient's first visit following the probationary order while the naturopathic doctor is on probation in any of the following circumstances:

(1) The accusation alleges, the statement of issues indicates, or the legal conclusions of an administrative law judge find that the naturopathic doctor is implicated in any of the following:

(A) Gross negligence.

(B) Repeated negligent acts involving a departure from the standard of care with multiple patients.

(C) Repeated acts of inappropriate and excessive prescribing of controlled substances, including, but not limited to, prescribing controlled substances without appropriate prior examination or without medical reason documented in medical records.

(D) Drug or alcohol abuse that threatens to impair a naturopathic doctor's ability to practice medicine safely, including practicing under the influence of drugs or alcohol.

(E) Felony conviction arising from or occurring during patient care or treatment.

(F) Mental illness or other cognitive impairment that impedes a naturopathic doctor's ability to safely practice medicine.

(2) The committee ordered any of the following in conjunction with placing the naturopathic doctor on probation:

(A) That a third-party chaperone be present when the naturopathic doctor examines patients as a result of sexual misconduct.

(B) That the naturopathic doctor submit to drug testing as a result of drug or alcohol abuse.

(C) That the naturopathic doctor have a monitor.

(D) Restricting the naturopathic doctor totally or partially from prescribing controlled substances.

(3) The naturopathic doctor has not successfully completed a clinical training program or any associated examinations required by the committee as a condition of probation.

(4) The naturopathic doctor has been on probation more than once.

(d) The naturopathic doctor shall obtain from each patient a signed receipt following the disclosure that includes a written explanation of how the patient can find further information on the naturopathic doctor's probation on the committee's Internet Web site.

(e) The naturopathic doctor shall not be required to provide the disclosure prior to the visit as required by subdivision (c) if the patient is unconscious or otherwise unable to comprehend the disclosure or sign the receipt

pursuant to subdivision (d) and a guardian or health care surrogate is unavailable to comprehend the disclosure or sign the receipt. In such an instance, the naturopathic doctor shall disclose her or his status as soon as either the patient can comprehend the disclosure and sign the receipt or a guardian or health care surrogate is available to comprehend the disclosure and sign the receipt.

(f) By July 1, 2018, the committee shall develop a standardized format for listing the following information pursuant to:

(1) The listing of the causes for probation alleged in the accusation, the statement of issues, or the legal conclusions of an administrative law judge.

(2) The length of the probation and the end date.

(3) All practice restrictions placed on the naturopathic doctor by the committee.

(g) By July 1, 2018, the committee shall provide the information listed in subdivision (f) as follows:

(1) To an inquiring member of the public.

(2) On any committee documents informing the public of probation orders and probationary licenses, including, but not limited to, newsletters.

(3) In plain view on the BreZE profile Internet Web page of a naturopathic doctor subject to probation or a probationary license.

SEC. 8. *Section 4962 is added to the Business and Professions Code, to read:*

4962. *(a) Except as provided by subdivision (c), the board shall require a licensee to disclose on a separate document her or his probationary status to a patient, the patient's guardian, or health care surrogate prior to the patient's first visit following the probationary order while the licensee is on probation in any of the following circumstances:*

(1) The accusation alleges, the statement of issues indicates, or the legal conclusions of an administrative law judge find that the licensee is implicated in any of the following:

(A) Gross negligence.

(B) Repeated negligent acts involving a departure from the standard of care with multiple patients.

(C) Drug or alcohol abuse that threatens to impair a licensee's ability to practice acupuncture safely, including practicing under the influence of drugs or alcohol.

(D) Felony conviction arising from or occurring during patient care or treatment.

(E) Mental illness or other cognitive impairment that impedes a licensee's ability to safely practice acupuncture.

(2) The board ordered any of the following in conjunction with placing the licensee on probation:

(A) That a third-party chaperone be present when the licensee examines patients as a result of sexual misconduct.

(B) That the licensee submit to drug testing as a result of drug or alcohol abuse.

(C) That the licensee have a monitor.

(3) The licensee has not successfully completed a training program or any associated examinations required by the board as a condition of probation.

(4) The licensee has been on probation more than once.

(b) The licensee shall obtain from each patient a signed receipt following the disclosure that includes a written explanation of how the patient can find further information on the licensee's probation on the board's Internet Web site.

(c) The licensee shall not be required to provide the disclosure prior to the visit as required by subdivision (a) if the patient is unconscious or otherwise unable to comprehend the disclosure or sign the receipt pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure or sign the

receipt. In such an instance, the licensee shall disclose her or his status as soon as either the patient can comprehend the disclosure and sign the receipt or a guardian or health care surrogate is available to comprehend the disclosure and sign the receipt.

(d) Section 4935 shall not apply to subdivision (a) or (b).

(e) By July 1, 2018, the committee shall develop a standardized format for listing the following information pursuant to subdivision (f):

(1) The listing of the causes for probation alleged in the accusation, the statement of issues, or the legal conclusions of an administrative law judge.

(2) The length of the probation and the end date.

(3) All practice restrictions placed on the licensee by the committee.

(f) By July 1, 2018, the board shall provide the information listed in subdivision (e) as follows:

(1) To an inquiring member of the public.

(2) On any board documents informing the public of probation orders and probationary licenses, including, but not limited to, newsletters.

(3) Upon availability of a licensee's BreEZe profile Internet Web page on the BreEZe system pursuant to Section 210, in plain view on the BreEZe profile Internet Web page of a licensee subject to probation or a probationary license.

SB 1418

**Clinical lab testing without order
from health care provider**



California
LEGISLATIVE INFORMATION

SB-1418 Medi-Cal: immigration status. (2015-2016)

AMENDED IN SENATE APRIL 26, 2016

AMENDED IN SENATE APRIL 13, 2016

AMENDED IN SENATE MARCH 28, 2016

CALIFORNIA LEGISLATURE— 2015–2016 REGULAR SESSION

SENATE BILL

No. 1418

Introduced by Senator Lara

February 19, 2016

~~An act to amend Section 1288 of, and to repeal and add Section 1246.5 of, the Business and Professions Code, relating to clinical laboratories.~~ *An act to add Section 14102.1 to the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1418, as amended, Lara. ~~Clinical-laboratory-testing.~~ *Medi-Cal: immigration status.*

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The federal Medicaid program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

This bill would extend eligibility for full-scope Medi-Cal benefits to individuals 19 years of age and older who are otherwise eligible for those benefits but for their immigration status if the department determines that sufficient funding is available, or for limited scope Medi-Cal benefits if funding for full-scope benefits is not available. The bill would require these individuals to enroll into Medi-Cal managed care health plans, and to pay copayments and premium contributions, to the extent required of otherwise eligible Medi-Cal recipients who are similarly situated. The bill would require that benefits for those services to be provided with state-only funds only if federal financial participation is not available. Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.

The bill would require the department to adopt regulations by July 1, 2018, and, commencing July 1, 2016, would require the department to provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs

mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

~~Existing law provides for the regulation and licensure of clinical laboratories and clinical laboratory personnel by the State Department of Public Health and makes a violation of a provision under this law a misdemeanor. Existing law authorizes a person to request, and a licensed clinical laboratory or public health laboratory to perform specified clinical laboratory tests, including pregnancy, glucose level, cholesterol, and occult blood tests. Existing law authorizes a registered clinical laboratory to perform these tests if the test is subject to a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988 and the laboratory has registered with the State Department of Public Health.~~

~~Existing law authorizes the results of the test to be provided directly to the person requesting the test if the test is on or for his or her own body. Existing law requires that those test results be provided in a manner that presents clear information and that identifies results indicating the need for referral to a physician.~~

~~This bill would repeal those provisions and instead allow a person to request, and a licensed clinical laboratory or public health laboratory to perform, any laboratory test that the laboratory offers to the public on a direct access basis without a healing arts licensee's order. If a laboratory test is conducted without an order from a healing arts licensee, the bill would require any report of the test results to be provided to the person who was the subject of the test. The bill would require the report to state in bold type that it is the responsibility of the person who was tested to arrange with his or her health care provider for consultation and interpretation of the test results. The bill would make additional conforming changes. By changing the definition of an existing crime, this bill would impose a state-mandated local program.~~

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

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

Vote: **majority**2/3 Appropriation: no Fiscal Committee: yes Local Program: yes

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

SECTION 1. (a) *The Legislature finds and declares all of the following:*

(1) The Legislature and the Governor, through the enactment of the Budget Act of 2015 (Chapter 11 of the Statutes of 2015), expanded Medi-Cal eligibility for children to ensure that no child in California who is income eligible will be denied access to health care coverage on the basis of immigration status.

