AGENDA ITEM:  8.1  
DATE:  September 12, 2019

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

REQUESTED BY:  Donna Gerber, Chair, Legislative Committee

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

The first table contains both Assembly and Senate bills for Board consideration today. The bills may have been amended since the last Committee or Board meeting, were previously presented at a Board meeting without prior Legislative Committee consideration or recommendation, or they are ones about which the Board has taken a position but may wish to discuss further and restate or modify its position. A bill analysis is provided for each of the bills listed in this table.

Assembly and Senate bills previously considered by the Legislative Committee or Board are listed on the next two tables. These tables indicate previous Committee and Board positions as well as the status of the bills in the legislative process.

NEXT STEPS:  As directed by the Board

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

PERSON TO CONTACT:  Kay Weinkam, M.S., RN, CNS  
(916) 574-7600
2019 TENTATIVE LEGISLATIVE CALENDAR
Revised 10-31-18

JANUARY

<table>
<thead>
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</table>

DEADLINES

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

FEBRUARY

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

MARCH

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Mar. 29 Cesar Chavez Day observed.

APRIL

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<th>Wk. 1</th>
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Apr. 11 Spring Recess begins upon adjournment (J.R. 51(a)(2)).
Apr. 22 Legislature reconvenes from Spring Recess (J.R. 51(a)(2)).
Apr. 26 Last day for policy committees to meet and report to fiscal committees fiscal bills introduced in their house (J.R. 61(a)(2)).

MAY

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</table>

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

*Holiday schedule subject to final approval by Rules Committee.
### JUNE

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

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

### JULY

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**July 4** Independence Day.

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

**July 12** Last day for **policy committees** to meet and report bills (J.R. 61(a)(11)). Summer Recess begins upon adjournment, provided Budget Bill has been passed (J.R. 51(a)(3)).

### AUGUST

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

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

### SEPTEMBER

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**Sept. 2** Labor Day.

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

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

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

### IMPORTANT DATES OCCURRING DURING INTERIM RECESS

**2019**

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

**2020**

- **Jan. 1** Statutes take effect (Art. IV, Sec. 8(c)).
- **Jan. 6** Legislature reconvenes (J.R. 51(a)(4)).

*Holiday schedule subject to final approval by Rules Committee.*
<table>
<thead>
<tr>
<th>BILL #</th>
<th>AUTHOR/ BILL SPONSOR</th>
<th>SUBJECT</th>
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<tbody>
<tr>
<td>AB 5</td>
<td>Gonzalez/ California Labor Federation</td>
<td>Worker status: employees and independent contractors</td>
<td>Watch 8/15/19</td>
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<td>Senate APPR</td>
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<tr>
<td>AB 241</td>
<td>Kamlager-Dove</td>
<td>Implicit bias: continuing education: requirements</td>
<td>Oppose unless amended 8/15/19</td>
<td>Oppose unless amended 6/13/19</td>
<td>Senate 2nd Reading</td>
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<tr>
<td>AB 1514</td>
<td>Patterson/ CANP</td>
<td>Deaf and Disabled Communications Program</td>
<td>Watch 8/15/19</td>
<td>Watch 4/11/19</td>
<td>Assembly Concurrence with Senate</td>
</tr>
<tr>
<td>AB 1544</td>
<td>Gipson</td>
<td>Community Paramedicine or Triage to Alternate Destination Act</td>
<td>Oppose 8/15/19</td>
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<td>Senate APPR</td>
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<tr>
<td>SB 227</td>
<td>Leyva/ CalifSC-SEIU et al</td>
<td>Health and care facilities: inspections and penalties</td>
<td>Support 8/15/19</td>
<td>Support 4/11/19</td>
<td>Assembly 3rd Reading</td>
</tr>
<tr>
<td>SB 601</td>
<td>Morrell/ R Street Institute</td>
<td>State agencies: licenses: fee waiver</td>
<td>Watch 8/15/19</td>
<td>Watch 4/11/19</td>
<td>Assembly Consent Calendar</td>
</tr>
<tr>
<td>SB 697</td>
<td>Caballero/ CAPA</td>
<td>Physician assistants: practice agreement: supervision</td>
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<td>Assembly APPR</td>
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<td>SB 700</td>
<td>Roth</td>
<td>Business and professions: noncompliance with support orders and tax delinquencies</td>
<td>Watch 8/15/19</td>
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<td>Senate Rules</td>
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</table>

These bills are either a new bill for Committee or Board consideration, one that has been amended since the last Committee or Board meeting, or one about which the Board has taken a position and may wish to discuss further and restate or change its position. To view a bill, use Control and then click on the bill number.
<table>
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<tr>
<td>AB 8</td>
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<td>Public health: mental health professionals</td>
<td>Information 1/10/19</td>
<td>Information 2/14/19</td>
<td>Senate Health</td>
</tr>
<tr>
<td>AB 62</td>
<td>Fong</td>
<td>State government: FI$Cal: transparency</td>
<td>Information 1/10/19</td>
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<td>Information 5/9/19</td>
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<td>Professions and vocations</td>
<td>Watch 3/14/19</td>
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<td>AB 251</td>
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<td>Personal income taxes: credit: family caregiver</td>
<td>Watch 3/14/19</td>
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<td>AB 312</td>
<td>Cooley</td>
<td>State government: administrative regulations: review</td>
<td>Watch 3/14/19</td>
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<td>Assembly APPR</td>
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<td>AB 329</td>
<td>Rodriguez</td>
<td>Hospitals: assaults and batteries</td>
<td>Watch 3/14/19</td>
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<td>Sexual assault forensic medical examination kits: databases</td>
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<tr>
<td>AB 362</td>
<td>Eggman/ DPA; HRC</td>
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<td>Substance use disorder treatment: peer navigators</td>
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<td>Blanca Rubio/ CHIRLA</td>
<td>Department of Consumer Affairs: task force: foreign-trained professionals</td>
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<td>Personal income taxes: credit: professional license fees</td>
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<td>Sexual assault: medical evidentiary examinations and reporting</td>
<td>Watch 3/14/19</td>
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<td>Professions and vocations: inactive license fees and accrued and unpaid renewal fees</td>
<td>Watch 3/14/19</td>
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<td>Wood</td>
<td>Opioid prescription drugs: prescribers</td>
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<td>AB 732</td>
<td>Bonta</td>
<td>County jails: prisons: incarcerated pregnant persons</td>
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<td>Eduardo Garcia</td>
<td>Pupil health: self-administration of prescribed asthma medication</td>
<td>Watch 3/14/19</td>
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<td>Phlebotomy</td>
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<td>AB 845</td>
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<td>AB 862</td>
<td>Kiley</td>
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<td>Wood</td>
<td>Nurse practitioners: scope of practice: unsupervised practice</td>
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<td>Smith</td>
<td>Community colleges: temporary faculty members: clinical nursing faculty</td>
<td>Watch 3/14/19</td>
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SUMMARY as amended 7/11:
1. Existing law, as established in the case of Dynamex Operations West, Inc. v. Superior Court of Los Angeles (2018) 4 Cal.5th 903 (Dynamex), creates a presumption that a worker who performs services for a hirer is an employee for purposes of claims for wages and benefits arising under wage orders issued by the Industrial Welfare Commission. Existing law requires a 3-part test, commonly known as the “ABC” test, to establish that a worker is an independent contractor for those purposes.

Existing law, for purposes of unemployment insurance provisions, requires employers to make contributions with respect to unemployment insurance and disability insurance from the wages paid to their employees. Existing law defines “employee” for those purposes to include, among other individuals, any officer of a corporation, and any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee, or is an employee of a person who holds or is required to obtain a valid state contractor’s license.

2. Existing provisions of the Labor Code make it a crime for an employer to violate specified provisions of law with regard to an employee. The Unemployment Insurance Code also makes it a crime to violate specified provisions of law with regard to benefits and payments.

ANALYSIS as amended 7/11:

This bill would, related to the numbered sections, above:
1.

- state the intent of the Legislature to codify the decision in the Dynamex case and clarify its application.
- provide that the factors of the “ABC” test be applied in order to determine the status of a worker as an employee or independent contractor for all provisions of the Labor Code and the Unemployment Insurance Code, unless another definition or specification of
“employee” is provided, except if a statutory exemption from employment status or from a particular obligation related to employment or where a statutory grant of employment status or a particular right related to employment applies.

- exempt specified professions from these provisions and instead provide that the employment relationship test for those professions shall be governed by the test adopted in S. G. Borello & Sons, Inc. v. Department of Industrial Relations (1989) 48 Cal.3d 341 if certain requirements are met. These exempt professions would include, among others, licensed insurance agents, certain licensed health care professionals, registered securities broker-dealers or investment advisers, a direct salesperson, salespersons, real estate licensees, workers providing hairstyling or barbering services, electrologists, estheticians, workers providing natural hair braiding, licensed repossession agencies who meet requirements described below, and those performing work under a contract for professional services. The bill would require the State Board of Barbering and Cosmetology to promulgate regulations for the development of a booth rental permit and a reasonable biennial fee upon workers providing specified hairstyling or barbering services, by no later than July 1, 2021. Services, with another business entity, or pursuant to a subcontract in the construction industry.
- expand the definition of employee, for purposes of unemployment insurance provisions, to include individuals who are defined as employees pursuant to the above-described provision of the Labor Code codifying the “ABC” test. Because this bill would expand the categories of individuals eligible to receive benefits from, and thus would result in additional moneys being deposited into, the Unemployment Fund, a continuously appropriated fund, the bill would make an appropriation.
- state that addition of the provision to the Labor Code does not constitute a change in, but is declaratory of, existing law with regard to violations of the Labor Code relating to wage orders of the Industrial Welfare Commission.

2. By expanding the definition of an employee for purposes of these provisions, the bill would expand the definition of a crime, thereby imposing a state-mandated local program.

BOARD POSITION: Not previously considered

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (8/15/19)

SUPPORT:
California Labor Federation (Sponsor)
Amalgamated Transit Union
American Federation of State, County and Municipal Employees
Berkeley City Council
BlueGreen Alliance
California Alliance for Retired Americans
California Association of Health Underwriters
California Conference of Machinists
California Federation of Teachers
California Immigrant Policy Center
California Nevada Conference of Operating Engineers
California Nurses Association
California Partnership for Working Families
California Professional Firefighters
California Rural Legal Assistance Foundation
California School Employees Association
Center on Policy Initiatives, San Diego
Central Coast Alliance United for a Sustainable Economy
Communication Workers of America, District 9
Direct Selling Association
East Bay Alliance for a Sustainable Economy
Employees Rights Center
Engineers and Scientists of California, IFPTE, Local 20
Greater California Livery Association
Independent Insurance Agents and Brokers of California
Labor and Employment Committee of National Lawyers Guild
Legal Aid at Work
Los Angeles Alliance for a New Economy
National Association of Insurance and Financial Advisors of California
National Domestic Workers Alliance
National Employment Law Project
National Union of Healthcare Workers
Orange County Communities Organized for Responsible Development
Professional and Technical Engineers, IFPTE, Local 21
Professional Beauty Federation of California
SEIU CA
SEIU Local 1000
Shaklee Corporation
Sierra Club California
Southern California Coalition for Occupational Safety and Health
State Building and Construction Trades Council
Teamsters Public Affairs Council
The Greenlining Institute
Union of Concerned Scientists
UNITE HERE
United Auto Workers, Local 2865
United Auto Workers, Local 5810
United Domestic Workers, AFSCME Local 3930
United Farm Workers
United Food and Commercial Workers Western States Council
University Professional and Technical Employees, CWA Local 9119
Warehouse Worker Resource Center, Inland Empire
Western Center on Law and Poverty
Western States Council of Sheet Metal, Air, Rail and Transportation
Worksafe
9 to 5

**OPPOSE:**
Anthony Hopkins Investigations
California Aesthetic Alliance
California Association of Winegrape Growers
California Hospital Association
California League of Food Processors
California Podiatric Medical Association
California Society for Respiratory Care
California Trucking Association
Chino Valley Chamber of Commerce
Coalition of DMV Motor Carrier Permit Holders
El Dorado County Joint Chambers Commission
Electrologists’ Association of California
Electronic Transactions Association
Elk Grove Chamber of Commerce
Folsom Chamber of Commerce
Fontana Chamber of Commerce
Greater Coachella Valley Chamber of Commerce
Greater Ontario Business Council
Hayward Chamber of Commerce
Hesperia Chamber of Commerce
Indy Hub
Inland Empire Economic Partnership
Insights Association
Lavell Water Truck Service LLC
Moreno Valley Chamber of Commerce
Murrieta/Wildomar Chamber of Commerce
National Federation of Independent Business
Rancho Cordova Chamber of Commerce
Rancho Cucamonga Chamber of Commerce
Recording Industry Association of America
Redlands Chamber of Commerce
Roseville Area Chamber of Commerce
Rover Inc.
Santoro Transportation Inc.
Southern California Contractors Association
TechNet
Victor Valley Chamber of Commerce
Western States Trucking Association
107 individuals
SUMMARY:

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

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

ANALYSIS:

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

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

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

Amended analysis as of 4/4:

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

- deletes the requirement for a minimum of eight hour of instruction;
- deletes “gender” from the included characteristics and adds gender identity, sexual orientation, and socioeconomic status to the list of characteristics that may produce differences in treatment;
- no longer require pre- and post-instruction testing.

Amended analysis as of 4/30:

The bill would require the Board to adopt regulations to require that all continuing education for licensees under this chapter contain curriculum that includes the understanding of implicit bias and the promotion of bias-reducing strategies to address how unintended biases in decision making may contribute to health care disparities by shaping behavior and producing differences in treatment along lines of race, ethnicity, gender identity, sexual orientation, socioeconomic status, or other characteristics.

The bill would delete the provision that a licensee shall meet the requirements of this section by the licensee’s next license renewal date and each subsequent renewal date thereafter.

Amended analysis as of 7/1:

The bill would retain January 1, 2022, as the date for adoption of regulations and adds January 1, 2023, as the date when continuing education providers would be required to comply with this bill’s provisions.

The bill would mandate audit of continuing education providers pursuant to BPC Section 2811.5.

A continuing education course dedicated solely to research or other issues that does not include a direct patient care component is not required to contain curriculum that includes implicit bias in the practice of nursing.

Continuing education courses that have a curriculum that includes an understanding of implicit bias shall address at least one or a combination of the following:
(1) Examples of how implicit bias affects perceptions and treatment decisions of licensees, leading to disparities in health outcomes.
(2) Strategies to address how unintended biases in decision making may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics.

Amended analysis as of 8/28:

The bill adds the date of January 1, 2023, as the date for implementation of the board’s auditing continuing education providers.

BOARD POSITION: Oppose unless amended (6/13/19)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Oppose unless amended (8/15/19)

SUPPORT:
American Civil Liberties Union of California
American Federation of State, County and Municipal Employees, AFL-CIO
Anti-Recidivism Coalition
APLA Health
California Black Health Network
California Black Women's Health Project
California Hawaii State Conference of the National Association for the Advancement of
  Colored People
California Immigrant Policy Center
California LGBTQ Health and Human Services Network
California Voices for Progress
County Health Executives Association of California
Courage Campaign
Disability Rights California
Emtrain
Equal Justice Society
Equality California
Fathers & Families of San Joaquin
Hathaway-Sycamores
Legal Aid at Work
Maternal Mental Health NOW
Medical Board of California
National Center for Lesbian Rights
Perinatal Mental Health Care
Planned Parenthood Affiliates of California
San Francisco AIDS Foundation
San Mateo Adult School Federation of Teachers – CFT Local 4681
Santa Cruz County Community Coalition to Overcome Racism
UDW/AFSCME Local 3930
Union of American Physicians and Dentists
United Nurses Association of California/Union of Health Care Professionals

**OPPOSE:**
Board of Registered Nursing
### SUMMARY:

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

Existing law:

- requires the commission to design and implement a program to provide a telecommunications device capable of serving the needs of individuals who are deaf or hearing impaired, together with a single party line, at no charge additional to the basic exchange rate, to any subscriber who is certified as an individual who is deaf or hearing impaired by a licensed physician and surgeon, audiologist, or a qualified state or federal agency, as determined by the commission.

- authorizes a physician assistant to certify the needs of an individual who has been diagnosed by a physician and surgeon as being deaf or hard of hearing to participate in the program after reviewing the medical records or copies of the medical records containing that diagnosis.

### ANALYSIS:

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

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

### Amended analysis as of 4/11:

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

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

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Watch (8/15/19)

**SUPPORT:**
California Association for Nurse Practitioners (Sponsor)
Association of Regional Center Agencies
Disability Rights California
The Utility Reform Network

**OPPOSE:** None received
SUMMARY:

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

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

2. Existing law:
   • authorizes a county to establish an emergency medical care committee and requires the committee, at least annually, to review the operations of ambulance services operating within the county, emergency medical care offered within the county, and first aid practices in the county.
   • requires the county board of supervisors to prescribe the membership, and appoint the members, of the committee.

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

ANALYSIS:

Re 1., above: This bill would:

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

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

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

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

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

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

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

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

Re 2. above: This bill would, notwithstanding these provisions:

• require the committee to include additional members, as specified, and to advise a local EMS agency within the county on the development of its community paramedicine or triage to alternate destination program if the local EMS agency develops that program.