(2) Expanding access and increasing enrollment in comprehensive health care coverage is of benefit to the health and welfare of all Californians.

(3) Longstanding California law provides full-scope Medi-Cal benefits to United States citizens, lawful permanent residents, and individuals permanently residing in the United States under color of law, including those granted deferred action.

(b) It is the intent of the Legislature in enacting this act to increase opportunities for enrollment in comprehensive health care coverage for adults, regardless of immigration status.

SEC. 2. *Section 14102.1 is added to the Welfare and Institutions Code, to read:*

14102.1. (a) (1) *Notwithstanding any other law, an individual 19 years of age or older who meets all of the eligibility requirements for full-scope Medi-Cal benefits under this chapter, but for his or her immigration status, may be enrolled for full-scope Medi-Cal benefits, pursuant to paragraph (2).*

(2) When a county completes the Medi-Cal eligibility determination process for an individual 19 years of age or older who meets all of the eligibility requirements for full-scope Medi-Cal benefits under this chapter, but for his or her immigration status, the county shall transmit this information to the department to determine if sufficient funding is available for this individual to receive full-scope Medi-Cal benefits. If sufficient funding is available, the individual shall be eligible for full-scope benefits. If sufficient funding is not available, the individual shall be

eligible for limited scope Medi-Cal benefits.

(b) This section shall not apply to individuals eligible for coverage pursuant to Section 14102.

(c) An individual who is eligible for coverage under subdivision (a) shall be required to enroll into Medi-Cal managed care health plans to the extent required of otherwise eligible Medi-Cal recipients who are similarly situated.

(d) An individual who is eligible for coverage under subdivision (a) shall pay copayments and premium contributions to the extent required of otherwise eligible Medi-Cal recipients who are similarly situated.

(e) Benefits for services under this section shall be provided with state-only funds only if federal financial participation is not available for those services. The department shall maximize federal financial participation in implementing this section to the extent allowable.

(f) Eligibility for full-scope Medi-Cal benefits for an individual 19 years of age or older pursuant to subdivision (a) shall not be an entitlement. The department shall have the authority to determine eligibility, determine the number of individuals who may be enrolled, establish limits on the number enrolled, and establish processes for waiting lists needed to maintain program expenditures within available funds.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The department shall adopt regulations by July 1, 2018, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2016, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

SEC. 3. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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

In order to expand access to health care coverage to every Californian as quickly as possible, it is necessary that this act go into immediate effect.

~~SECTION 1. Section 1246.5 of the Business and Professions Code is repealed.~~

~~SEC. 2. Section 1246.5 is added to the Business and Professions Code, to read:~~

~~1246.5.(a) Notwithstanding any other law, a person may request, and a licensed clinical laboratory or public health laboratory may perform, any laboratory test that the laboratory offers to the public without an order from a healing arts licensee or his or her representative.~~

~~(b) If a laboratory test of a person is conducted without an order from a healing arts licensee or his or her representative, the test results shall be provided to the person who was the subject of the test. The test results report shall state in bold type that it is the responsibility of the person who was tested to arrange with his or her health care provider for consultation and interpretation of the test results.~~

~~(c) A healing arts licensee is not required to review or act on a laboratory test result if the healing arts licensee or his or her representative did not order the laboratory test. A healing arts licensee is not subject to liability or disciplinary actions for failure to review or act on the results of a laboratory test of any person if the healing arts licensee or his or her representative did not order the laboratory test.~~

~~(d) This section does not require that any laboratory test be covered by a health care service plan contract or health insurance policy.~~

~~SEC. 3. Section 1288 of the Business and Professions Code is amended to read:~~

~~1288. A report of results issuing from a clinical laboratory shall show clearly the name and address of the laboratory and the name of the director.~~

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

Enforcement Report

OMBC Enforcement Report

May 5, 2016

The following OMBC Enforcement Report covers a 12 month period starting from 2nd Quarter 2015 though 1st Quarter 2016. The OMBC Enforcement Report is divided into five sections; Intake, Investigations, Enforcement, Performance Measures, and Probation. The data is reproduced from the Breeze Enforcement Reports.

COMPLAINT INTAKE

In Table 1 below, under TOTAL INTAKE, OMBC received 537 complaints. 30 of these cases were convictions/arrests. During this period, 589 cases were assigned for investigations and the average number of days to assign a case was 31.

	2Q/2015			3Q/2015			4Q/2015			1Q/2016			
COMPLAINTS	4/15	5/15	6/15	7/15	8/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	YTD
Received	43	48	30	53	30	38	53	29	49	48	44	42	507
Assigned	47	68	57	44	17	39	32	13	41	45	109	47	559
Aging	15	63	31	14	18	34	22	22	54	61	39	14	32
	2Q/2015			3Q/2015			4Q/2015			1Q/2016			
CONV/ARRESTS	4/15	5/15	6/15	7/15	8/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	YTD
Received	2	4	2	4	5	1	2	1	3	0	3	3	30
Assigned	2	4	3	3	5	2	2	1	3	0	2	3	30
Aging	5	2	58	2	3	13	1	5	7	0	1	3	8
	2Q/2015			3Q/2015			4Q/2015			1Q/2016			
TOTAL INTAKE	4/15	5/15	6/15	7/15	8/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	YTD
Received	45	52	32	57	35	39	55	30	52	48	47	45	537
Assigned	49	72	60	47	22	41	34	14	44	45	111	50	589
Aging	15	59	32	13	15	33	21	20	51	61	38	13	31
Pending	63	43	15	25	38	3	57	73	81	84	20	14	

Table 1: Complaint Intake with Convictions/Arrests

In Figure 1.1 below, TOTAL COMPLAINT INTAKE, the average number of complaints received (blue line) during this 12 month period averaged around 44 cases per month. Assigned cases (green) gradually fell to 14 in November causing pending cases (red) to grow substantially during the 4Q 2015. However, in February, the pending cases fell dramatically, from 84 to 20, as assigned cases spiked at 111.

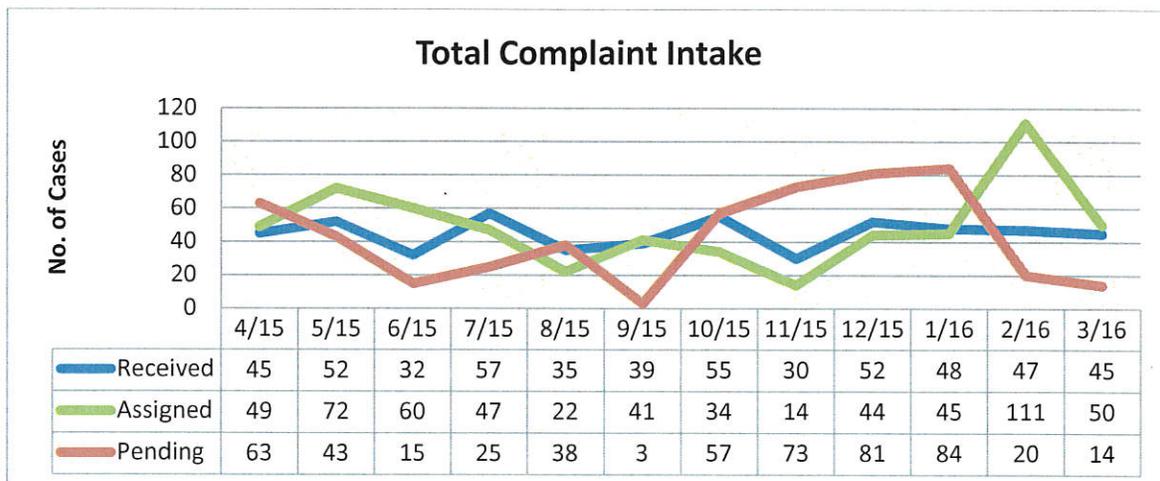


Figure 1.1: Total Complaint Intake

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In Figure 1.2 below, the bar graph illustrates the monthly average number of days to assign a complaint. The aging measures the period from the time the complaint is received in the office (the date stamp) to the time the complaint is assigned to investigations. In the months of May, December and January, the aging was significantly higher which is indicative that case assignment fall behind.