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

• repeal these provisions on January 1, 2030.

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

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

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

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

Amended analysis as of 7/11:

The bill would delete the specialty of providing short-term post-discharge followup for persons recently discharged from a hospital due to a serious health condition, including collaboration with, and by providing referral to, home health services, when eligible, from inclusion in a community paramedicine program.

BOARD POSITION: Oppose (4/11/19)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Oppose (8/15/19)

SUPPORT:
California Professional Firefighters (sponsor)

OPPOSE:
California Nurses Association
California State Association of Counties
County Health Executives Association of California
National Nurses United
Rural County Representatives of California
Urban Counties of California

Note: The above is based on the analysis provided to the Senate Judiciary Committee for its 7/9 meeting. An analysis provided to the Senate Health Committee for its 7/3 meeting still identifies the California Chapter of the American College of Emergency Physicians as a co-sponsor and lists more organizations both in support and in opposition to this bill. Although earlier in time, that information is provided here:

SUPPORT:
California Professional Firefighters (co-sponsor)
California Chapter of the American College of Emergency Physicians (co-sponsor)
California Fire Chiefs Association
California State Firefighters’ Association
City of Alameda
City of Murrieta
City of San Diego
City of Santa Monica
League of California Cities
Steinberg Institute

OPPOSE:
Advocates for Health Economics and Development
Association of Regional Center Agencies
California Ambulance Association
California Association for Health Services at Home
California Coalition for Children’s Safety and Health
California Emergency Nurses Association
California Nurses Association / National Nurses United
California Paramedic Foundation
California State Association of Counties (unless amended)
County Health Executives Association of California (unless amended)
Emergency Medical Services Administrator’s Association of California (unless amended)
Emergency Medical Services Medical Directors Association of California (unless amended)
Rural County Representatives of California (unless amended)
San Joaquin County Board of Supervisors (unless amended)
Urban Counties of California (unless amended)
Dear Senator Portantino:

The California Nurses Association/ National Nurses United (CNA), representing over 100,000 union nurses statewide, is in strong opposition to AB 1544 (Gipson, Gloria & Hertzberg). This bill would implement the deeply flawed and fiscally unsustainable Health Workforce Pilot Project #173, Community Paramedicine (HWPP #173) which threatens patient safety and inappropriately increases paramedics' scope of practice.

- **AB 1544 Will Result In Significant General Fund Costs To The Emergency Medical Services Authority**

Last year, a substantially similar bill, AB 3115 (Gipson), was estimated to cost the Emergency Medical Services Authority (EMSA) at least $692,000 General Fund costs for the first year of the program and $814,000 General Fund costs in the second and subsequent years. These costs were for ongoing staffing, one-time data and programming, contracting an independent evaluator, completing a regulatory process, data reporting requirements, review and approval requirements, and additional costs for the Commission on Emergency Services. EMSA's cost estimates meant that AB 3115 would have cost at least $1.1 million in General Fund dollars in just the first calendar year. AB 1544 is substantially similar to AB 3115, and therefore likely to have similar cost estimates. CNA believes this is simply not money well spent given the problems with the community paramedicine pilot projects, as explained in more detail below.

- **Enrollment In The Frequent EMS Users Pilot Projects Was Low, And More Patients Refused To Consent To Care By Community Paramedics Than The Total Number Of Patients Actually Enrolled—Is This Really Money Well Spent?**

Both the San Diego and Alameda "Frequent EMS Users" pilot projects anticipated enrollment that far exceeded the number of patients who actually enrolled. For example, the San Diego pilot project baseline data projected that they could have at least 4,800 eligible enrollees available throughout San Diego over the 12-month period of time\(^1\) which was reported through September 2016 and yet they only successfully enrolled 37 patients. That

\(^1\) Baseline Report Community Paramedicine, Table 34 Frequent 911 Callers—Eligible Patients by Gender, May 29, 2015, Table 34 at 44. 12 months X 400 potential enrollees monthly = 4,800.
averages to only three patients per month. In addition, the Frequent EMS User projects’ own statistics reveal more eligible patients refused to participate in the projects than actually agreed to participate.

This clearly demonstrates low patient acceptance of community paramedicine services. Furthermore, CNA would question whether community paramedicine programs are a good use of taxpayer funds when there is such a low acceptance of paramedics serving in this role.

- Alleged “Savings” Are Illusory For Many Of The Pilot Projects

Much has been made of the “cost savings” of community paramedicine programs in general, and the HWPP #173, in particular. A good portion of this rhetoric is based on the HWPP #173 Evaluations by UCSF. As noted in additional detail below, however, the UCSF reports contain selective use of partial data favorable to the pilot projects as well as underreporting, or even omission, of unfavorable data. For example, although some costs of operating the pilot projects were included in the first-year Evaluation, those costs are not included in more recent updates. And, UCSF’s own cost analysis of both Alameda projects through September 2016 shows losses as follows:

✓ The Alameda Post-Discharge Project cost $3,966 more per enrolled patient than the project saved through reduced hospital re-admissions, according to the first-year UCSF Evaluation. That loss does not even take into consideration emergency department visits post discharge that were not reported by the first-year Evaluation.

✓ The Alameda Frequent EMS Users project cost $641 more per enrolled patient than the project saved through reduced emergency department and transport costs, according to the first-year UCSF Evaluation.

- AB 1544 Inappropriately Takes Sides In A Public v. Private Turf Battle By Giving Public Agency Community Paramedicine Providers The Right Of First Refusal

AB 1544 would require local EMS agencies to provide a right of first refusal to public agency “community paramedicine program” providers. As a result, the bill is nothing more than the product of a longstanding turf battle between public and private EMS providers.

- California’s Fires And Environmental Disasters Have Stretched EMS Resources Thin While The Number Of Registered Nurses And Licensed Vocational Nurses Are Adequate To Meet Workforce Needs Through 2034

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3 Id., Table 9 at 18.
California faces a shortage of firefighters so it is not clear why dually certified firefighter paramedics should be diverted from their primary role in protecting California from environmental disasters such as California has experienced during the past fire season and the subsequent disasters associated with mudslides and flooding during last year’s rainy season.  

On the other hand, there are 400,000 licensed RNs in California, 100,000 Licensed Vocational Nurses and more than 75,000 behavioral health licensed professionals who can provide direct acute and chronic care to patients in all care settings. The number of EMTs and Paramedics in the entire U.S. number just 251,000. In California, 19,660 EMTs and Paramedics are employed, according to the Bureau of Labor Statistics. There are also approximately 30,000 firefighters who are dually certified as EMTs or paramedics. Even if it were possible to create this alternate health care system, it is arguably poor public policy to divert such a small number of first responders from their primary roles of responding to fires and stabilizing and transporting emergency patients in pre-hospital care and inter-hospital transport. Private ambulance companies and public sector firefighter employers do not have the financial resources or the expertise to create a safe, quality parallel health care structure.

- San Diego “Frequent EMS Users” Pilot Had To Shut Down Enrollment Because The EMS Employer Could Not Meet Its Chief Responsibility Of Responding To 911 Calls

The myth that these new paramedic roles provide continuity, quality, and are accepted by the community is clearly debunked by the San Diego Frequent EMS User pilot project experience which offered “case management” services to frequent 911 callers. There, the pilot project community paramedics had to suspend enrollment and abandon clients because they could not meet their contractual 911 response times. Enrollment ceased 15 months into the pilot project, and the enrolled clients were left to be “case managed” by others. AB 1544 includes the Frequent EMS User community paramedicine programs despite the obvious failure of the San Diego pilot project.

- The Patient Population Enrolled In The Community Paramedicine Pilot Projects Does Not Reflect California’s Diverse Population

Importantly, the patient population enrolled in the community paramedicine pilot projects does not reflect California’s diverse population. With the exception of two projects, the first-year data showed the overwhelming majority of people enrolled in the pilot projects were disproportionately English-speaking white.

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5 https://www.bls.gov/oes/current/oes292041.htm#st.
6 Id.
males. Although information concerning the racial make-up of the pilot projects' patient population was
included in the initial evaluation of HWPP #173 by UCSF, more recent Evaluations do not include this data.

- **AB 1544 Threatens Patient Safety**

Under the alternate destination pilot projects—which are included in AB 1544—there have been instances where
patients have been misdiagnosed by a paramedic and brought to an alternate destination (with limited medical
services) instead of the ER. Any subsequent delay in care wastes valuable time for patients in emergency
situations and could be life-threatening. And, surprisingly, this misdiagnosis or delay in care is not considered
an “adverse outcome” for the UCSF pilot project Evaluation so these projects appear “safer” than they really are.

Studies have found that misdiagnosis, or “under-triage,” by paramedics is a significant problem. A February
2017 editorial in the Western Journal of Emergency Medicine written by two ER doctors at UC Davis and
Kaiser, South Sacramento entitled “Community Paramedicine: 911 Alternative Destinations Are a Patient
Safety Issue,” cited 13 research studies that found significant rates of under-triage by EMS personnel. The
studies reveal under-triage rates as high as 32 percent in the transport of patients to alternate destinations.
Because patients calling 911 may have multiple underlying medical conditions, emergency department
screening is simply the safest way to assure the appropriate level of care.

- **AB 1544 Is Duplicative And Unnecessary Because Paramedics Can Already Lawfully Provide
  Directly Observed Therapy (Dot) For Tuberculosis Treatment**

Under existing law, DOT is provided by unlicensed Community Health Workers. Paramedics, therefore, can
already provide directly observed therapy to tuberculosis patients. As a result, no scope of practice change is
needed, and AB 1544 is duplicative and unnecessary.

- **Current Post-Discharge Pilot Projects Allowed To Remain In Operation Even Though Some Have
  Resulted In Increased Rates Of Re-Hospitalization And Actually Cost More Money Than They Save**

While the most recent amendments to AB 1544 would prohibit new post-discharge pilot projects from starting
up (including those that have been approved by the Office of Statewide Health Planning and Development
(OSHPD) but have not yet begun to enroll patients), the bill would still allow existing post-discharge pilot
projects to remain in operation for three years despite the fact that they have resulted in increased rates of
re-hospitalization. For example, with respect to the Alameda post-discharge pilot project, there has been a

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8 “Community Paramedicine: 911 Alternative Destinations Are a Patient Safety Issue,” Western Journal of Emergency
9 While the Butte post-discharge pilot project has seen the worst increases in the rates of hospital re-admissions (30% rate
of re-admission in the most recent February 2019 UCSF Evaluation), it is CNA’s understanding that this pilot
project—which was closed in December 2018—will not be allowed to continue under AB 1544 should its sponsors decide
continued increase in the rate of re-hospitalization over the pre-pilot re-admission rate, despite the fact that the goal of the project is to decrease hospital re-admissions. The data show that intervention by paramedics instead of registered nurses worsened the rates of hospital re-admissions for enrollees of the pilot, topping out at 23.1% in the July 12, 2018 UCSF Evaluation. The most recent Evaluation indicated a 20.0% rate of re-admission which is still higher than the re-admission rate of 19.4% before the pilot project began.

Moreover, these pilot projects also cost more money than they saved. In its Evaluations, UCSF has ignored baseline cost data, substituted manufactured inflated costs of hospitalizations, and omitted the cost of care in order to hide the cost-ineffectiveness of all post-discharge projects. Using HWPP #173 baseline hospitalization data and estimated cost of care data from UCSF’s first-year Evaluation, the post-discharge projects collectively cost an estimated $405,553 more than the payers (Medi-Cal, hospitals, and Medicare) saved.

For all of the above reasons, CNA opposes AB 1544 and asks that you vote “NO” when it comes before your committee.

Sincerely,
CALIFORNIA NURSES ASSOCIATION/
NATIONAL NURSES UNITED, AFL-CIO

Stephanie Roberson
Director, Governmental Relations

cc: Members, Senate Committee on Appropriations
Community Paramedicine: 911 Alternative Destinations Are a Patient Safety Issue

Nick T. Sawyer, MD, MBA*  
John D. Coburn, MD†  
*University of California, Davis, Department of Emergency Medicine, Sacramento, California  
†The Permanente Medical Group, South Sacramento Kaiser, Department of Emergency Medicine, Sacramento, California  
‡California American College of Emergency Physicians Board of Directors

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The 2010 Patient Protection and Affordable Care Act (ACA) served as a conduit for many previously uninsured U.S. citizens to obtain health insurance; however, insurance does not necessarily equate to timely access to care. A 2015 study found that efforts by policymakers and health insurance plans to drive Medicaid patients out of emergency departments (ED) and into primary care clinics are not working.¹ More than half of all providers listed by Medicaid managed care plans could not offer timely appointments to enrollees, despite a provision in the ACA temporarily boosting pay to primary care physicians treating Medicaid patients. The median wait time was two weeks, but over one-quarter of providers had wait times greater than one month. Consequently, newly insured patients are increasingly seeking care in EDs and the reliance on emergency care remains stronger than ever. In a May 2015 poll, three-quarters of emergency physicians reported that emergency visits were going up. This represents a significant increase from just one year ago when less than half reported increases.² Lastly, a recent analysis of health plans under the ACA revealed that one in five plans did not even list any emergency services on the list of covered benefits.³ This results in increased financial burden to patients when emergency care is provided by an “out-of-network” emergency physician, frequently leading to the patient receiving a “surprise” balance bill.

Increased demand for emergency services leads to longer wait times, crowding and increased patient boarding in the ED. All have been associated with several negative patient-oriented outcomes — from lower patient satisfaction scores to higher inpatient mortality rates.⁴ Recognizing this, multiple stakeholders are currently working to mitigate the ballooning crowding dilemma.

One approach gaining popularity is community paramedicine (CP). CP is a "model of community based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations."⁵ Interest in CP has substantially grown in recent years based on the belief that it may improve access and quality of care while also reducing costs.⁶

In February 2014, California’s Emergency Medical Services Authority (EMSA) submitted a proposal to the Office of Statewide Health and Planning (OSHPD) to train experienced paramedics and expand their scope of practice to include the ability to transport patients with specific conditions to alternative destinations (AD). Such destinations would include primary care, general medical clinics, urgent care centers, and other social or psychological services.

Proponents of CP maintain that such programs expand access to care in an era of primary care shortage, while improving quality and lowering healthcare costs. Further, they argue that utilizing paramedics in expanded roles is attractive because they are already trained to recognize and manage life-threatening conditions in out-of-hospital settings. This may facilitate more appropriate use of emergency care resources and/or enhance access to primary care. These claims require close scrutiny, however, as the effect of CP on ED utilization, cost savings and enhanced primary care access is still being assessed, and to date, limited data exist to support these claims.

CP is not a new idea. Programs have been piloted in several states including New Mexico, Nevada, Colorado, Texas, Maine and Pennsylvania. To quote Scot Phelps, a former paramedic and professor of disaster science regarding a prior CP attempt in New Mexico, “We tried this in 1995 in Red River, New Mexico, and what we found, after spending hundreds of thousands of dollars, was that it didn’t actually save any money or improve any care. So [that community] abandoned it, and
now coming eight years later it is the topic du jour.\textsuperscript{16}

Several concerns have been raised regarding CP, most notably, the risk of paramedic under-triage and transport of patients requiring emergency care to AD. AD projects involve previously unknown patients who may have one or more unknown illnesses, injuries, or psychosocial problems. Complex patients are common in the prehospital and ED setting. Standard paramedic practice focuses on recognition of patients' unstable physiology and management with temporizing and lifesaving interventions until transport to an ED is complete. The ED is the controlled environment for complete stabilization, evaluation, diagnosis, and disposition with care coordination. The ED, contrary to most or all ADs, has extensive diagnostic and therapeutic resources to help ferret out the occult medical emergency.

Under-Triage is a Patient Safety Issue

As reported in the \textit{Annals of Safety Medicine} in 2014, studies have revealed under-triage by paramedics when not transporting patients to AD.\textsuperscript{7} The potential for under-triage is real if there is a failure of a community paramedic to recognize a real emergency when it exists. Further, identifying non-emergent patients based on their initial presentation is hazardous. In a study by Raven et al, \textit{11\%} of patients with "primary care treatable" visits required immediate intervention, 12.5\% were admitted, and 3.4\% went directly to the operating room emergently.\textsuperscript{8}

According to Morganti et al., "Nearly all studies published to date have found significant rates of under-triage by EMS Personnel..." These investigators identified 13 research studies examining the ability of paramedics and EMTs to determine the need for transport to the ED. These studies reveal EMS AD under-triage rates from 3\% to 32\%. They commented that the ability of EMS professionals to safely determine nonemergency patient "has not been clearly established." Included in these studies was one study describing a cohort of under-triaged patients, who EMS professionals felt did not require transport to the ED for care, and who subsequently required admission to the hospital (18\%), including a subset who required admission to the intensive care unit (6\%). These problems were attributed to EMS professionals misusing study guidelines, undertraining in proper use of the guidelines, and improper or unclear instructions within the guidelines that could result in under-triage. These studies also revealed poor agreement between EMS professionals and emergency physicians about who required transport to the ED for care. Additional training is not likely to eliminate the problem of under-triage.