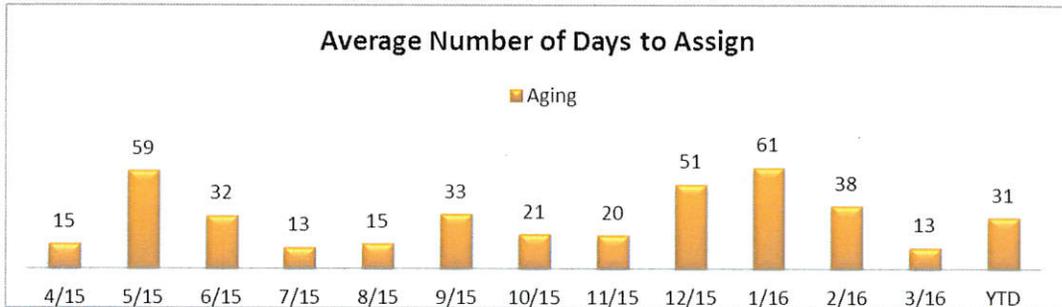


Figure 1.2:

INVESTIGATIONS

Desk Investigations

For all desk investigations during this period, Table 2 below breaks down the monthly totals for how many complaints were assigned, completed, and the average number of days to complete (aging). During this period, a totaled of 573 desk investigations were assigned, 584 were completed, and the average number of days to complete an investigations was 117 (previously 111). Pending cases represent cases assigned but have not been completed.

	2Q/2015			3Q/2015			4Q/2015			1Q/2016			
Desk Inv.	4/15	5/15	6/15	7/15	8/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	YTD
Assigned	49	72	60	47	22	41	34	14	44	45	67	78	573
Completed	55	15	39	36	40	39	31	47	136	45	43	58	584
Aging	176	44	70	103	140	116	61	153	280	136	63	61	117
Pending	194	251	272	284	267	270	273	238	145	148	173	193	193

Table 2: Desk Investigations

In Figure 2.1 below, the assigned cases (blue line) gradually declined from 72 cases in May 2015 to 14 cases in November and then gradually increased to 78 in March 2016. Completed desk investigations (red line) were constant until December 2015 with over 136 completed cases; partly due to cases closed for lack of response from complainant.

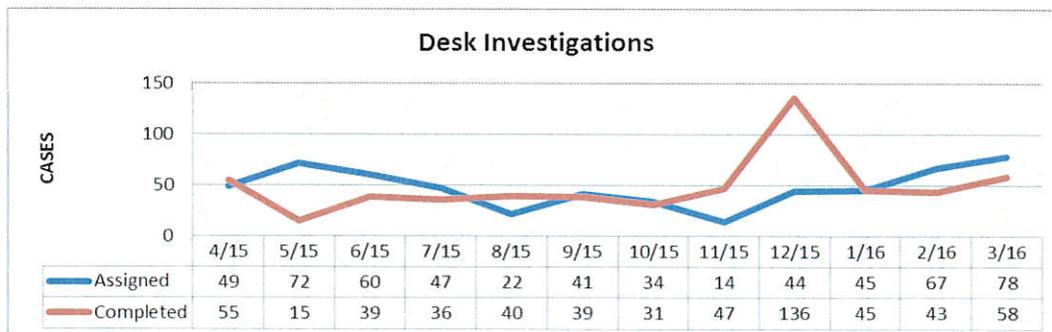


Figure 2.1: Desk Investigations

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The average number of days to complete a desk investigation, in Figure 2.2 below shows a respectable 117 during this 12 month period. The month of December was high with an average of 280 days (9 months) to complete an investigation. The reason for this high aging is due to the closure of cases that had not received a response from the complainant and cases that were part of a class action lawsuit.

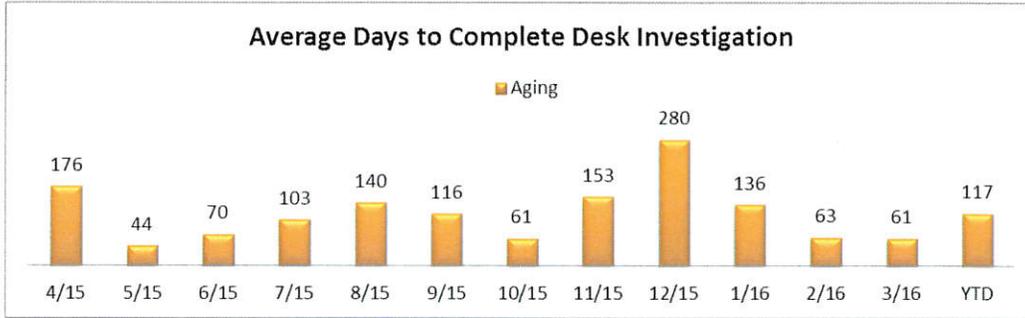


Figure 2.2: Desk Investigations Aging

Field (Sworn) Investigations

For all field investigations, Table 3 below tracks number of cases referred to Division of Investigation (DOI) field offices. These investigations are conducted by sworn peace officers regarding serious allegations that generally take more time and resources. Investigations that discover sufficient evidence are then referred to the Attorney General’s office for disciplinary actions. During this 12 month period, 33 cases were assigned to field investigations; 33 were completed; and the average number of days to complete an investigation was 315 (previously 350).

	2Q/2015			3Q/2015			4Q/2015			1Q/2016			YTD
	4/15	5/15	6/15	7/15	8/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	
Field Inv.	4/15	5/15	6/15	7/15	8/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	YTD
Assigned	0	1	0	4	2	2	4	4	4	1	6	5	33
Completed	5	1	4	1	4	3	3	0	2	2	5	3	33
Aging	162	83	363	451	406	531	422	0	200	317	355	176	315
Pending	29	29	25	28	27	26	27	31	34	33	37	39	39

Table 3: Field Investigations

In Figure 3.1 below, the average number of days to complete a field investigation measures the date the case was received at intake to the date that the field investigation is completed. For the past 12 months the aging averaged 315 days to complete a field investigation. No cases were closed in the month of November.

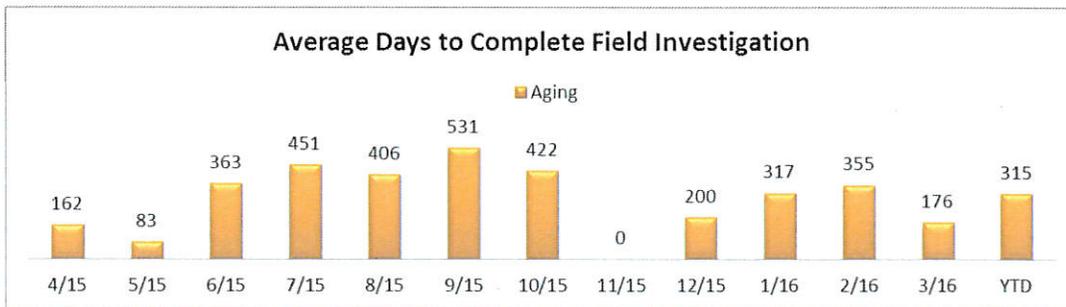


Figure 3.1: Field Investigations Aging

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Aging for Desk and Field Investigations

All Inv Aging	2Q/2015			3Q/2015			4Q/2015			1Q/2016			YTD
	4/15	5/15	6/15	7/15	8/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	
90 days	24	13	25	17	19	12	15	8	19	15	33	42	242
91-180 days	7	1	14	8	13	22	7	22	34	9	2	10	149
181-1 yr	23	0	1	2	5	5	4	15	56	16	4	5	136
1 yr-2 yrs	5	1	3	4	3	2	2	0	13	3	0	0	36
2 yrs-3 yrs	0	0	0	0	2	0	0	0	9	0	1	0	12
over 3 yrs	0	0	1	0	0	0	0	0	5	0	1	0	7

Table 4: All Investigations Aging

In Table 4 above we see the aging matrix for the number of desk and field investigations that were closed per month within a specific time period. 242 cases, (42%) were completed within 90 days; 149 cases (26%) were completed between 91-180 days; 136 cases (23%) were completed between 181-365 days; 36 cases (6%) were completed between 1 – 2 years; 12 cases (2%) were completed between 2-3 years; and 7 cases (1%) were completed after 3 years. The majority of the investigations (70%) were completed within 6 months; 90% of all investigations were completed within a year.