Alternative Destinations will Disproportionately Affect Critically Ill and Vulnerable Patient Populations

Patients who call 911 are more likely to be critically ill, elderly, and economically disadvantaged relying on public rather than private insurance.\textsuperscript{9} The patient population that arrives by ambulance does not reflect the general ED population. Whereas a proposed estimate of 13.7\% of ambulance calls could be diverted to an urgent care center based on a Health Affairs study by Weinick et al., this study reviewed all ED visits rather than the population of patients who call 911.\textsuperscript{10} Rugar et al. analyzed ambulance transports and triage category and found less than 2\% of patients arriving by ambulance had a triage category of less urgent or non urgent.\textsuperscript{11} Patients with a triage category of emergent were nine times more likely to arrive by ambulance, and with a triage category requiring immediate interventions, 50 times more likely to arrive by ambulance. This suggests a vast majority of ambulance transports are appropriate. The policy of diverting 911 patients away from EDs will not target low acuity visits. Studies suggest that it may target sick, vulnerable patients who already have limited access to care, and may further limit their access to specialty care. Even though EDs certainly have problems referring patients for specialty care, or achieving consultation during the ED visit, such referrals and consultations from ADs would most likely be even more difficult, if not impossible.

In conclusion, lowering healthcare costs for payers should not come at the expense of patient safety. Limiting access to high quality emergency and specialty care may show immediate cost savings to payers, but concerns remain over the longer term expense to patients and payers in terms of overall health outcomes. To date, the literature does not support paramedic-guided diversion of ambulance patients away from the ED to AD in terms of cost savings or equivalent health outcomes. As interest grows in CP programs, rigorous research methods should be applied to validate claims that CP is safe, improves quality and lowers healthcare costs.
REFERENCES
Maldistribution of medical resources is a serious problem in the United States. One proposed solution is to expand the role of emergency medical technicians (EMTs) and have them provide limited nonemergency care.\(^1\)–\(^3\) New Mexico is highly rural, with many counties having few or no physicians. To address this, a consortium that included one rural town, the nearest hospital, the University of New Mexico School of Medicine – Department of Emergency Medicine (UNM), and the New Mexico Department of Health (DOH) was created in 1992 to develop a pilot expanded emergency medical services (E-EMS) program. The consortium used $394,000 in federal grant funding for this project. The state senate passed legislation requiring that a program be developed and evaluated. Although several services were initially involved, and some providers were actually trained, E-EMS services were quickly discontinued in all but one location. The issues involved in this decision are beyond the scope of this editorial but involved local politics and resource availability.

The town chosen for the project had a well-developed paramedic EMS system, strong political leadership, and an active medical director with a long-standing relationship with the service. When the project started, there was virtually no local medical care available other than EMS in the community. For the first years of program operation, a part-time outpatient clinic existed 15 miles away. For the past few years, a clinic staffed by physician assistant (PA) has been open part of the year in the town. Both clinics have expanded and are now available during almost all business hours. The PA resides in town and is on call, after hours. In addition to these services, a community health nurse runs a vaccination program in the town. There are no local pharmacy, dental, or physician services. The closest hospital is 38 miles away, a 60-minute drive through a narrow mountain canyon. There are several primary care and specialty physicians, a pharmacy, and an outpatient clinic near the hospital.

The town medical director and the state approved 78 protocols covering various treatments and situations that the E-EMS providers were expected to encounter. UNM developed a training curriculum consisting of 380 contact hours at the UNM EMS Academy and 600 clinical hours largely provided by local health care providers. Providers were trained to perform more complete histories and physical examinations. Minor acute care problems such as sinus and migraine headaches were addressed. Chronic disease surveillance, community health education, and prevention were intended to be a major part of the E-EMS project. Protocols were included for health maintenance, including long-term care of diabetes, alcoholism, hypertension, and family planning. Providers were authorized to administer a single dose of several different medications ranging from oral antibiotics and lidocaine to over-the-counter analgesics and antihistamines. Specific procedures were approved for advanced wound care and suturing. Providers were authorized to use an advanced triage system with four categories: emergency transport, immediate physician consultation treatment and referral back to E-EMS or other medical provider, and treatment via protocol alone. The intention of this triage system was to provide quality service for patients while reducing the transport rate.\(^5\)

Sixteen EMTs started and three completed the training. Initially the program was viewed as quite successful. It received considerable positive publicity and garnered national interest.\(^7\) Five years later, only one E-EMS provider was still practicing and the service requested permission to train five new ones to allow full-time coverage. In response, the DOH asked UNM to perform a formal review.

The investigators performed a multipart evaluation. The service
compiled all patient contacts into a database. The service agreed to provide all charts involving an E-EMS procedure or medication from eight nonconsecutive months. The sampling period was chosen to provide approximately 30 charts based on the number of E-EMS visits in the entire five-year period. This was intended to be a preliminary review. Care was evaluated using the same quality-review process used by the UNM Hospital. We visited the clinic and surrounding area several times. A trained interviewer went door-to-door and gave a standardized verbal survey to all residents who were home. Representative staff, local emergency physicians, and primary care providers were given open-ended interviews by the investigators. The evaluation was approved by our institutional review board with the stipulation that patient and interviewee identities be held in confidence.

The database included 3,345 patient visits over a 63-month period. This number is only approximate because the service stopped recording incidental patient visits such as blood pressure checks partway through the study period. An E-EMS provider saw 1,351 patients, and E-EMS services were provided during 1,089 visits. In 56% of the visits to an E-EMS provider, the patient was treated and released without a referral, 9% of the time the patient was treated and advised to obtain follow-up care, and 15% of the time the patient received treatment locally after online medical direction. The ability to triage patients instead of transporting them was intended to reduce unnecessary transports, but there was relatively little difference between E-EMS and standard EMS transport rates (19% and 29%). Approximately 12% of the visits were for wound care. Ten percent were for “health checks.” The researchers were told by service personnel that these were primarily insurance and school physicals. This was concerning because the E-EMS curriculum did not include the skills necessary to perform these examinations and there were apparently no protocols that covered them. State law requires that school physicals be performed by a licensed physician, nurse practitioner, or PA. These examinations appeared to be practice beyond the level of licensure. We were told that patients paid for these examinations. Billing for procedures that a provider can not legally perform is fraudulent. Medication administrations were documented for 30 patients, and 18 patients were reported to have had prescriptions filled. Filling outside prescriptions would violate both state EMS and pharmacy regulations.

The clinic, located on the second floor of the town hall, was not accessible to disabled patients and failed to meet essential legal design requirements for a health care facility. The provision of care out of ambulances only partly alleviated this problem.

A review of the record-keeping practices found that medical records were kept in computer databases without password protection. Records were easily and untraceably alterable, and electronic signatures and tracking were not used. As mentioned, not all visits were recorded. Documentation and record keeping were clearly not in accordance with medical records standards.

The service provided only nine charts for review: seven lacerations, one insect bite, and one abrasion and presumed dislocated patella. The quality of care was problematic. The patient with an insect bite had a local reaction and received diphenhydramine hydrochloride (Benadryl), which was authorized only for systemic allergic reactions. The patient with a presumed dislocated patella had no follow-up x-ray or referral documented as was required by protocol. As this was apparently a first-time injury, the risk of a chip fracture or other associated injury was high. A patient with a nail bed laceration was repaired with 5-0 polypropylene (Prolene) sutures without magnification. This was also a protocol violation as well as beneath the local standard of care. Compliance with the tetanus immunization protocol was particularly poor. All nine patients were potential candidates for vaccination, but no tetanus information was recorded on three charts. Four patients were noted to need a tetanus booster, but only two apparently received one. No follow-up was documented for any of the patients; in fact, service personnel stated that no follow-up information existed for “85%” of all E-EMS patients. It is not clear whether the small number of charts provided was due to chance or an inability to retrieve relevant records, or whether specific records were deliberately selected. The researchers chose not to request more charts after it became clear that records could be untraceably altered or created at any time. The extremely high incidence of protocol violations and substandard care was concerning regardless of whether the sample was random or selected.

A convenience sample of 73 residents was surveyed. Forty-four (60%) had used the EMS service. Residents rated the service highly, giving it an average score of 9.4 on a 10-cm linear analog scale, but apparently had little knowledge of the E-EMS program. When asked “Are you aware that [the local] EMS provides extra services in addition to routine EMS services?” two thirds responded affirmatively but only 17 were able to name an E-EMS service.

Our interviews with local health care providers were particularly disturbing. Although every provider was supportive of some expansion of EMS in theory, many specific concerns were raised. Several physicians independently reported receiving calls from E-EMS providers requesting prescriptions for patients. They expressed concern that prescribing medications for patients with
whom they had no relationship was inappropriate, illegal, and risky from a malpractice standpoint. Indeed, our state medical licensing board confirmed that such prescribing would constitute grounds for disciplinary action. Reports were received that when a request for a prescription was refused, the E-EMS providers proceeded to call other physicians, seeking a prescription order. Several physicians independently stated that they had concerns about, and gave examples of, substandard care. Perhaps the most worrisome accusation was that E-EMS procedures, in addition to the triage activity discussed above, were being done by staff who were neither trained nor authorized to perform them. The investigators interviewed providers, residents, and patients who independently claimed to have direct first-person knowledge that non-E-EMS providers routinely did procedures, including suturing lacerations.

Although coordination with local health resources was an integral part of the program as initially envisioned, several local providers and residents complained that the service overly competed for patients. E-EMS care was routinely provided at times when other local health care services were available. Evidence was obtained that the service deliberately bypassed the local clinic.

The effect of this program on health care costs was complex. E-EMS providers were unable to bill third parties. Patients were required to pay directly for E-EMS care or find another provider. For insured patients, direct payment might increase their total health care expenditures. Uninsured patients might pay less for treatment by an E-EMS provider, but the service had less flexible payment options than other medical facilities. In theory, patient care revenue could have been used to decrease tax-based support of EMS, but there is no evidence that this occurred. More seriously, because money paid for E-EMS was not available for other providers, the E-EMS services had an inherent conflict of interest with other local health care providers. Competition by a municipal service that was supported almost entirely by tax revenue was clearly an issue. The impact on a local medical community is potentially serious as E-EMS presence may inhibit the establishment or maintenance of other health care facilities.

As our study progressed, we experienced increasing difficulty obtaining cooperation from the service. In addition, several past and current employees refused to be interviewed even after being offered confidentiality, citing fear of retaliation. Admittedly, it might well have been possible to identify respondents by their statements alone. Although it is a tax-supported municipal service, the service refused to allow the researchers access to any financial data.

This program was developed by an enthusiastic consortium of state officials, local EMS, and a university group with considerable experience with rural EMS training. Funding was generous. The program was actively supported by the university and local health care providers. What went wrong?

The proximate cause of the program's failure was the influence of local politics and the lack of external quality control. Simply put, the program evolved away from its original goal of allowing a limited kind of primary care to be delivered conveniently to a rural population. It became a functionally unsupervised acute care clinic that did a limited variety of apparently low-quality care. In the end, it refused even to adequately cooperate with the review mandated by the state agency that originally developed it. The essential question is to what degree this occurred because of the individuals involved and to what degree it was a result of an inevitable flaw in the concept.

In retrospect, it seems clear that both problems occurred. Although the original protocols were very broad and comprehensive, the actual practice was very narrow and involved only a few specific skills beyond routine paramedic practice. Dependence on protocols might limit the ability to offer comprehensive care. Few residents appeared to use E-EMS for primary care, preventive care, or health maintenance. Presumably they received these services through more traditional means. It is not clear that distance was a deterrent to care, since trips to larger towns were commonly made for other reasons. It probably makes sense for patients to obtain care where there is a pharmacy or from providers who can legally supply medications. Some of the quality-of-care issues were probably predictable. No formal E-EMS continuing education was required or obtained by the providers, and we found that changes in medical practice were not reflected in E-EMS practice. The low volume of E-EMS care and lack of follow-up provided little practice or feedback for providers. It also made assessing the appropriateness of nontransport decisions impossible for either the providers or the investigators.

Although the site was chosen because it was thought to have a stable and dedicated EMS group, turnover decimated it. Not only did the site lose all but one of its E-EMS providers, the surrounding communities chose to withdraw before actively participating. This reflects the relative instability of EMS in general. Unlike physicians or midlevel providers, few EMTs continue to provide care during their entire working lives, particularly on a full-time basis. Although rural care was the raison d'être of the program, the rural nature of the service made supervision difficult from the beginning. The medical director originally practiced locally. However, after he moved his practice to a city two hours away, the service chose to continue to use him for quality assurance rather than contracting with a more local
provider. The numerous violations of industry standards, state regulations, and laws that appear to have occurred were partly a product of ignorance and circumstance, but they were clearly aggravated by provider attitude and lack of supervision.

Several regulatory and program design changes might have led to a better outcome for this project. These could have included requiring integration with other local providers and agencies, continuing medical education, a minimum number of patient contacts, and mandatory patient follow-up. It is noteworthy that all of these were conceived and written into the original project proposal but were not executed due to a lack of regulatory oversight at local, state, and regional levels. Presumably, strong local medical control provided by a committed and involved physician and medical director would be the best assurance that all of these elements would be realized.

Having medical direction be supplied by the nearest qualified provider was unacceptable to the E-EMS providers. Clinical rotations with local primary care providers or in a local emergency department would have provided patient care experience, but this would have been inconvenient for the E-EMS providers. Requiring more local involvement in oversight and continuing education might have helped with the relative lack of demand from patients, but this would probably have had direct impact on the service's finances.

It may be fruitful to compare this program with the largest medical system that employs providers with a similar level of training in the United States. Military Corpsmen carry out a limited mission that is quite like that originally proposed for the E-EMS project. However, they undergo a well-standardized and homogeneous structured training. They work in a highly hierarchical environment with rigorous direct and indirect supervision. Their patients have few alternative sources of care and an entirely different medical-legal risk situation. Thus, it seems unlikely that this model is generalizable to rural America.

Although EMTs can clearly be trained to perform functions beyond their usual scope of practice, this attempt to develop a community-based practitioner appears to have failed. It is likely that the amount of training available was inadequate for a quasi-independent practitioner. Perhaps the two years of full-time education required of PAs is a realistic minimum. It may also be that, at least in the lower 48 states, this form of expanded service would be needed only in an area that had inadequate local medical support and patient volume to maintain it. However, one basic flaw was that lack of mandatory integration into the local medical community allowed the service to become too independent. New Mexico's experience indicates that rules and structures must be put in place to ensure continued compliance with the principles agreed to by all the involved parties when a program is developed. Without these, expanded EMS is set up for failure.

After the investigators' report was given to the DOH, the program voluntarily ceased operation, and the license of one of the EMTs was restricted by the New Mexico EMT Licensing Board.

References
SUMMARY:
1. Existing law:
   • generally requires the State Department of Public Health to license, regulate, and inspect health and care facilities.
   • specifically requires the department to adopt regulations that require a general acute care hospital, an acute psychiatric hospital, and a special hospital to meet minimum nurse-to-patient ratios and assign additional staff according to a documented patient classification system for determining nursing care requirements.
   • generally requires the department to periodically inspect every health facility for which a license or special permit has been issued for compliance with state laws and regulations.

2. Existing law requires:
   • the department to promulgate regulations establishing criteria to assess an administrative penalty against a general acute care hospital, acute psychiatric hospital, or special hospital for a deficiency constituting an immediate jeopardy violation and a violation of the rules and regulations applicable to these types of hospitals that do not constitute an immediate jeopardy.
   • certain penalties collected by the department to be deposited into the Internal Departmental Quality Improvement Account, to be expended, upon appropriation by the Legislature, for internal quality improvement activities in the Licensing and Certification Program.

ANALYSIS:
Re 1., above: This bill would require:
   • the periodic inspections of these specified health facilities to include reviews of compliance with the nurse-to-patient ratios and staff assignment regulations described above.
   • the department to ensure that these inspections are not announced in advance of the date of inspection.
Re 2., above: This bill would require:
- the department to assess specified administrative penalties for a violation of the nurse-to-patient ratios and staff assignment regulations described above.
- those penalty moneys to be deposited into the State Department of Public Health Licensing and Certification Program Fund, to be expended, upon appropriation by the Legislature, for the purpose of enforcing those regulations.

**Amended analysis as of 6/27:**
The bill would reduce administrative penalties for the first violation of the regulation and each subsequent violation from thirty thousand dollars and sixty thousand dollars, respectively, to fifteen thousand dollars and thirty thousand dollars for the second and each subsequent violation.

The bill would provide that a general acute care hospital shall not be subject to an administrative penalty under that paragraph if the hospital demonstrates to the satisfaction of the department all of the following:
(i) That any fluctuation in required staffing levels was unforeseeable and uncontrollable.
(ii) Prompt efforts were made to maintain required staffing levels.
(iii) In making those efforts, the hospital immediately used and subsequently exhausted the hospital’s on-call list of nurses and the charge nurse, in that order.