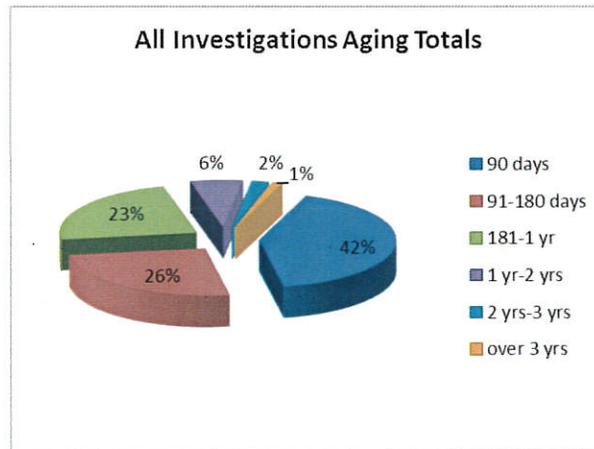


Figure 4.1: All Investigations Aging

Investigations Closed Without Disciplinary Referral

	2Q/2015			3Q/2015			4Q/2015			1Q/2016			YTD
	4/15	5/15	6/15	7/15	8/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	
Closed	58	14	41	30	40	41	26	44	134	42	38	53	561
Aging	173	55	91	132	134	151	74	143	289	153	77	71	161

Table 5: Investigations Closed without Discipline Referral

In Table 5 above we see the number of desk and field investigations that were completed each month and were not referred to the Attorney General for disciplinary action. The total during the 12 month period was 561 (previously 399). The average number of days-to-close was 161, an increase from the last report of 136.

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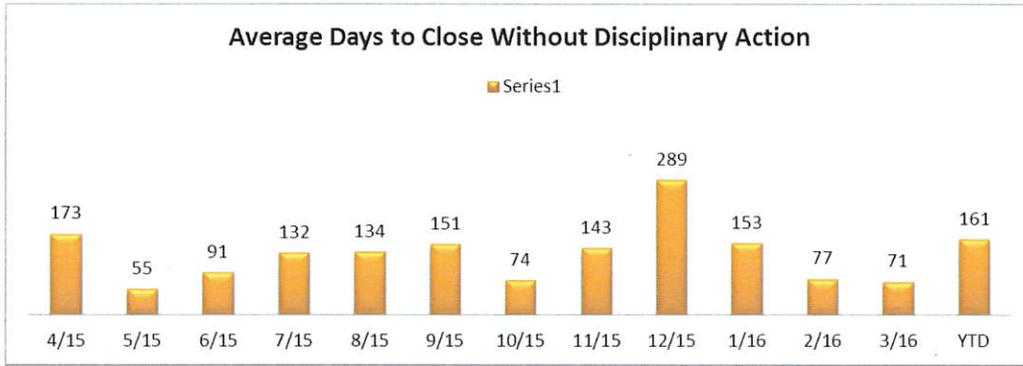


Figure 5.1: Desk and Field Investigations Aging - Closed with no Referral

ENFORCEMENT ACTIONS

	2Q/2015			3Q/2015			4Q/2015			1Q/2016			YTD
	4/15	5/15	6/15	7/15	8/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	
AG Cases Initiated	1	1	3	2	2	0	1	0	3	0	3	3	19
Acc/SOI Filed	0	1	0	2	5	1	2	0	0	0	2	4	17
Final Disciplinary Orders	2	1	1	2	2	2	2	0	1	1	2	1	17
Acc Withdrawn	0	0	0	0	0	0	0	0	0	0	0	0	0
Closed w/out Disc Action	0	0	0	0	0	0	0	0	0	0	0	0	0
Citations	0	0	0	0	0	0	0	2	0	1	0	1	4
Interim Sus Orders Issued	0	0	0	0	0	0	0	0	0	0	0	0	0
PC 23 Orders Issued	0	0	0	0	0	0	0	0	0	0	0	0	0
AG Cases Pending	18	17	19	19	20	19	18	18	20	19	20	22	22

Table 6: Enforcement Actions

For all enforcement actions, Table 6 above breaks down the monthly totals for each disciplinary action. During this 12 month period, 19 cases were transmitted to the Attorney General’s Office for disciplinary actions; 17 Accusations and Statement of Issues were filed; 17 Final Disciplinary Orders were filed and 4 citations were issued. At the end of 1Q 2016 there were 22 pending AG cases.



Figure 6.1: Enforcement Actions Totals

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Total Final Orders Aging

Total Orders Aging	2Q/2015			3Q/2015			4Q/2015			1Q/2016			YTD
	4/15	5/15	6/15	7/15	8/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	
90 Days	0	0	0	0	0	0	0	0	0	0	0	0	0
91-180 Days	0	0	0	0	0	0	0	0	0	0	1	0	1
181 - 1 Yr	0	0	0	0	1	0	0	0	0	0	0	1	2
1 - 2 Yrs	0	0	0	1	1	0	2	0	1	1	0	0	6
2 - 3 Yrs	1	0	0	0	0	1	0	0	0	0	0	0	2
3-4 Yrs	1	1	1	1	0	1	0	0	0	0	1	0	6
4 yrs	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	2	1	1	2	2	2	2	0	1	1	2	1	17

Table 7: Total Final Orders Aging Matrix

In Table 7 above we see the aging matrix of the 17 Final Orders that were completed from 2Q 2015 to 1Q 2016. The aging measures the period from the date the case was received in the office to the order date (file date) of the Final Order. The pie chart below shows the percentage of cases distributed within each time period. Of the 17 final orders, 1 case (6%) was completed within 180 days; 2 cases (12%) within 181-365 days; 6 cases (35%) within 1-2 years; 2 cases (12%) within 2-3 years; and 6 cases (35%) within 3-4 years.