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

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Support (8/15/19)

**SUPPORT:**
Co-Sponsors:
California State Council of Service Employees
SEIU 121RN
United Nurses Association of California/Union of Health Care Professionals
American Federation of State, County and Municipal Employees, AFL-CIO
California Labor Federation, AFL-CIO
California Nurses Association
California Professional Firefighters
California School Employees Association
California School Nurses Organization
California Teamsters Public Affairs Council
Congress of California Seniors
Consumer Attorneys of California
Engineers and Scientists of California Local 20, IFPTE AFL-CIO and CLC
International Longshore & Warehouse Union Local 13
San Francisco AIDS Foundation

**OPPOSE:**
Adventist Health
Adventist Health and Rideout
Adventist Health Bakersfield
Adventist Health Glendale
Adventist Health Hanford
Adventist Health Sonora
Adventist Health, Clear Lake
Adventist Health, St. Helena
Adventist Health Simi Valley
Alameda Health System
Alliance of Catholic Health Care, Inc.
Alta Hospitals System
Association of California Healthcare Districts, and Affiliated Entity Alpha Fund
Bakersfield Memorial Hospital
Ballard Rehabilitation Hospital
Banner Lassen Medical Center
Barlow Respiratory Hospital
Barstow Community Hospital
Barton Health
Bear Valley Community Healthcare District
Beverly Community Hospital Association
California Chamber of Commerce
California Children's Hospital Association
California Hospital Association
California Hospital Medical Center
Canyon Ridge Hospital
Cedars-Sinai Medical Center
Centinela Hospital Medical Center
Chinese Hospital
Chino Valley Medical
Community Hospital of Huntington Park
Community Hospital of San Bernardino
Community Hospital of the Monterey Peninsula
Community Medical Centers
Corona Regional Medical Center
Cottage Health
Del Amo Behavioral Health System Of Southern California
Delano Regional Medical Center
Desert Valley Hospital
Dignity Health
Dignity Health - Inland Empire
District Hospital Leadership Forum
Dominican Hospital
Eastern Plumas Health Care
Eisenhower Health Medical Center
El Camino Health
Emanate Health
Emanate Health – Queen of the Valley Hospital
Encompass Health Rehabilitation Hospital Of Bakersfield
Enloe Medical Center
Fairchild Medical Center
Fremont Hospital
French Hospital Medical Center
Glendale Memorial Hospital and Health Center
Hazel Hawkins Memorial Hospital
HCA - Hospital Corporation of America
Healdsburg District Hospital
Henry Mayo Newhall Hospital
Hospital Corporation Of America
Huntington Hospital
Inland Valley Medical Center
John C. Fremont Healthcare District
John Muir Health
Kaiser Permanente
Kern Medical
Kern Valley Healthcare District
Kindred Healthcare
Kindred Hospital Baldwin Park
Kindred Hospital La Mirada
Kindred Hospital Los Angeles
Kindred Hospital Riverside
Kindred Hospital San Francisco Bay Area
Kindred Hospital San Gabriel Valley
Kindred Hospital South Bay
La Palma Intercommunity Hospital
Loma Linda University Adventist Health Sciences Center and its Affiliated Entities
Lompoc Valley Medical Center
Los Robles Hospital & Medical Center
Mad River Community Hospital
Marian Regional Medical Center
Marin General Hospital
Marshall Medical Center
Mayers Memorial Hospital District
Memorial Hospital of Gardena
Memorialcare Health System
Mendocino Coast District Hospital
Mercy General Hospital
Mercy Hospital of Folsom
Mercy Hospitals of Bakersfield
Mercy Medical Center
Mercy Medical Center Mt. Shasta
Mercy Medical Center Redding
Mercy San Juan Medical Center
Methodist Hospital Of Sacramento
Methodist Hospital Of Southern California
Mission Community Hospital
Modoc Medical Center
Monterey Park Hospital
Mountain Communities Healthcare District
Mountain View Child Care, Inc
Northbay Healthcare
Northridge Hospital Medical Center
Oak Valley Hospital District
Olympia Medical Center
Orchard Hospital
Parkview Community Hospital Medical Center
PIH Health
Plumas District Hospital
Pomona Valley Hospital Medical Center
Providence Little Company of Mary Medical Center San Pedro
Providence St. Joseph Health
Rancho Springs Medical Centers
Redlands Community Hospital
Redwood Memorial Hospital
Regional Medical Center
Ridgecrest Regional Hospital
Riverside Community Hospital
Saint Agnes Medical Center
Saint Francis Memorial Hospital
Salinas Valley Memorial Healthcare System
San Antonio Regional Medical Center
San Diego Regional Chamber Of Commerce
San Gabriel Valley Economic Partnership
San Gorgonio Memorial Hospital
San Jose Behavioral Health
Scripps Health
Select Specialty Hospital - San Diego
Seneca Healthcare District
Sequoia Hospital
Sharp Healthcare
Shasta Regional Medical Center
Sierra View Medical Center
Sierra Vista Hospital
Sierra Vista Regional Medical Center
Sohum Health
Sonoma Valley Hospital
Southern Humboldt Community Healthcare District and Jerold Phelps Community Hospital
Southwest California Legislative Council
Southwest Healthcare System
St. Bernardine Medical Center
St. Elizabeth Community Hospital
St. Francis Medical Center
St. Joseph Health – Humboldt County
St. Joseph’s Behavioral Health Center
St. Joseph’s Medical Center
St. Mary Medical Center
St. Rose Hospital
Stanford Health Care
Stanford Health Care Valleycare
Stanford Hospital & Clinics
Surprise Valley Health Care District
Sutter Health
Sutter Health Sutter Auburn Faith Hospital
Sutter Health Sutter Coast Hospital
Tahoe Forest Health System
Tenet Healthcare Corporation
The Chamber Greater Coachella Valley
Torrance Memorial Medical Center
Totally Kids Rehabilitation Hospital
Trinity Hospital
Trinity Hospital, Mountain Communities Healthcare District
United Hospital Association
Valley Children’s Healthcare
Vibra Hospital Of Northern California
Vibra Hospital of Sacramento
Vista Del Mar
West Anaheim Medical Center
West Hills Hospital & Medical Center
Woodland Memorial Hospital
AUTHOR: Mitchell  
BILL NUMBER: SB 464  
SPONSOR: ACT for Women and Girls and 4 others  
BILL STATUS: Assembly Committee on Appropriations  
SUBJECT: California Dignity in Pregnancy and Childbirth Act  
DATE LAST AMENDED: June 27, 2019

SUMMARY:
Existing law:
- requires the State Department of Public Health to maintain a program of maternal and child health, which may include, among other things, facilitating services directed toward reducing infant mortality and improving the health of mothers and children.
- requires the Office of Health Equity within the department to serve as a resource for ensuring that programs collect and keep data and information regarding ethnic and racial health statistics, and strategies and programs that address multicultural health issues, including, but not limited to, infant and maternal mortality.

ANALYSIS:

This bill would:
- make legislative findings relating to implicit bias and racial disparities in maternal mortality rates.
- require a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities.
- require the health care provider to complete initial basic training through the program and a refresher course every two years thereafter, or on a more frequent basis if deemed necessary by the facility.
- require the department to track and publish data on maternal death and severe morbidity, disaggregated by county, facility, and racial and ethnic identity.

The bill also addresses death certificates. It amends HSC Section 102875 to add the provision that the certificate of death shall indicate whether the decedent was pregnant within 42 days of death or within 43 to 365 days of death.
Amended analyses of 4/1 and 4/11:
The bill removes the previous requirement that data tracked and published related to maternal death and severe morbidity need not be disaggregated by county, facility, and racial and ethnic identity.

New: Existing law requires hospitals to provide specified information regarding patient’s rights to each patient upon admission or as soon thereafter as reasonably practical, including, among other things, information about the right to be informed of continuing health care requirements following discharge from the hospital.

This bill would require:
- the hospital to additionally provide patients with information on the patient’s right to be free of discrimination on the basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language, or immigration status.
- The bill would additionally require the hospital to provide patients with information on how to file a complaint with specified state entities.

Amended analysis as of 6/27:
The bill would require the facility to provide a certificate of training completion upon request, to accept certificates of completion from other facilities, and to offer training to physicians not directly employed by the facility.

BOARD POSITION: Watch (4/11/19)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (8/15/19)

SUPPORT:
ACT for Women and Girls (cosponsor)
Black Women for Wellness (cosponsor)
California Nurse-Midwives Association (cosponsor)
NARAL Pro Choice California (cosponsor)
Western Center on Law & Poverty (cosponsor)
Asian Americans Advancing Justice - Los Angeles
BreastfeedLA
California Commission on the Status of Women and Girls
California Hospital Association
California Latinas for Reproductive Justice
California Legislative Women's Caucus
California Pan-Ethnic Health Network
Child Care Law Center
Children and Families Commission of Los Angeles County
Children's Defense Fund-California
Coalition of California Welfare Rights Organizations
Consumer Watchdog
County Health Executives Association of California
County of Los Angeles Board of Supervisors
Courage Campaign
Fields Family Counseling Services
First 5 LA
Friends Committee on Legislation of California
Having Our Say Coalition
Health Access California
OPPOSE: None received
SUMMARY:
Existing law requires various licenses to be obtained by a person before engaging in certain professions or vocations or business activities, including licensure as a healing arts professional by various boards within the Department of Consumer Affairs.