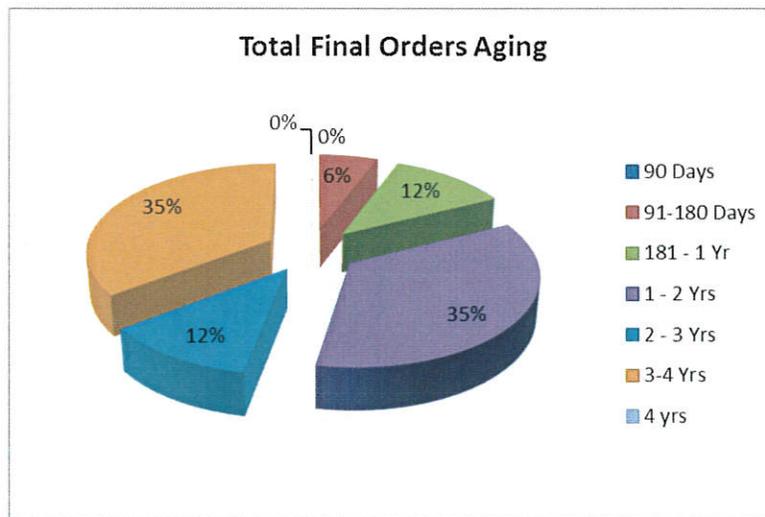


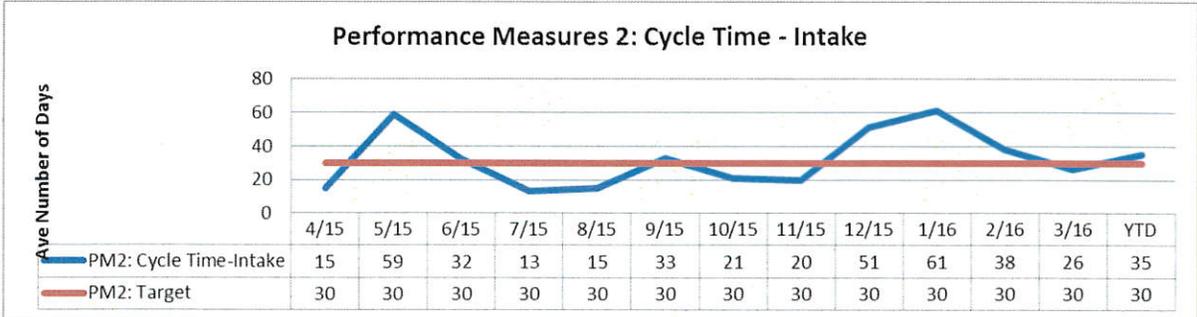
Figure 7.1: Total Orders Aging

OMBC Enforcement Report

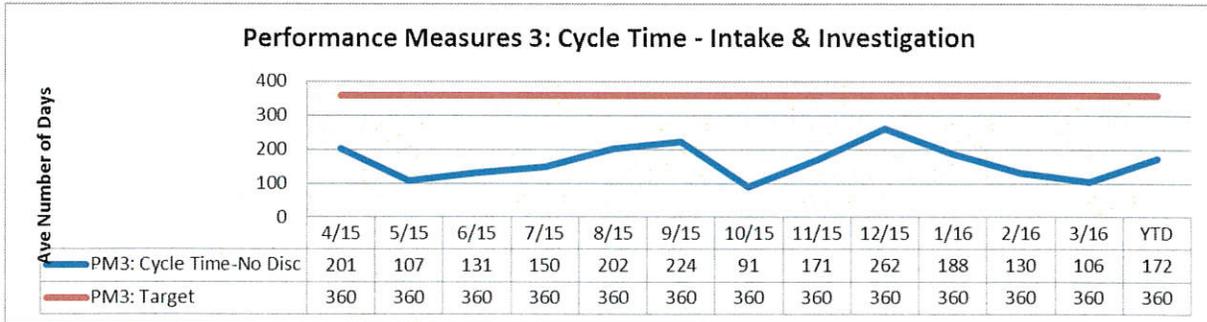
May 5, 2016

PERFORMANCE MEASURES

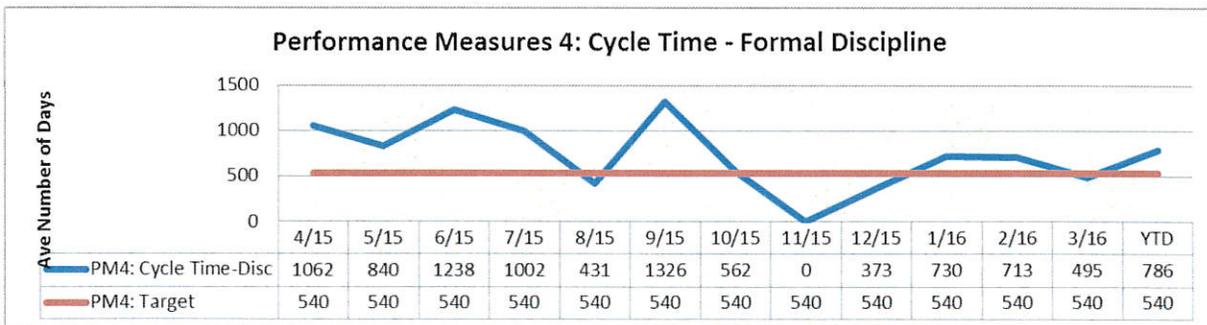
PM2: CYCLE TIME-INTAKE: Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



PM3: CYCLE TIME – INTAKE & INVESTIGATION: Average number of days to complete the entire enforcement process for cases not transmitted to the Attorney General. (Includes Intake and Investigation)



PM4: CYCLE TIME – FORMAL DISCIPLINE: Average number of days to complete the entire enforcement process for cases transmitted to the Attorney General for formal discipline. (Includes intake, investigation, and transmittal outcome)



PROBATION

There are currently 41 probation cases, of which 22 cases have an outstanding cost recovery order. The total ordered cost recovery is currently \$390,239.25. \$245,820.25 has been paid leaving a balance of \$144,419.00.

TABLE 7

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TABLES

Section 1661.2

**Diversion Evaluation Committee
Duties and Responsibilities**

Section 1663

Disciplinary Guidelines

**Availability of Modified Text &
Documents added to the
Rulemaking File**

**AVAILABILITY OF MODIFIED TEXT AND
DOCUMENTS ADDED TO THE RULEMAKING FILE**

NOTICE IS HEREBY GIVEN that the Osteopathic Medical Board of California has proposed modifications to the text of section 1663 in Title 16 of the California Code of Regulations which were the subject of a regulatory hearing on September 17, 2015. A copy of the modified text, including any document incorporated by reference, is enclosed.

NOTICE IS ALSO GIVEN that the following document is being added to the rulemaking record for the regulatory proceeding concerning sections 1661.2 and 1663 of Title 16 of the California Code of Regulations:

- *Uniform Standards Regarding Substance-Abusing Healing Arts Licensees (04/2011)*

The above documents are now available for public inspection and/or comment until April 14, 2016 at the location referenced below.

Any person who wishes to comment on the proposed modifications may do so by submitting written comments on or before April 14, 2016 to the following:

Contact Person: Machiko Chong
Agency Name: Osteopathic Medical Board of California
Address: 1300 National Drive, Suite 150
Sacramento, CA 95834-1991
Telephone No.: 916-928-7636
Fax No.: 916-928-8392
E-mail Address: Machiko.Chong@dca.ca.gov

Materials regarding this proposal can be found at www.ombc.ca.gov.

DATED: March 31, 2016



Angelina Burton
Executive Officer
Osteopathic Medical Board of California

**Addendum to the Initial Statement
of Reasons**

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
ADDENDUM TO THE INITIAL STATEMENT OF REASONS

Hearing Date: September 17, 2015

Subject Matter of Proposed Regulations: Uniform Standards for Substance Abusing Licensees and Disciplinary Guidelines as required by SB 1441

Sections Affected: California Code of Regulations, title 16, sections 1661.2 and 1663

Updated Underlying Data:

Technical, theoretical or empirical studies or reports relied upon (if any): *Uniform Standards Regarding Substance-Abusing Healing Arts Licensees (04/2011)*

Proposed Language

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Proposed Language

Changes to the originally proposed language are shown by underlining for new text and strikethrough for deleted text.

Changes to the originally proposed language are shown by double underline for new text and double strikeout for deleted text.

1. Amend Section 1661.2 of Division 16 of Title 16 of the California Code of Regulations to read as follows:

§ 1661.2 Diversion Evaluation Committee Duties and Responsibilities.

A diversion evaluation committee shall have the following duties and responsibilities in addition to those set forth in Section 2366 of the Code:

- (a) To consider recommendations of the program manager and any consultants to the committee;
- (b) To set forth in writing for each physician in a program a treatment and rehabilitation plan established for that physician with the requirement for supervision and surveillance.
- (c) To use the uniform standards for substance-abusing licensees contained in "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees" (04/2011), which is hereby incorporated by reference.

NOTE: Authority cited: Osteopathic Act (Initiative Measure, Stats. 1923, p.xciii), Section 1; and Section 3600-1, Business and Professions Code. Reference: Section 2366, Business and Professions Code.

2. Amend Section 1663 of Division 16 of Title 16 of the California Code of Regulations to read as follows:

§ 1663. Disciplinary Guidelines.

(a) In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Osteopathic Medical Board of California shall consider the disciplinary guidelines entitled "Osteopathic Medical Board of California Disciplinary Guidelines of ~~1996~~ 2014" (Rev 08/14) ("Guidelines"), which are hereby incorporated by reference. Deviation from ~~these g~~ Guidelines and orders, including the standard terms of probation, is appropriate where the Osteopathic Medical Board of California in its sole discretion determines that the facts of the particular case warrant such a deviation – for example: the presence of mitigating factors; the age of the case; evidentiary problems.

(b) (1) Notwithstanding the Guidelines, any proposed decision issued in accordance with the procedures set forth in Chapter 5 (commencing with Section 11500) of Part 1 of

Division 3 of Title 2 of the Government Code that contains any finding of fact that the licensee engaged in any act of sexual contact, as defined in subdivision (c) of Section 729 of the Code, with a patient, or any finding that the licensee has committed a sex offense or been convicted of a sex offense, shall contain an order revoking the license. The proposed decision shall not contain an order staying the revocation of the license.

(2) As used in this section, the term "sex offense" shall mean any of the following:

- (a) Any offense for which registration is required by Section 290 of the Penal Code or a finding that a person committed such an offense.
- (b) Any offense defined in Section 261.5, 313.1, 647b, or 647 subdivision (a) or (d) of the Penal Code or a finding that a person committed such an offense.
- (c) Any attempt to commit any of the offenses specified in this section.
- (d) Any offense committed or attempted in any other state or against the laws of the United State which, if committed or attempted in this state, would be punishable as one or more of the offenses specified in this section.

(c) If the conduct found to be a violation involves drugs, alcohol, or both, and the individual is permitted to practice under conditions of probation, a clinical diagnostic evaluation shall be ordered as a condition of probation in every case, without deviation. The clinical diagnostic evaluator's report shall be submitted in its entirety to the board.

- (1) Each of the "Terms and Conditions of the Uniform Standards for Substance-Abusing Licensees," as set forth in the Guidelines, shall be included in any order subject to this subsection, but may be imposed contingent upon the outcome of the clinical diagnostic evaluation.
- (2) The Substance Abuse Coordination Committee's *Uniform Standards Regarding Substance Abusing Healing Arts Licensees (04/2011)*, which are hereby incorporated by reference, shall be used in applying the probationary conditions imposed pursuant to this subsection.

(d) Nothing in this section shall prohibit the Board from imposing additional terms or conditions of prohibition in any order that the Board determines would provide greater public protection.

NOTE: Authority cited: Osteopathic Act (Initiative Measure, Stats. 1923, p.xciii), Sections 1, 2018, 2451, and 3600-1, Business and Professions Code; and Section 11400.21, Government Code. Reference: Sections 315, 726 and 729, 2246, 2452, 3600-1, and 3600-2 Business and Professions Code; Sections 11400.21 and 11425.50(e), Government Code; Sections 261.5, 290, 313.1, 647b, and 647 subdivision (a) or (d), Penal Code.

Initial Statement of Reason

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
INITIAL STATEMENT OF REASONS

Hearing Date: September 17, 2015

Subject Matter of Proposed Regulations: Uniform Standards for Substance Abusing Licensees and Disciplinary Guidelines as required by SB 1441

Sections affected: Division 16 of Title 16 of California Code of Regulations Sections 1661.2 and 1663

Introduction

Senate Bill 1441: On June 30, 2008, the Medical Board of California was scheduled to sunset its Diversion Program and reverted to disciplinary action as the only means of addressing physicians with substance abuse problems. The sunset was primarily due to the program's failure of its fifth audit, conducted by the Center for Public Interest Law (the Medical Board's Enforcement Monitor), for overall ineffectiveness, lack of standards and failure to protect the public from harm. At the same time, there was extensive media coverage citing deficiencies in the Medical Board's Diversion Program, including patients harmed by physicians who continued to practice even after testing positive for drugs. On January 24, 2008, with the sunset of its Diversion Program imminent, the Medical Board held a Diversion Summit to discuss other options for physicians with substance abuse problems.

On March 10, 2008, the Senate Business, Professions and Economic Development Committee (Senate Committee) held a hearing to review physician's and health practitioner's substance abuse programs. The resulting legislation, authored by the Senate Committee Chair, Senator Ridley-Thomas, was Senate Bill (SB) 1441: Healing arts practitioners: substance abuse (Chapter 548, Statutes of 2008).

In September 2008, SB 1441 was signed into law. The Legislature declared that substance abuse monitoring programs, particularly for health care professionals, must operate with the highest level of integrity and consistency. Patient protection is paramount. The legislation, in part, mandated that the Department of Consumer Affairs (Department) establish a Substance Abuse Coordination Committee (Committee) subject to the Bagley-Keene Open Meeting Act comprised of the Executive Officers of the Department's healing arts boards, a representative of the California Department of Alcohol and Drug Programs, and chaired by the Director of the Department. The Committee was charged with developing consistent and uniform standards and best practices in sixteen specific areas for use in dealing with substance abusing licensees, whether or not a Board chooses to have a formal diversion program. The Department is committed to ensuring that licensees who are confirmed to be abusing drugs and/or alcohol, and who pose a risk to the public, are not diverted from an enforcement action or public

disclosure of that action. The Department is also committed to ensuring that licensees who have undergone treatment and have made steps towards recovery can safely return to practice. The Committee has developed sixteen uniform standards as required by SB 1441. The Board is proposing to implement Uniform Standards 1-12 in its Disciplinary Guidelines through the regulatory process.

Other Amendments/Deletions: The disciplinary and probationary environments have changed significantly since 1996 and the Board's proposed changes are meant to address this. Many of the changes are based on best practices exemplified by the Department of Consumer Affairs' various Boards and Bureaus that have proven to be effective and in the best interest for consumers and the licensees receiving discipline.

Specific Purpose of each adoption, amendment, or repeal:

The Board proposes to add specified uniform standards related to substance abuse by incorporating them by reference into CCR section 1661.2. This proposal also updates the Board's existing standards and optional terms of probation. The following describes those uniform standards being added by the Board, including the updates of its Disciplinary Guidelines and other clarifying and minor changes.

CCR section 1661.2

Section 1661.2 is amended as follows:

- Incorporates by reference the new guidelines, including the "Uniform Standards Regarding Substance-Abusing and Healing Arts Licensees" (04/2011).

CCR section 1663

Section 1663 is amended as follows:

- Incorporates by reference the Board's Disciplinary Guidelines entitled "Osteopathic Medical Board of California Disciplinary Guidelines of 2014" (Rev 08/14).
- Adds clarifying language indicating when it is appropriate to use the Disciplinary Guidelines and Uniform Standards.

Factual Basis/Rationale:

In order to comply with SB 1441, the Board proposes to add the following standards, which shall be adhered to in every case where a licensee is placed on probation due, in part, to a substance abuse problem. These standards are not guidelines and shall be followed in all instances, except that the Board may impose more restrictive conditions, if necessary, to protect the public.

Standard 1. Clinical Diagnostic Evaluation and Reports

Requires that if a licensee is ordered to undergo a clinical diagnostic evaluation, the evaluation must be conducted by a licensed practitioner who holds a valid, unrestricted license to conduct clinical diagnostic evaluations, has three (3) years of experience in providing evaluations of

health care professionals with substance abuse disorders and is approved by the Board. This standard also identifies the information that must be addressed or contained in the evaluation report and timeframes for submitting the report to the Board.

The purpose of this standard is to increase consumer protection by: 1) specifying requirements for a clinical diagnostic evaluation of the licensee and the required qualifications for the providers charged with evaluating the licensee along with timeframes for completing the clinical diagnostic evaluation; 2) ensuring that the Board is notified quickly if the licensee is a threat to himself or herself or the public; 3) ensuring the Board is provided with a professional opinion as to whether the licensee has a substance abuse problem, and whether the licensee is a threat to himself or herself or others; and 4) prohibiting personal, financial and business relationships between the evaluator and licensee, thereby ensuring objectivity in assessments.

Because of the complexity of an addictive disease, professional substance abuse evaluations are needed to assist the Board in making informed decisions regarding a licensee's ability to practice safely. The evaluator can present recommendations for a therapeutic treatment plan.

The treatment recommendations may be incorporated into a Board order as elements for monitoring. By specifying that the Board be provided with expert recommendations for treatment and practice restrictions, the standard also ensures that licensees who have undergone treatment and have made steps towards recovery can safely return to practice.

Standard 2. Diversion Program – Alcohol and Drugs

Requires that the licensee shall enroll and participate in the Board's Diversion Program within thirty (30) days of the effective date of decision, and remain in the program until the Board determines that further treatment and rehabilitation is no longer necessary. The standard makes note that quitting the Diversion Program without permission or being expelled for cause shall constitute a violation of probation by the licensee.

This standard also requires that the vendor providing diversion services report any major violations committed by the licensee to the board within one (1) business day and any minor violations within five (5) business days. It also outlines standards for testing, specimen collection and handling and requirements for the laboratories who perform the handling and processing of test results.

This standard would increase consumer protection because it requires that the licensee enroll in a program where he or she is regularly monitored by an alternate party, and ensures that they remain in compliance during the term of their probationary period through randomly regulated specimen collections.

Standard 3. Drugs – Abstain from Use

This standard requires that the licensee shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, and dangerous drugs as defined in the California Business and Professions Code, or any

drugs requiring a prescription except for ordering or possessing medications lawfully prescribed to the licensee by another practitioner, for a bona fide illness or condition.

As controlled substances impair a licensee's ability to practice safely the board requires all licensee to comply with the Uniform Standards developed by the Substance Abuse Coordination Committee. The boards highest priority is maintaining the protection of consumers and this standard would ensure consumer safety by prohibiting probationers use of controlled substances as a condition of their probation.

Standard 4. Alcohol – Abstain from Use

Requires that the licensee shall abstain completely from the use of alcoholic beverages.

As alcohol impairs a licensee's ability to practice safely the board requires all licensee to comply with the Uniform Standards developed by the Substance Abuse Coordination Committee. The boards highest priority is maintaining the protection of consumers and this standard would ensure consumer safety by prohibiting probationers use of alcohol as a condition of their probation.

Standard 5. Notification to Employer

Requires a licensee who has an employer to provide the Board with the names, physical addresses, mailing addresses and phone numbers of all employers and supervisors. This standard also requires that the licensee provide written consent to allow Board staff to communicate with the work site monitor and employer about the licensee's work status, performance and monitoring.

Standard 6. Biological Fluid Testing

Requires the Board to randomly test a licensee whose license is placed on probation due to substance abuse and establishes guidelines for the testing frequency.

Randomness is a very important component in drug testing. The testing frequency schedule being proposed by the Board allows for appropriate randomness in testing (without regular interval or pattern), preventing licensees from gauging when they will be tested. By establishing minimum testing frequency "ranges" and employing randomness in testing, licensees will not be able to consider one or more days as a "safety period" following the submission of a biological sample for testing. Requiring a licensee to submit a specimen on the same day as directed will eliminate the ability of a licensee to "flush" their system overnight. The standard is broad enough to allow the Board to evaluate each licensee's situation on a case-by-case basis, if appropriate. For example, one of the exemptions allows the Board to adjust the testing frequency schedule in cases where a licensee who is an admitted recovered substance abuser or addict, has already participated in a rehabilitation program before being placed on probation. In cases where there is evidence that the person has randomly tested and has maintained sobriety, some flexibility should be granted to the Board in determining the duration of high frequency testing, that is equivalent to the proposed testing schedule. Allowing exceptions will not only

protect the public and fit each licensee's needs, but it will ensure successful rehabilitation of the licensee by providing a plan that is manageable and realistic.

Standard 7. Group Support Meetings

Requires that if the Board orders a licensee to participate in group support meeting, the criteria established in the uniform standards must be used to determine the frequency of group meeting attendance and to verify that the meeting facilitator are experienced, mental health professionals.

The purpose of this standard is to increase consumer protection by:

- Holding licensees placed on probation due to substance abuse accountable for attending meetings and being active in their own recovery;
- Allowing the group meeting facilitator and the Board to work together to assist in the licensee's recovery and quickly prevent relapse with open channels of communication; and
- Ensuring that licensees are receiving professional help from a person not related to them in any way that will allow for objectivity and balance during their recovery.

Standard 8. Worksite Monitor

Requires the Board to determine if a worksite monitor is necessary for a particular licensee and outlines the requirements the proposed monitor must meet in order to be approved by the Board to serve as a monitor. In addition, this standard outlines the duties and responsibilities a worksite monitor must perform.

SB 1441 required the Department to establish monitor requirements and standards, including, but not limited to: (1) required qualification of monitors; (2) required methods of monitoring by monitors; and (3) required reporting by monitors. The worksite monitor's role is to have face-to-face contact with a licensee who has a substance abuse history to ensure that the licensee is not abusing drugs and/or alcohol. The monitor is also responsible for reporting to the Board whether patient safety may be at risk and any change in the licensee's behavior that may be cause for suspected substance abuse.

The licensee and the worksite monitor must sign and submit consent forms in order for the Board to communicate with the monitor regarding the licensee's performance while at work. Implementing this standard provides (1) ongoing documentation of the licensee's behavior and would ensure the public's safety; and (2) immediate notification to the Board if a licensee is suspected of working under the influence of drugs and/or alcohol.

Standard 9. Results of Biological Fluid Tests

Requires the Board to suspend the licensee if he or she tests positive for a prohibited substance and notify the licensee's employers that he or she cannot provide medical services while the suspension or cease practice order is in place.

Protection of the public is the highest priority of the Board in exercising its licensing, regulatory and disciplinary functions. In order to carry out this mandate, it is appropriate for the Board to immediately suspend a licensee's license if he or she tests positive for a prohibited substance until he or she has been assessed and the results interpreted. It is also appropriate for the Board to notify the licensee's employer that the licensee may not practice until the suspension is lifted. Testing positive for a prohibited substance is a violation of their probation and the Board shall pursue disciplinary action based on the probation violation.

Standard 10. Major and Minor Violations

In compliance with SB 1441, major and minor violations and consequences are being defined. If a licensee commits a major violation, the Board could issue an immediate cease practice order and refer the matter for disciplinary action or other action as determined by the Board. If a licensee commits a minor violation, the Board would be required to determine what action is appropriate based on the violation.

Protection of the public is the highest priority of the Board in exercising its licensing regulatory and disciplinary functions. The Board protects the public through its Practice Act, regulations and related statutes. Major violations would result in consequences that would be the maximum allowed by law under the Board's Practice Act and regulations.

Minor violations would result in consequences determined appropriate by the Board, e.g., issuing a cease practice order or issuing a citation, which is not considered discipline.

Standard 11. Request by a Substance-Abusing Licensee to Return to Practice

In compliance with SB 1441, this standard defines the criteria that a licensee must meet in order to return to practice after practice restrictions were deemed appropriate by the evaluator performing a clinical diagnostic evaluation or following the issuance of a cease practice order.

This standard would increase consumer protection because it requires the licensee to be completely compliant with the conditions in their recovery program and/or probation before the Board will even consider this type of request. All licensees will be held to the same standard.

Standard 12. Request by a Substance-Abusing Licensee for Reinstatement of a full and unrestricted license – Petition for Reinstatement

This standard defines the criteria that licensee must meet in order to request reinstatement of a full and unrestricted license and clarifies the meaning of "Petition for Reinstatement."

This standard would ensure consumer protection as it requires the licensee to meet certain criteria and maintain a level of compliance with terms of their disciplinary order prior to submitting a request for "Petition for Reinstatement" of licensure.

Underlying Data:

Technical, theoretical or empirical studies or reports relied upon (if any): [*Uniform Standards Regarding Substance-Abusing Healing Arts Licensees \(04/2011\)*](#) ~~None~~

Business Impact/Specific Technologies or Equipment:

This regulation will not have a significant adverse economic impact on businesses, specific technologies, or equipment. This regulation only impacts licensees disciplined by the Osteopathic Medical Board of California. This regulation does not mandate the use of specific technologies or equipment.

Economic Impact Assessment:

This regulation will not have a significant adverse economic impact on the creation or elimination of jobs or businesses in the State of California. This initial determination is based on the fact that the regulation will only impact physicians who have been placed on probation who are ordered to cease practice for testing positive for drugs and/or alcohol use. The number of physicians impacted would be less than a half of one percent of the licensee population.

The regulation will not affect the expansion of businesses currently doing business within the State of California because the regulations will only affect licensed individuals and not businesses already operating in the State.

Benefits of the Proposed Action: This regulatory proposal benefits the health and welfare of California residents by providing protection from substance-abusing osteopathic physicians, requiring the osteopathic physicians to be completely compliant with the conditions in their recovery program and/or probation, or the Board can issue a cease practice order.

The regulatory proposal does not affect worker safety nor will it affect the state's environment because it does not affect those areas of law.

Specific Technologies or Equipment:

This regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:

No reasonable alternative to the regulation would be either more effective in carrying out the purpose for which the action is proposed, or would be as effective and less burdensome to affected private persons and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the law being implemented or made specific.

Section 1610
Application; Refund of Fee;
Expirations; Renewals

OMB.1

**Application for Osteopathic
Physician's and Surgeon's
Certificate**



APPLICATION FOR OSTEOPATHIC PHYSICIAN'S AND SURGEON'S CERTIFICATE

Please read all instructions prior to completing this application. All questions on this application must be answered unless otherwise indicated.

In addition to this form, other essential application requirements must be completed.

FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

1. NAME: Last:		First:	Middle:
OTHER NAMES USED if any:			2. SOCIAL SECURITY NO. OR INDIVIDUAL TAXPAYER ID NO.:
3. DATE OF BIRTH:	4. PLACE OF BIRTH:		5. SEX: Male <input type="checkbox"/> Female <input type="checkbox"/>
6. ADDRESS:			
MAILING ADDRESS if different:			
7. CONTACT INFORMATION FOR APPLICATION PROCESS:			
Daytime Phone Number:		E-Mail address (optional):	
8. PRE-OSTEOPATHIC COLLEGE(S)		ADDRESS	DATES OF ATTENDANCE
9. OSTEOPATHIC COLLEGE(S)		ADDRESS	DATES OF ATTENDANCE:
			DATE OF DEGREE:
10. POSTGRADUATE TRAINING INTERNSHIP (AOA)	Hospital Name	Address	Type of Service Dates of Attendance
RESIDENCY/FELLOWSHIP:		Dates of Service	
11. BOARD CERTIFIED: Yes <input type="checkbox"/> No <input type="checkbox"/>		DATE CERTIFIED:	NAME OF CERTIFYING BOARD:
12. LIST ALL WRITTEN EXAMINATIONS TAKEN e.g. NBOME, State Written Boards, USMLE, FLEX etc. B & P 2099.5			
STATE WHICH EXAMINATIONS AND WHERE TAKEN		DATE COMPLETED	
13. LIST ALL STATES IN WHICH YOU ARE NOW LICENSED OR HAVE EVER BEEN LICENSED TO PRACTICE OSTEOPATHIC MEDICINE			
<small>*Written examination, reciprocity, National Boards, etc.</small>			
STATE	DATE LICENSED	* HOW LICENSED	LICENSE NUMBER
14. Are you serving, or have you previously served in the military?			Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Are you married to, or in a domestic partnership or other legal union, with an active duty member of the US military officially assigned to a duty station in California?			Yes <input type="checkbox"/> No <input type="checkbox"/>

16. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training? If Yes, attach explanation.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgment or arbitration award of over \$30,000.00?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18. Has there ever been any peer group or professional association inquiry or action involving your practice or relationship with patients alleging unprofessional conduct, wrongdoing or negligence?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19. Have you ever withdrawn an application from any hospital, public entity or licensing agency? If Yes, When?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
21. Have you ever had a medical or any healing art license restricted, suspended, revoked, disciplined or denied in any state?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22. Have you ever been denied permission to practice medicine or any healing art in any state?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
23. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW: <input type="checkbox"/> A condition which required admission to an inpatient psychiatric treatment facility <input type="checkbox"/> Alcohol or chemical substance dependency or addiction <input type="checkbox"/> Emotional, mental or behavioral disorder <input type="checkbox"/> Other (explain) _____ FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
24. Have you ever been convicted of, or pled guilty or nolo contendere to ANY criminal or civil offense in the United States, its territories, or a foreign country? This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code Sections 11357 (b), (c), (d), (e), OR section 11360 (b) which are two years or older should NOT be reported. Convictions that were later dismissed pursuant to sections 1203.4, 1203.4a, or 1204.41 of the California Penal Code or equivalent non-California law MUST be disclosed. Proof of Dismissal: If you have obtained a dismissal of your conviction(s) pursuant to Penal Code sections 1203.4, 1203.4a, or 1203.41, please submit a certified copy of the court order dismissing the conviction(s) with your application.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
25. Is any criminal action related to the above now pending?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, ATTACH DETAILED EXPLANATION AND SUPPORTING DOCUMENTS.</p> <p>CERTIFICATION</p> <p>I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT.</p> <p>_____ Signature of Applicant - Sign in Presence of the Notary</p> <p>_____ Date</p>		

NOTICE OF COLLECTION OF PERSONAL INFORMATION

Agency requesting information: Osteopathic Medical Board of California, 1300 National Drive, Suite 150, Sacramento, CA 95834, (916) 928-8390.

The information requested herein is mandatory, unless otherwise indicated, and is maintained by the Osteopathic Medical Board of California (Board), 1300 National Drive, Suite 150, Sacramento, California 95834, Executive Officer, (916) 928-8390, in accordance with Business & Professions Code section 3600 et seq. Disclosure of your individual taxpayer identification number or social security number is mandatory and collection is authorized by Section 30 of the Business & Professions Code. Failure to provide all or any part of the requested mandatory information will result in the rejection of your application as incomplete. Except for the individual taxpayer identification number or social security number, the information requested will be used to identify and evaluate applicants for licensure, issue and renew licenses, and enforce licensing standards set by statutes and regulations. Your individual taxpayer identification number or social security number will be used exclusively for tax enforcement purposes, compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or verification of licensure or examination status by a licensing or examination board where licensing is reciprocal with the requesting state. It will not be deemed to be a public record and will not be disclosed to the public. If you fail to disclose your individual taxpayer identification number or social security number you will be reported to the Franchise Tax Board (FTB), which may assess a \$100 penalty against you. Upon request, the Board will provide the FTB with your name, address(es) of record, individual taxpayer identification number or social security number, type of license and status, and effective date and expiration date of your license or renewal. You have the right to review your personal information maintained by the agency unless the records are exempt from disclosure. Please note that certain information you provide may be disclosed under some circumstances, such as: in response to a Public Records Act (PRA) request (beginning with Government Code section 6250), to another government agency as required by state or federal law, or in response to a court or administrative order, subpoena, or search warrant.

Photo Area
Paste a recent 2" x 2"
(approximate size)
photograph here.

Photo must be of your
head and shoulder areas
only. CCR 1613

APPLICANT DECLARATION/SIGNATURE and NOTARY

State of California

County of _____

On _____ before me, _____ (insert name and title of officer),

personally appeared, _____ who proved to me on the basis of satisfactory evidence to

be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the forgoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

Notary Seal



_____ Address

My Commission expires _____

Section 1610
Proposed Language

Article 4. Physician and Surgeon Applications

§1610. Applications; ~~and Refund of Fee; Expirations; Renewals.~~

- (a) All applications (~~Application for Osteopathic Physician's and Surgeon's Certificates OMB-1 Rev.01/92) for a Physician and Surgeon Certificate shall be accompanied by the appropriate fees set forth in Section 1690.~~
- (b) An application shall be denied without prejudice and the applicant shall be refunded whatever fee is due as set forth by Section 1690 when an applicant's credentials are insufficient or the examination is not taken.
- (c) Applications shall be valid for one (1) year.
- (d) The processing times for original Physicians and Surgeons applications are set forth in Section 1691.
- (e) When an application is deemed complete and approved, the applicant's initial license fee and renewal shall be determined based on the applicant's birth month, as follows:

(i)(1) The initial licensing fee shall be prorated based on the number of months of licensure, based on license expiration at midnight on the last day of the applicant's birth month for no less than three months and no more than twenty-four months;

(ii)(2) Applicants with even-numbered birth months shall be billed for a license expiring in an even year.) Applicants whose birth months are in February, April, June, August, October, December, shall renew every even-numbered year;

(iii)(3) Applicants with odd-numbered birth months shall be billed for a license expiring in an odd year; Applicants whose birth months are in January, March, May, July, September, November, shall renew every odd-numbered year);

(iv)(4) A prorated license fee shall be no less than \$25 and no more than \$400. The license fee shall be prorated monthly based on a biennial fee of \$400 for a two year license, renewable every other year in their birth month.

NOTE: Authority cited: Osteopathic Act (Initiative Measure, Stats. 1923, p. xciii), Section 1; and Section 3600-1, Business and Professions Code. Reference: Sections 152.5, 152.6, 2099.5, 2154 and 2455, and 2456.1. Business and Professions Code.

HISTORY

1. Repealer of chapter 16 (sections 1600-1697, not consecutive) and new chapter 16 (sections 1600-1697, not consecutive and Appendix) filed 12-10-87; operative 1-9-88 (Register 87, No. 52). For prior history, see Registers 81, No. 50; 81, No. 36; 81, No. 9; 80, No. 40; 78, No. 15; 77, No. 21; and 63, No. 25.

2. Amendment of subsections (b) and (d) filed 9-28-90; operative 10-28-90 (Register 90, No. 45).
3. Amendment of subsections (a), (b), and (f) filed 1-26-95; operative 1-26-95 pursuant to Government Code section 11343.4(d) (Register 95, No. 4).

Section 1636
Continuing Medical Education
Progress Report

§ 1636. Continuing Medical Education Progress Report.

Physicians shall report the total number of continuing medical education (CME) hours to the Board with the renewal application. This may be accomplished by:

- (a) The physician sending the Board a copy of their computer printout of CME activity as compiled from documents submitted to the AOA Division of Continuing Medical Education by both sponsors and the physician (Individual Activity Report) which will list the amount of CME credit hours, or
- (b) Sending the Board copies of any certificates given for the CME credit hours of attendance at any program approved by the Board, or
- (c) Reports from any program approved by the Board; to be furnished by the physician, showing his CME credit hours of attendance hours as verified by the program organizer.
- (d) CME categories are defined by Section 1635(e).

NOTE: Authority cited: Osteopathic Act (Initiative Measure, Stats. 1923, p. xciii), Section 1; and Section 3600-1, Business and Professions Code. Reference: Sections 2190 and 2452, Business and Professions Code.

HISTORY

1. Repealer of Chapter 16 (Sections 1600-1697, not consecutive) and new Chapter 16 (Sections 1600-1697, not consecutive and Appendix) filed 12-10-87; operative 1-9-88 (Register 87, No. 52). For prior history, see Registers 81, No. 50; 81, No. 36; 81, No. 9; 80, No. 40; 78, No. 15; 77, No. 21; and 63, No. 25.
2. Amendment of first paragraph, subsection (a) and Note filed 1-26-95; operative 1-26-95 pursuant to Government Code section 11343.4(d) (Register 95, No. 4).

TABLE 9

Osteopathic Medical Board

Future Agenda Items

Agenda Item	Requestor

TABLE 10

Osteopathic Medical Board

Future Meeting Dates

Date	Place	Time
October 7, 2016	Touro University – Mare Island Vallejo CA	10 a.m. – 5 p.m.
January 20, 2017	Sacramento CA	10 a.m. – 5 p.m.

**Please note that all meetings should be held in the best interest of the Board. Meetings in resorts or vacation areas should not be made. Using Conference areas that do not require contracts and or payment is the best option for the Board. No overnight travel. If an employee chooses a mode of transportation which is more costly than another mode, a Cost Comparison form must be completed. Reimbursement by the State will be made at the lesser of the two costs. Taxi Service should be used for trips within but not over a 10-mile radius. Receipts are required for taxi expenses of \$10.00 and over. Tips are not reimbursable.*