ANALYSIS:
This bill would authorize any state agency that issues any business license to reduce or waive any required fees for licensure, renewal of licensure, or the replacement of a physical license for display if a person or business establishes to the satisfaction of the state agency that the person or business has been displaced by a declared emergency.

Amended analysis as of 3/28:
This bill would now authorize any state agency that issues any business license to reduce or waive any required fees for licensure, renewal of licensure, or the replacement of a physical license for display if a person or business establishes to the satisfaction of the state agency that the person or business has been displaced or affected by a declared federal emergency or proclaimed state emergency.

Amended analysis as of 6/27:
The language has been revised and the bill would now authorize any state agency that issues any business license to establish a process for a person or business that has been displaced or is experiencing economic hardship as a result of an emergency, as defined, to submit an application for reduction or waiver of fees required by the agency to obtain a license, renew or activate a license, or replace a physical license for display.

The bill would define: displaced, economic hardship, emergency, and license.

BOARD POSITION: Watch (4/11/19)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (8/15/19)
**SUPPORT:**
R Street Institute (sponsor)
Rebuild Paradise Foundation
California Board of Accountancy
California Chamber of Commerce
Southwest California Legislative Council
California Dental Association
Board of Behavioral Sciences
California State Board of Pharmacy
San Gabriel Valley Economic Partnership
Contractors State License Board
National Association of Social Workers
Professional Fiduciary Association of California

**OPPOSE:** None on file
SUMMARY:

1. The Physician Assistant Practice Act provides for licensure and regulation of physician assistants by the Physician Assistant Board, which is within the jurisdiction of the Medical Board of California. That act requires the board to issue licenses under the name of the Medical Board of California.

2. The act:
   - authorizes a physician assistant to perform medical services as set forth by regulations and the act and when those services are rendered under the supervision of a licensed physician and surgeon.
   - requires the physician assistant and the supervising physician and surgeon to establish written guidelines and protocols for adequate supervision and a delegation of services agreement.

3. The act authorizes a physician assistant, under the supervision of a physician and surgeon, to administer or provide medication to a patient, or transmit orally, or in writing on a patient’s record or in a drug order, an order to a person who may lawfully furnish the medication or medical device.

4. The act defines various terms for its purposes.

ANALYSIS:

Re 1, above:
This bill would rename the board the Physician Assistant Board of California and instead provide that the board is within the Department of Consumer Affairs. The bill would require the board to issues licenses under its name.

Re 2., above:
This bill would:
Instead authorize a physician assistant to perform various medical services, including evaluating, diagnosing, managing, and providing medical treatment, pursuant to a practice agreement or in certain organized health care practice settings if the medical services are provided in collaboration with a physician and surgeon or other qualified health care provider in a manner consistent with the education, training, experience, and competencies of the physician assistant and the standard of care, as specified.

Authorize a physician assistant to bill and receive direct payment for medical services they provide.

Re 3., above:
This bill would:
- Instead authorize a physician assistant to, unless otherwise prohibited, prescribe, dispense, order, administer, and procure drugs and medical devices to a patient or a person who may lawfully furnish the medication or medical device.
- Authorize a physician assistant to initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including, but not limited to, durable medical equipment, nutrition, blood and blood products, and diagnostic support services, including, but not limited to, home health care, hospice, and physical and occupational therapy.

Re 4., above:
This bill would:
- Revise and change the definitions as applicable to carry out the bill’s provisions.
- Provide that any reference to “protocols” or “delegation of services agreement” in any other law referencing the act means “practice agreement,” as defined by the act, and that any reference to “supervision” in any other law referencing the act means “collaboration,” as defined by the act.
- Also make various conforming changes.

Amended analyses of 4/10:

The subject of the bill changed from “Physician assistants: scope of practice” to “Physician assistants: practice agreement: supervision.”

The bill now deletes the provision renaming the Physician Assistant Board and placing it within the Department of Consumer Affairs rather than the Medical Board of California.

The Physician Assistant Practice Act currently:
- Prohibits a physician and surgeon from supervising more than 4 physician assistants at any one time;
requires the medical record to identify the physician and surgeon who is responsible for the supervision of the physician assistant;

requires the supervising physician and surgeon to be physically available to the physician assistant for consultation when that assistance is rendered;

requires the physician assistant and the supervising physician and surgeon to establish written guidelines for adequate supervision;

authorizes the supervising physician and surgeon to satisfy this requirement by adopting protocols for some or all of the tasks performed by the physician assistant;

authorizes a delegation of services agreement to authorize a physician assistant to order durable medical equipment, to approve, sign, modify, or add to a plan of treatment or plan of care for individuals receiving home health services or personal care services, or to certify disability.

This bill would:
- remove the limit on the number of physician assistants that a physician and surgeon may supervise;
- remove the requirements that the medical record identify the responsible supervising physician and surgeon and that those written guidelines for adequate supervision be established;
- authorize a physician assistant to perform various medical services if certain requirements are met including that the medical services are rendered pursuant to a signed delegation of services agreement or a practice agreement, as defined, and the physician assistant is competent to perform the medical services;
- require a practice agreement between a physician assistant and a physician and surgeon to meet specified requirements.

This bill would change the provisions of 3., above, in SUMMARY:

This bill would now:
- authorize a physician assistant to furnish or order a drug or device subject to specified supervision. Specifically, the bill would prohibit a physician and surgeon from supervising more than 6 physician assistants for purposes of the provisions relating to physician assistants furnishing or ordering drugs or devices.

This bill would further refine definitions of 4., above, in SUMMARY:

The bill would now:
• delete the word “protocol” and provide that any reference to “delegation of services agreement” in any other law means “practice agreement” and provides a definition for “practice agreement;”

• provide that “supervision” does not require the supervising physician and surgeon to be physically present.

Amended analysis as of 4/24:

Additionally, the Physician Assistant Practice Act requires the Physician Assistant Board to make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration and approval of applications by licensed physicians to supervise physician assistants.

This bill would:
• remove the requirement that the Physician Assistant Board make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration and approval of applications by licensed physicians and surgeons to supervise physician assistants;

• provides that the PA renders services pursuant to a practice agreement and deletes the language “a delegation of services agreement.”

Amended analysis as of 7/1:
The most significant provision is: Except as provided in Section 3502.5 [which deals with a PA providing services during any state of war emergency, state of emergency, or state of local emergency, as defined in Section 8558 of the Government Code, etc] a physician and surgeon shall not supervise more than four physician assistants at any one time.

Amended analysis as of 7/11:
The bill would provide clarification related to Supervision:

“Supervision” means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant. Supervision, as defined in this subdivision, shall not be construed to require the physical presence of the physician and surgeon, but does require the following:
(A) Adherence to adequate supervision as agreed to in the practice agreement.
(B) The physician and surgeon being available by telephone or other electronic communication method at the time the PA examines the patient.

Related to the Physician Assistant Board:
(2) Nothing in this subdivision shall be construed as prohibiting the board from requiring the physical presence of a physician and surgeon as a term or condition of a PA’s reinstatement or probation.

BOARD POSITION: Oppose (6/13/19)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Oppose (8/15/19)
SUPPORT:
California Academy of PAs (Sponsor)
America's Physician Groups
Association of California Healthcare Districts, and Affiliated Entity Alpha Fund
California Academy of Family Physicians
California Association for Health Services At Home
California Hospital Association
California Medical Association
California Psychiatric Association
California+health+ Advocates
Medical Board of California

OPPOSE:
California Chapter of the American College of Emergency Physicians (unless amended)
California Rheumatology Alliance (unless amended)
California Society of Plastic Surgeons
Physician Assistant Board (unless amended)
One individual (unless amended)
AUTHOR: Roth  BILL NUMBER: SB 700
SPONSOR:  BILL STATUS: Senate Committee on Rules
SUBJECT: Business and professions: noncompliance with support orders and tax delinquencies  DATE LAST AMENDED: Introduced

SUMMARY:
Under existing law, each applicant for the issuance or renewal of a license, certificate, registration, or other means to engage in a business or profession regulated by specified entities, who is not in compliance with a judgment or order for child or family support, is subject to support collection and enforcement proceedings by the local child support agency.

Existing law also makes each licensee or applicant whose name appears on a list of the 500 largest tax delinquencies subject to suspension or revocation of the license or renewal by a state governmental licensing entity.

ANALYSIS:
This bill would make nonsubstantive changes to those provisions.

The bill language may change to address nursing education programs and displacement from clinical sites.

BOARD POSITION: Watch (4/11/19)
LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (8/15/19)
SUPPORT:
OPPOSE: