California State Assembly

BUSINESS AND PROFESSIONS

MARC BERMAN
CHAIR

1020 N Street, Room 379
(916) 319-3301
FAX: (916) 319-3306

AGENDA

Tuesday, April 16, 2024
9:30 a.m. -- 1021 O Street, Room 1100

BILLS HEARD IN FILE ORDER

1.	AB 1991	Bonta	Licensee and registrant records.
2.	AB 2051	Bonta	Psychology interjurisdictional compact.
3.	AB 2115	Haney	Controlled substances: clinics.
4.	AB 2231	Gipson	Pawnbrokers: education.
5.	AB 2246*	Ramos	Medical Practice Act: health care providers: qualified autism service paraprofessionals.
6.	AB 2265	McCarty	Animals: spaying, neutering, and euthanasia.
7.	AB 2425	Essayli	Bowie's Law: animals: adoption, shelter overcrowding, and breeding.
8.	AB 2526	Gipson	Nurse anesthetists.
9.	AB 2566	Wilson	Healing arts: counseling.
10.	AB 2578	Flora	Nursing: students in out-of-state nursing programs.
11.	AB 2651	Bains	Alcohol drug counselors.
12.	AB 2862	Gipson	Licenses: African American applicants.
13.	AB 2918	Zbur	State Board of Barbering and Cosmetology: licensee information.
14.	AB 3176	Hoover	Professional land surveyors: surveying practices: monuments and corner accessories.

* ***Proposed for Consent***

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1991 (Bonta) – As Amended March 11, 2024

SUBJECT: Licensee and registrant records.

SUMMARY: Requires all healing arts boards under the Department of Consumer Affairs (DCA) to collect specified workforce data from their licensees and registrants at least biennially as a requirement of license or registration renewal, and requires that information to be subsequently provided to the Department of Health Care Access and Information (HCAI).

EXISTING LAW:

1) Establishes the DCA within the Business, Consumer Services, and Housing Agency. (Business and Professions Code (BPC) §§ 100 *et seq.*)

2) Establishes various boards, bureaus, and other entities within the jurisdiction of the DCA. (BPC § 101)

3) Establishes "healing arts" boards under the jurisdiction of DCA, which includes the following entities:

    a) Acupuncture Board;

    b) Board of Behavioral Sciences;

    c) State Board of Chiropractic Examiners;

    d) Dental Board of California;

    e) Dental Hygiene Board of California;

    f) Medical Board of California;

    g) California Board of Naturopathic Medicine;

    h) California Board of Occupational Therapy;

    i) California Board of Optometry;

    j) Osteopathic Medical Board of California;

    k) California State Board of Pharmacy;

    l) Physical Therapy Board of California;

    m) Physician Assistant Board;

    n) Podiatric Medical Board of California;

o) Board of Psychology;

p) Board of Registered Nursing;

q) Respiratory Care Board of California;

r) Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board;

s) Veterinary Medical Board;

t) Board of Vocational Nursing and Psychiatric Technicians.

(BPC §§ 500 *et seq.*)

4) Requires information retained by each board under the DCA relating to license applicants with criminal records to include the final disposition and demographic information, consisting of voluntarily provided information on race or gender. (BPC § 480(g))

5) Requires the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians, the Physician Assistant Board, and the Respiratory Care Board of California to collect specified workforce data from their respective licensees and registrants for future workforce planning at least biennially, with data collected at the time of electronic license or registration renewal as applicable. (BPC § 502(a)(1))

6) Provides that all other healing arts boards shall request the specified workforce data for future workforce planning at least biennially, with data collected at the time of electronic license or registration renewal as applicable. (BPC § 502(a)(2))

7) Specifies the following information as included within the workforce data collected or requested by healing arts boards:

a) Anticipated year of retirement.

b) Area of practice or specialty.

c) City, county, and ZIP Code of practice.

d) Date of birth.

e) Educational background and the highest level attained at time of licensure or registration.

f) Gender or gender identity.

g) Hours spent in direct patient care, including telehealth hours as a subcategory, training, research, and administration.

h) Languages spoken.

i) National Provider Identifier.

j) Race or ethnicity.

k) Type of employer or classification of primary practice site among the types of practice sites specified by the board, including, but not limited to, clinic, hospital, managed care organization, or private practice.

l) Work hours.

m) Sexual orientation.

n) Disability status.

(BPC § 502(b))

8) Requires each board to maintain the confidentiality of the information it receives from licensees and registrants and to only release information in an aggregate form that cannot be used to identify an individual. (BPC § 502(c))

9) Requires the DCA, in consultation with HCAI, to specify for each board the specific information and data that will be collected or requested. (BPC § 502(d))

10) Requires each board, or the DCA on its behalf, to provide the workforce data it collects to HCAI on a quarterly basis in a manner directed by HCAI, including license or registration number and associated license or registration information. (BPC § 502(e))

11) Prohibits boards from requiring a licensee or registrant to provide the workforce data as a condition for license or registration renewal, or from disciplining licensees or registrants for not providing the information. (BPC § 502(f))

12) Requires licensed dentists to report to the Dental Board of California, upon initial licensure and any subsequent application for renewal, the licensee's practice status and any completed advanced educational program, as well as information regarding the licensee's cultural background and foreign language proficiency if reported by the licensee. (BPC § 1715.5)

13) Requires licensed dental hygienists to the Dental Hygiene Board, upon initial licensure and any subsequent application for renewal, the licensee's practice or employment status, as well as information regarding the licensee's cultural background and foreign language proficiency if reported by the licensee. (BPC § 1902.2)

14) Requires licensed physicians and surgeons to report to the Medical Board of California, immediately upon issuance of an initial license and at the time of license renewal, their practice status and any specialty board certification they hold, along with information relating to their cultural background and foreign language proficiency unless the licensee declines to provide that information. (BPC § 2425.3)

15) Requires licensed osteopathic physicians and surgeons to report to the Osteopathic Medical Board of California, either immediately upon issuance of an initial license or at the time of renewal, as provided, any specialty board certification they hold and their practice status, along with information relating to their cultural background and foreign language proficiency if reported by the licensee. (BPC § 2455.2)

16) Authorizes the Bureau of Real Estate Appraisers to request that a licensee identify their race, ethnicity, sexual orientation, gender, or gender identity. (BPC § 11347)

17) Requires the Board of Registered Nursing to incorporate regional forecasts into its biennial analyses of the nursing workforce and to develop a plan to address shortages. (BPC § 2717)

18) Authorizes the California Architects Board to request that a licensee identify their race, ethnicity, sexual orientation, gender, or gender identity. (BPC § 5552.2)

19) Establishes HCAI, previously established as the Office of Statewide Health Planning and Development, vested with responsibilities related to health planning and research development. (Health and Safety Code (HSC) §§ 127000 *et seq.*)

20) Provides for a Health Professions Career Opportunity Program to increase the number of ethnic minorities in health professional training and minority health professionals practicing in health shortage areas, subject to the appropriation of funds. (HSC §§ 127875 – 127885)

21) Requires HCAI to establish a health care workforce research and data center to serve as the central source of health care workforce and educational data in the state. (HSC § 128050)

22) Requires HCAI to work with the Employment Development Department's Labor Market Information Division, state licensing boards, and state higher education entities to collect, to the extent available, all of the following data:

    a) The current supply of health care workers, by specialty.

    b) The geographical distribution of health care workers, by specialty.

    c) The diversity of the health care workforce, by specialty, including, but not necessarily limited to, data on race, ethnicity, and languages spoken.

    d) The current and forecasted demand for health care workers, by specialty.

    e) The educational capacity to produce trained, certified, and licensed health care workers, by specialty and by geographical distribution, including, but not necessarily limited to, the number of educational slots, the number of enrollments, the attrition rate, and wait time to enter the program of study.

    (HSC § 128051)

23) Requires HCAI to prepare an annual report to the Legislature that does all of the following:

    a) Identifies education and employment trends in the health care profession.

    b) Reports on the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas.

    c) Recommends state policy needed to address issues of workforce shortage and distribution.

    d) Describes the health care workforce program outcomes and effectiveness.

    (HSC § 128052)

THIS BILL:

1) Provides that healing arts boards under the DCA that are not already required to collect workforce data from their licensees and registrants shall be required to collect that workforce data for future workforce planning at least biennially.

2) Requires a licensee or registrant to provide the workforce data information as a condition for license or registration renewal.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the author, who is Chair of the Assembly Committee on Health. According to the author:

> "California faces major shortages of health workers, isn't producing enough new workers to meet future needs, and the current health workforce does not match the diversity of the state. These workforce supply and diversity problems have a major impact on health access, quality, and equity. There are sixteen health care professional oversight boards that "request" workforce data but do not require workforce data to be reported as condition as licensure. Without accurate information about the makeup of California's health workforce, it is difficult to assess whether or not programs designed to improve diversity and increase access to care in underserved areas are working as intended. This information will provide HCAI with data necessary to assess whether or not loan repayment programs intended to increase the diversity of the health workforce, and to encourage providers to serve in underserved areas, are working as intended."

Background.

California has long faced significant gaps and inequities in its health care workforce. There has historically been a persistent shortage of accessible health professionals overall, which disproportionately impacts communities with concentrated populations of immigrant families and people of color. A recent study found that between 2010 and 2019, the number of primary care physicians in proportion to population remained largely unchanged nationally. Meanwhile, counties with a higher proportion of minorities saw a decline during that period.[1]

Compounding these issues of access is a significant lack of diversity among health care practitioners, with several minority groups remaining persistently underrepresented within the healing arts fields. A recent study of data from the American Community Survey and the Integrated Postsecondary Education Data System found that Black, Hispanic, and Native American people are nationally represented across 10 different health care professions.[2] As a result, minorities seeking to enter these professions face significant systemic obstacles, and patients who are representative of minority groups or immigrant communities often do not have access to practitioners who possess the cultural or linguistic competence to provide them with appropriate care.

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[1] Liu M, Wadhera RK. *Primary Care Physician Supply by County-Level Characteristics*, 2010-2019.
[2] Salsberg, Edward *et al*. "Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce." *JAMA network open* vol. 4,3 e213789. 1 March 2021.

Research cited by the California Health Care Foundation (CHCF) in its 2021 report "Health Workforce Strategies for California: A Review of the Evidence" found that while 39 percent of Californians identified as Latino/x in 2019, only 14 percent of medical school matriculants and 6 percent of active patient care physicians in California were Latino/x.[3] A 2018 study published by the Latino Policy & Politics Initiative at the University of California, Los Angeles found that while nearly 44 percent of the California population speaks a language other than English at home, many of the most commonly spoken languages are underrepresented by the physician workforce.[4] While the physician community has worked with the Medical Board of California to improve linguistic competency among providers, these efforts have yet to resolve systemic challenges with addressing language barriers in California.

Another issue resulting from underrepresentation in the health professions relates to implicit bias. According to the Stanford Encyclopedia of Philosophy, "implicit bias" can be described as "a term of art referring to relatively unconscious and relatively automatic features of prejudiced judgment and social behavior." In her 2019 book *Biased: Uncovering the Hidden Prejudice That Shapes What We See, Think, and Do*, Dr. Jennifer L. Eberhardt explains that "implicit bias is not a new way of calling someone a racist. In fact, you don't have to be a racist at all to be influenced by it. Implicit bias is a kind of distorting lens that's a product of both the architecture of our brain and the disparities in our society." Dr. Eberhardt goes on to describe how "bias is not limited to one domain of life. It is not limited to one profession, one race, or one country. It is also not limited to one stereotypic association."[5]

In December 2015, the American Journal of Public Health published a systematic review titled *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes*. The review concluded that "most health care providers appear to have implicit bias in terms of positive attitudes toward whites and negative attitudes toward people of color." Additional published studies suggest that implicit bias in regards to gender, sexual orientation and identity, and other characteristics has resulted in inconsistent diagnoses and courses of treatment being provided to patients based on their respective demographic. These trends take into account not only the characteristics of the person being treated, but those of the licensed professional in correlation to that patient.

The results of implicit bias can have serious consequences in the provision of health care. For example, one frequently cited statistic is that Black women have average maternal mortality rates that are three-to-four times higher than white women. While much of the research and action relating to implicit bias has been focused on the area of law enforcement and police procedure, there has been a growing call to also address the presence of implicit bias in the healing arts professions through additional awareness and training. In 2019, the Legislature enacted Assembly Bill 241 (Kamlager-Dove) to require continuing education courses for physicians and surgeons, nurses, and physician assistants to include the understanding of implicit bias and the promotion of bias-reducing strategies. While implementation of these requirements has undoubtedly had at least some impact on improving health care outcomes for minority patients, education and training is not a substitute for increasing diversity and representation among providers.

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[3] https://www.chcf.org/publication/health-workforce-strategies-california
[4] https://latino.ucla.edu/wp-content/uploads/2019/08/The_Patient_Perspective-UCLA-LPPI-Final.pdf
[5] Eberhardt, Jennifer L. *Biased: Uncovering the Hidden Prejudice That Shapes What We See, Think, and Do.* New York: Viking, 2019.

In February 2024, the Assembly Committee on Health held an informational hearing focused on Diversity in California's Health Care Workforce. This hearing included perspectives from various stakeholders and public health researchers, along with policymakers who provided updates on the state's efforts to increase diversity. The background paper for the hearing[6] cited research published in December 2022 by the Fitzhugh Mullan Institute for Health Workforce Equity at George Washington University in a report titled "The Race and Ethnicity of the California Health Care Workforce," which demonstrated that "a health workforce that reflects the racial and ethnic diversity of the population can improve access to, quality of, and outcomes of care."[7] As explained in the Health Committee's background paper, underrepresentation in the health care workforce both "contributes to health disparities" and "limits access to high-paying, meaningful professions for underrepresented minorities."

California has historically attempted to resolve these longstanding issues of representation and access through a number of different approaches. For example, the Legislature has previously enacted and funded loan repayment programs, such as the Dental Corps Loan Repayment Program of 2002, which provided grants to qualifying dentists who agreed to work for at least three years in a clinic or dental practice located in a dentally unserved area, or in which at least 50 percent of patients are from a dentally underserved population. The Health Professions Career Opportunity Program within HCAI similarly supports initiatives designed to enhance diversity and representation in the health professions by awarding grant funding through competitive programs.

As discussed in the Health Committee's background paper, it is often challenging to evaluate the long-term impacts of these programs, as "HCAI does not currently collect longitudinal data that could demonstrate which of these programs are more effective." During sunset review oversight hearings on healing arts boards that were held jointly in 2024 by the Assembly Committee on Business and Professions and the Senate Committee on Business, Professions, and Economic Development, committee members expressed frustration that there was not sufficient data to confirm whether any particular strategy to improve access has been successful. This is in large part due to a lack of consistent data from healing arts licensees to inform policymakers about how many practitioners of particular specialties are providing services in any given area of the state, or about the demographic makeup of those practitioners.

The California Health Workforce Research and Data Center, previously established in 2007 as the Healthcare Workforce Clearinghouse under the prior Office of Statewide Health Planning and Development, serves as California's central source for collection, analysis, and reporting of information on the healthcare workforce employment and educational data trends for the state. As part of its statutory duties, HCAI is mandated to prepare an annual report to the Legislature that accomplishes the following three goals: (1) identifying education and employment trends in the health care professions (2) reporting on the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas; and (3) recommending state policy needed to address issues of workforce shortage and distribution.

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[6] https://ahea.assembly.ca.gov/media/1665

[7] Bogucki C, Brantley E, Salsberg E. "The Race and Ethnicity of the California Health Workforce." Fitzhugh Mullan Institute for Health Workforce Equity. Washington, DC: George Washington University, 2022.

In 2014, the Legislature enacted Assembly Bill 2102, authored by Assemblymember Phil Ting and co-sponsored by the California Pan-Ethnic Health Network and the Latino Coalition for a Healthy California. The bill required four specified healing arts boards—the Board of Registered Nursing, the Physician Assistant Board, the Respiratory Care Board of California, and the Board of Vocational Nursing and Psychiatric Technicians—to collect and report specific demographic data related to its licensees. Specifically, AB 2102 mandated that the four boards collect the following data from licensees: (1) location of practice, including city, county, and zip Code; (2) race or ethnicity; (3) gender; (4) languages spoken; (5) educational background and (6) classification of primary practice site, such as clinic, hospital, managed care organization, or private practice. In order to implement AB 2102, the DCA and HCAI established an interagency agreement to facilitate the specified data collection and exchange.

Assemblymember Ting subsequently introduced Assembly Bill 2704 in 2020, which sought to replace the distinct data collection requirements for the four healing arts boards with a single statute requiring data collection for all healing arts boards. The bill ultimately was not set for a hearing in this committee. The next year, Assemblymember Ting reintroduced the bill as Assembly Bill 1236, adding sexual orientation and disability status to the list of required data points. This bill passed this committee but the author ultimately decided to hold the bill on the Assembly floor.

Instead, language was included in the omnibus health trailer bill as part of the Budget Act of 2021 consolidating the existing workforce data collection requirements for the four healing arts boards into one section with an expanded list of data points. However, the trailer bill did not require this data to be collected by any additional boards under the DCA; instead, it provided that all other healing arts boards *request* the information. The trailer bill also expressly provided that licensees could not be required to provide the information as a condition for license renewal, and that they could not be disciplined for failing to provide the information.

This bill would amend the consolidated data collection law enacted through the trailer bill to require all healing arts boards to collect the workforce data and report it to HCAI. The author cites recommendations in a 2019 report by the California Future Health Workforce Commission, which included among its goals an objective to "expand and scale pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers." The author believes that providing HCAI with workforce data for all healing arts licensees will allow legislators and policymakers to more effectively evaluate the success of efforts to improve representation and diversity in the state's health care professions.

Current Related Legislation.

AB 2862 (Gipson) would require boards under the DCA to prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States. *This bill is pending in this committee.*

AB 2860 (Garcia) recasts and expands provisions of law relating to the Licensed Physicians and Dentists from Mexico Pilot Program. *This bill is pending in the Assembly Committee on Appropriations.*

SB 1067 (Smallwood-Cuevas) would require healing arts boards to expedite the licensure process for applicants who intend to practice in a medically underserved area. *This bill is pending in the Senate Committee on Appropriations.*

Prior Related Legislation.

AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) consolidated workforce data collection requirements and requires all healing arts boards to request, if not require, that data.

AB 1236 (Ting) of 2021 would have consolidated workforce data collection requirements and required all healing arts boards to collect that data. *This bill died on the inactive file of the Assembly Floor.*

AB 2704 (Ting) of 2020 would have consolidated workforce data collection requirements and required all healing arts boards to collect that data. *This bill was not set for a hearing in this committee.*

AB 2102 (Ting, Chapter 420, Statutes of 2014) required four specified healing arts boards to collect and report specific demographic data related to its licensees.

ARGUMENTS IN SUPPORT:

The **California Pan-Ethnic Health Network** supports this bill, writing: "HCAI administers several Loan Repayment Programs that offer financial support to health professionals who agree to provide direct patient care in medically underserved areas. However, California has recently faced major shortages of health workers, not producing enough new workers to meet future needs, and the current health workforce does not match the state's diversity. Reports have also found that Hispanic and Black workers are very underrepresented in the existing health workforce in California. AB 1991 would help support workforce supply and diversity problems to help improve the impacts on health access, quality, and equity in our most underserved communities."

The **Latino Coalition for a Healthy California** also supports this bill, writing: "We urge you to support AB 1991, as California faces major shortages of health workers, isn't producing enough new workers to meet future needs, and the current health workforce does not match the diversity of the state. These workforce supply and diversity problems have a major impact on health access, quality, and equity. Specifically, there are sixteen health care professional oversight boards that 'request' workforce data but do not require workforce data to be reported as condition as licensure. Without accurate information about the makeup of California's health workforce, it is difficult to assess whether or not programs designed to improve diversity and increase access to care in underserved areas are working as intended."

ARGUMENTS IN OPPOSITION:

None on file.

POLICY ISSUE(S) FOR CONSIDERATION:

This bill and current law provide that the workforce data is collected as part of the license renewal process, and this bill would confirm that licensees must report the information as part of their renewal application. However, the intent of the author is not for licensees to be denied renewal of their license simply because they declined to provide all the information required, some of which is arguably personal and sensitive. The author has therefore agreed to clarify that failure to provide the information is not on its own cause for a license renewal to be denied.

AMENDMENTS:

To ensure that licensees are not denied a license renewal simply because they did not provide all or part of the required workforce data, amend subdivision (f) in Section 1 of the bill as follows:

(f)(1) A licensee or registrant shall be required to provide the information listed in subdivision (b) as a condition for license or registration renewal.

(2) Notwithstanding paragraph (1), a board described in paragraph (2) of subdivision (a) shall not deny an application for license or registration renewal solely because the licensee or registrant failed to provide any of the information listed in subdivision (b).

REGISTERED SUPPORT:

California Pan-Ethnic Health Network
Latino Coalition for a Healthy California

REGISTERED OPPOSITION:

None on file.

Analysis Prepared by: Robert Sumner / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2051 (Bonta) – As Introduced February 1, 2024

SUBJECT: Psychology interjurisdictional compact.

SUMMARY: Codifies the Psychology Interjurisdictional Compact (PSYPACT) to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state lines for licensees who have authorization.

EXISTING LAW:

1) Establishes the Psychology Licensing Law, which provides for the state's licensure and regulation of psychologists. (Business and Professions Code (BPC) §§ 2900 *et seq.*)

2) Establishes the Board of Psychology (Board or BOP) within the Department of Consumer Affairs (DCA) for purposes of implementing and enforcing the Psychology Licensing Law. (BPC § 2920)

3) Specifies that no person may engage in the practice of psychology, or represent themselves to be a psychologist, without a license issued by the BOP. (BPC § 2903(a))

4) Defines the "practice of psychology" as rendering or offering to render to individuals, groups, organizations, or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations. (BPC §2903(a))

5) Defines "psychotherapy," for purposes of the Psychology Licensing Law, as the use of psychological methods in a professional relationship to assist a person or persons to acquire greater human effectiveness or to modify feelings, conditions, attitudes, and behaviors that are emotionally, intellectually, or socially ineffectual or maladaptive. (BPC § 2903(c))

6) Authorizes a licensed psychologist to use biofeedback instruments which do not pierce or cut the skin to measure physical and mental functioning. (BPC § 2903.1)

7) Specifies that the practice of psychology does not include prescribing drugs, performing surgery, or administering electroconvulsive therapy. (BPC § 2904)

8) Specifies that corporations are prohibited from having any professional rights, privileges, or powers, and are not permitted to practice psychology or limit the liability of a licensed psychologist. (BPC § 2907)

9) Authorizes a person who is licensed as a psychologist at the doctoral level in another state or territory of the United States or in Canada to offer psychological services in California for a period not to exceed 30 days in any calendar year. (BPC § 2912)

10) Requires an applicant for licensure to have earned a doctoral degree, as specified, from a college or institution of higher education that is accredited by a regional accrediting agency recognized by the United States Department of Education. (BPC § 2914(b))

11) Requires an applicant for licensure trained in an educational institute outside the United States or Canada to demonstrate to the satisfaction of the BOP that the applicant possesses an acceptable doctoral degree that is equivalent to a degree earned from a regionally accredited academic institution in the United States or Canada, as specified, or by the National Register of Health Service Psychologists, and any other documentation the board deems necessary. (BPC § 2914(b)(5))

12) Requires an applicant for licensure to have two years of supervised professional experience under the direction of a licensed psychologist or under suitable alternative supervision as determined by the BOP, at least one year of which must have occurred after the applicant was awarded the qualifying doctoral degree. (BPC § 2914(c))

13) Requires an applicant for licensure to take and pass a specified examination, unless otherwise exempted by the Board. Specifies that an applicant for licensure who has completed all academic coursework required for a doctoral degree, as documented by a written certification from the registrar of the applicant's educational institution or program, is eligible to take any and all examinations required for licensure. If a national licensing examination entity approved by the BOP imposes additional eligibility requirements beyond the completion of academic coursework, the BOP shall implement a process to verify that an applicant has satisfied those additional eligibility requirements. (BPC § 2914(d))

14) Requires an applicant for licensure to complete coursework or provide evidence of training in the detection and treatment of alcohol and other chemical substance dependency as well as in spousal or partner abuse assessment, detection, and intervention. (BPC §§ 2914.1 – 2914.2)

15) Requires the BOP to develop guidelines, as specified, for the basic education and training of psychologists whose practices include patients with medical conditions and patients with mental and emotional disorders, who may require psychopharmacological treatment and whose management may require collaboration with physicians and other licensed prescribers. (BPC § 2914.3(b))

16) Requires a licensed psychologist to complete 36 hours of approved continuing professional development, as specified, every two years as a condition of license renewal. (BPC § 2915)

17) Requires, effective January 1, 2020, an applicant for licensure as a psychologist to show, as part of the application, that they have completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention. Licensed psychologists, as a one-time requirement, must, prior to their next license renewal after January 1, 2020, or an applicant for reactivation or reinstatement to

an active license status, complete a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention (BPC § 2915.4)

18) Requires any applicant for licensure as a psychologist as a condition of licensure, to complete a minimum of six contact hours of coursework or applied experience in aging and long-term care, as specified. (BPC § 2915.5)

19) Specifies that confidential relations and communications between psychologist and client are privileged, as specified. (BPC § 2918)

20) Requires a licensed psychologist to retain a patient's health service records for a minimum of seven years from the patient's discharge date. If the patient is a minor, the patient's health service records shall be retained for a minimum of seven years from the date the patient reaches 18 years of age. (BPC § 2919)

21) Requires that protection of the public be the Board's highest priority in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (BPC § 2920.1)

22) Authorizes the Board to refuse to issue any registration or license, or may issue a registration or license with terms and conditions, or may suspend or revoke the registration or license of any registrant or licensee, as specified. (BPC §§ 2960 *et seq.*)

23) Specifies that any person who violates the Psychology Licensing Law is guilty of a misdemeanor punishable by imprisonment in the county jail not exceeding six months, or by a fine not exceeding two thousand dollars ($2,000), or by both. (BPC § 2970)

24) Requires a board under the DCA to expedite the initial licensure process for an applicant who has served as an active duty member of the Armed Forces of the United States and was honorably discharged. (BPC § 115.4)

25) Requires a board under the DCA to expedite the licensure process for an applicant who is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders; and who holds a current license in another state in the profession or vocation for which they are seeking a license from the board. (BPC § 115.5)

26) Requires the boards under the DCA to grant temporary licenses to applicants who are married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces and who holds a current, active, and unrestricted license in another state. (BPC § 115.6)

THIS BILL:

1) Codifies the entirety of the PSYPACT, including provisions that do all of the following:

a) Require compact states to do all of the following for a psychologist's home state license authorizes them to practice telepsychology in another compact state or temporarily practice psychology in-person in another compact state:

   i) Require the psychologist to hold an active E.Passport or Interjurisdictional Practice Certificate (IPC) issued by the Association of State and Provincial Psychology Boards (ASPPB), to practice telepsychology or temporarily practice psychology in-person, respectively;

   ii) Have a mechanism in place for receiving and investigating complaints about licensed individuals;

   iii) Notify the Psychology Interjurisdictional Compact Commission (Commission), as specified, of any adverse action (i.e. disciplinary action) or significant investigatory information regarding a licensed individual;

   iv) Require of all applicants at initial licensure an Identity History Summary, defined as a summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service, no later than 10 years after activation of the PSYPACT.

   v) Comply with the Commission's bylaws and rules.

b) Set forth requirements for a psychologist who is licensed in a compact state to practice telepsychology or temporarily practice psychology in-person in other compact states in which the psychologist is not licensed, and requires compact states to recognize the rights of psychologists who meet those requirements.

c) Provide that the PSYPACT shall come into effect on the date of which the PSYPACT is enacted into law by seven member states.

d) Specify that an out-of-state psychologist practicing telepsychology or psychology in-person temporarily as authorized under the PSYPACT is subject to the scope of practice in the state in which the psychologist is providing psychological services.

e) Require a psychologist's E.Passport or IPC to be revoked if the psychologist's license is restricted, suspended, or otherwise limited in their home state or if their Authority to Practice Interjurisdictional Telepsychology (APIT) or Temporary Authorization to Practice (TAP) is restricted, suspended, or otherwise limited.

f) Authorize a compact state to take adverse action on an out-of-state psychologist's APIT and/or TAP in that state.

g) Require state licensing authorities to investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee in another compact state as it would if such conduct had occurred in its own state. Additionally requires state licensing authorities to investigate and take appropriate action with respect to reported inappropriate conduct engaged in by an out-of-state psychologist as it would if such conduct had occurred by a licensee within their own state.

h) Authorize state licensing authorities to issue subpoenas for hearings and investigations that require the attendance and testimony of witnesses and the production of evidence, as well as issue cease and desist and/or injunctive relief orders to revoke an out-of-state psychologist's APIT and/or TAP.

i) Provide that the Commission must develop and maintain a Coordinate Licensure Information System and reporting system containing licensure and disciplinary action information on all psychologists to whom the Compact is applicable.

j) Require compact states to provide specified information about licensees.

k) Provide for the establishment of a joint public agency known as the Psychology Interjurisdictional Compact Commission, consisting of one voting representative appointed by each compact state.

l) Authorize the Commission to, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct, as specified.

m) Authorize the Commission to levy on and collect an annual assessment from each Compact state or impose fees on other parties to cover the cost of the Commission's operations and activities, and its staff.

n) Require the Executive, Legislative, and Judicial branches of state government in each compact state to enforce the compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent.

2) Requires BOP to comply with the requirements of the PSYPACT.

3) Prohibits a person from engaging in the practice of psychology without a license from the BOP or a privilege to practice under the PSYPACT.

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

COMMENTS:

Purpose. This bill is co-sponsored by the **Steinberg Institute** and **Mental Health America, CA**. According to the author:

> Mental illness affects nearly one in six Californians, yet according to a 2018 poll, 57% of Californians surveyed reported that they have been unable to access needed mental health services. On top of the existing shortage of mental health professionals, California faces an 11% decline in psychologists in the next four years due to retirement. We must act now to increase patient access to psychological services. By joining the Psychology Interjurisdictional Compact (PSYPACT), Californians will gain access to more psychologists. Moreover, through PSYPACT, Californians who relocate temporarily, move, or frequently travel out of state, like college students, can seamlessly continue their care with their provider using telehealth, ensuring uninterrupted access to mental health services across the lifespan.

Background.

Board of Psychology. The BOP is the state licensing entity responsible for licensing and regulating psychologists in California. Its mission is to "protect consumers of psychological services by licensing psychologists, regulating the practice of psychology, and supporting the evolution of the profession."[1] The BOP has authority to take disciplinary action against licensees who violate the Psychology Licensing Law, the laws and regulations governing the practice of psychology in California. At its disposal are an escalating scale of penalties ranging from citations and fines to formal disciplinary action to suspend or revoke a license. The board is self-funded through license, application, and examination fees, and receives no General Fund revenue.

Applicants for a Psychologist license must have a qualifying doctorate degree from a college or institution of higher education that is accredited by a regional accrediting agency recognized by the United States Department of Education, complete a minimum of 3,000 hours of supervised professional experience, half of which must be accrued post-doctorally, and pass both a national examination and a California law and ethics examination. Licensees are also required to complete more than 36 hours of continuing professional development every two years as a condition of license renewal. During the Board's 2021 Sunset Review, the Board reported that in Fiscal Year (FY) 2018/19 (the most recent FY for which data was provided), there were 18,719 actively licensed psychologists in California. At the time, the BOP reported that based on data as of August 29, 2019, it took about 25 days to review initial applications for a psychologist license and notify the applicant of application deficiencies or next steps.

Interstate Licensing Compacts. An interstate licensing compact represents a legally binding agreement between multiple states to facilitate cross-state practice for licensed professionals without requiring them to obtain full licensure in each participating state. To participate in such a compact, a state must adopt model statutory language provided by a compact organization. Typically, a practitioner must already hold a license in their home state before seeking authorization to practice in a compact member state. California currently does not participate in any licensing compacts related to the healing arts professions.

The Psychology Interjurisdictional Compact. The PSYPACT is an interstate compact designed to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state boundaries.[2] To date, 41 states have joined the PSYPACT. Each state may appoint one voting member to sit on the PSYPACT Commission, the governing body of the PSYPACT. The PSYPACT Commission is responsible for establishing the bylaws, rules, and regulations that govern the interstate practice of psychology. The PSYPACT Commission is also responsible for granting psychologists the authority to practice psychology in every Compact. To be eligible for an APIT or for a TAP, psychologists must be licensed in a PSYPACT state, have an unrestricted license with no history of disciplinary action taken against their license, and obtain an E.Passport Certificate or Interjurisdictional Practice Certificate (IPC) from the ASPPB. Psychologists must also pay application and renewal fees. Psychologists are subject to the laws and regulations in the state in which they are practicing telepsychology or temporary in-person psychological services. A psychologist's APIT or TAP may be revoked by a PSYPACT state if

[1] 2021 Updated Sunset Report and Board Actions and Responses to COVID-19 (ca.gov)
[2] About Us - Psychology Interjurisdictional Compact (PSYPACT)

found to have violated the laws and regulations governing the practice of psychology in that state. Forty-two states have joined the PSYPACT and a handful of others are considering joining.

The author's office report that there are approximately 11,000 psychologists who participate in the PSYPACT. That number has the potential to double—to the benefit of other PSYPACT states—if California were to join. This bill would enact the PSYPACT thereby allowing out-of-state psychologists to provide telepsychology to Californians and temporarily provide services in-person in this state.[3] According to the author and sponsors of this bill, California's membership in the PSYPACT will help address the shortage of behavioral health providers affecting the state. A workforce needs study by the Steinberg Institute, one of the co-sponsors of this measure, found that California needs to add more than 370,000 behavioral health professionals, including more than 16,000 psychologists, specifically, by 2030 to meet need.[4]

Current Related Legislation.

AB 2566 (Wilson) would enact the Interstate Counseling Compact to facilitate interstate practice of licensed professional counselors. *AB 2566 is pending in this committee.*

AB 1328 (Gipson) would enact the Cosmetology Licensure Compact to facilitate California's participation in a multistate licensing program whereby cosmetologists can receive reciprocity to practice in other states that have adopted the Cosmetology Licensure Compact and vice versa. *AB 1328 is pending in the Senate Business, Professions, and Economic Development Committee.*

AB 3232 (Dahle) would enact the Nurse Licensure program, under which the Board of Registered Nursing and the Board of Vocational Nursing and Psychiatric Technicians would be authorized to issue a multistate license to practice in all party states. *AB 3232 is pending in this committee.*

ARGUMENTS IN SUPPORT:

As co-sponsors of this bill, the **Steinberg Institute** and **Mental Health America of California** write in support:

> Occupational licensure compacts are one way that we can address the behavioral health workforce shortage and get Californians the care they need now. Through licensure compacts, states establish and agree upon uniform standards that enable multi-state practice. There are currently 15 Occupational Licensure Compacts recognized by the National Center for Interstate Compacts. Occupational licensure compacts are one way that we can address the behavioral health workforce shortage and get Californians the care they need now. Through licensure compacts, states establish and agree upon uniform standards that enable multi-state practice. There are currently 15 Occupational Licensure Compacts recognized by the National Center for Interstate Compacts. PSYPACT, the occupational licensure compact for psychologists, was created by the Association of State and Provincial Psychology Boards (ASSPB) in 2014. To date, 40 states have enacted

[3] BPC § 2912 currently allows out-of-state psychologists who have a doctorate to practice in California for up to 30 days per calendar year.
[4] *Estimating Our Behavioral Health Workforce Needs: Initial Findings from New Tool*, Steinberg Institute. February 26, 2024.

PSYPACT legislation, joining the compact. By providing a means for psychologists to practice across state lines, PSYPACT increases access to care and allows for continuity of care when patients or providers relocate or travel. Because all compact states enact the same model legislation, PSYPACT promotes cooperation between states and provides a means for telepsychology regulation and consumer protection. California can't afford not to join PSYPACT. We must use all tools at our disposal to address our behavioral health workforce shortage and ensure clients have continuity of care.

ARGUMENTS IN OPPOSITION:

The **Board of Psychology** raises in its opposition letter numerous concerns related to consumer protection, need for the bill, cost and workload, and equity, and writes, in part, the following:

The Board has concerns with [this bill], including the promulgation of rules and laws by PSYPACT's Commission which would have the force of law in California. This delegation of substantial authority to a non-governmental entity located in another jurisdiction and dominated in large part by smaller states many of which do not share some of the contemporary core values of California is problematic. It vests in this nongovernmental entity the authority to promulgate regulations that would affect the Board, California licensees, and California consumers. For instance, many of the nonresident psychologists who practice telehealth with California consumers will not be from jurisdictions that share the same requirements for continuing professional development in social justice and diversity, equity, and inclusion like California licensees, thereby subjecting California consumers to potential harm. Further, some of the states in which out of state practitioners reside still allow practices such as conversion therapy for LGBTQ+ children and adolescents or mandatory counseling for women seeking to terminate an unwanted pregnancy.

POLICY ISSUE(S) FOR CONSIDERATION:

Sufficiency of Existing Laws. While one of the potential benefits of joining a state licensing compact is to expedite licensure for active duty service members of the United States Armed Forces and military spouses, the federal Servicemembers Civil Relief Act already authorizes service members or their spouses who currently hold a valid license in good standing in another state to practice in California within the same profession or vocation, if they are required to relocate to California because of military orders.[5] Additionally, the BOP expedites the licensure process for military veterans who were honorably discharged, as well as domestic partners of active duty servicemembers.[6]

Another understood benefit of joining the PSYPACT is that qualifying out-of-state psychologists would be able to practice psychology in other PSYPACT states temporarily for up to 30 days, which may be useful to psychologists who are traveling or have patients in a neighboring state. However, BPC § 2912 already allows out-of-state psychologists who have a doctorate to practice in California for a period not to exceed 30 days per calendar year.

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[5] Federal Professional License Portability and State Registration - California Department of Consumer Affairs
[6] Information for Military (Former and Active) and Military Spouse/Partner Applicants and Licensees - California Board of Psychology

Delegation of Authority. By joining PSYPACT, California would be delegating all authority to a multistate commission to determine and enforce licensing requirements for out-of-state psychologists to provide psychology services to Californians. Moreover, with just one voting member on the PSYPACT Commission—equal to all other PSYPACT states—California's representation would be vastly disproportionate to the number of licensees California would contribute to the compact. By a simple majority vote, the PSYPACT Commission would have the ability to make decisions at odds with California's position.

Fairness. Psychologists licensed by the BOP are required to obtain a qualifying doctorate degree from a college or institution of higher education that is accredited by a regional accrediting agency recognized by the United States Department of Education, complete a minimum of 3,000 hours of supervised professional experience, half of which must be accrued post-doctorally, and pass both a national examination and a California law and ethics examination. In addition, California psychologists are required to complete 36 hours of continuing education every two years. According to data shared by the author's office, slightly more than one third of states require fewer hours of supervised professional experience and nearly half of PSYPACT states require fewer hours of continuing education. However, under the terms of PSYPACT, those out-of-state psychologists whose qualifications are less than what this state has deemed appropriate and necessary for licensure would have the same ability to practice telepsychology in California.

Consumer Protection. Considering the varying the licensing requirements for out-of-state psychologists, joining PSYPACT could make Californians susceptible to consumer harm, although the author's office reports that there is not a history of complaints made against out-of-state psychologists practicing in another PSYPACT state. While California psychologists are required to pass a California-specific law and ethics exam, the BOP would not have any authority to require out-of-state psychologists with either an APIT or TAP to do the same. As such, while PSYPACT requires participating psychologists to abide by the laws of the remote state (wherever the patient is), there's still the potential for consumer harm considering out-of-state psychologists may not be aware of or understand CA's laws and regulations pertaining to the practice of psychology. Because California is unable to modify any provision of the PSYPACT, the state cannot require out-of-state psychologists to take specific qualifying coursework or continuing education, or pass a California-specific law and ethics exam prior to seeing California patients.

IMPLEMENTATION ISSUES:

Equity for California Licensees. While obtaining a doctoral degree from an institution of higher education that is accredited by the American Psychological Association is necessary for an E.Passport issued by the ASPPB, and therefore a requirement to participate in the PSYPACT,[7] there is no such requirement for licensure in California. Consequently, if California were to join PSYPACT, more than a third of psychologists licensed by the BOP could not participate in PSYPACT. Additionally, applicants for an APIT or TAP are required to provide their social security number (SSN). Applicants for licensure in California may provide a SSN or an Individual Taxpayer Identification Number.[8] California-licensed psychologists who do not have a SSN may be excluded from participating in the compact despite being otherwise qualified.

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[7] APA Accredited Programs - The Association of State and Provincial Psychology Boards (asppb.net)
[8] Application for Licensure as a Psychologist

Cost. The PSYPACT Commission is authorized to collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of its operations, activities, and staff. According to the author's office the annual assessment is capped at $6,000. However, it is unclear from where that money would come if California were to join the PSYPACT as the BOP is fully supported by application, exam, and licensing fees. Additionally, if such a fee were to be determined by the number of psychologists participating in the PSYPACT from each member state, California could potentially be required to pay a much higher assessment.

BOP Workload. As a PSYPACT state, the BOP would be required to investigate reports of inappropriate conduct by an out-of-state psychologist and take appropriate action as they would if such conduct occurred by one of its own licensees. Additionally, the BOP would be responsible for investing and taking action against California psychologists practicing in other PSYPACT states. Because the BOP would not be permitted to charge a fee from out-of-state psychologists, there is no reimbursement for the Board's added workload. Without adequate resources, the Board may be limited in its enforcement capability—to the detriment of California patients.

Ease of Leaving the PSYPACT. In the same way that legislation is required to join the PSYPACT, so too is legislation required to leave the PSYPACT. In the event that California joined and subsequently wanted to leave the PSYPACT, doing so would be subject to affirmative action on behalf of the Legislature.

AMENDMENTS:

Considering the policy and implementation concerns above, the author has agreed to amend to bill to make its enactment contingent upon approval by the BOP.

REGISTERED SUPPORT:

Steinberg Institute (Co-sponsor)
Mental Health America of California (Co-sponsor)
ATA Action
California Association of Social Rehabilitation Agencies
California Health Coalition Advocacy
California Youth Empowerment Network
Depression and Bipolar Support Alliance California
Rural County Representatives of California
One individual

REGISTERED OPPOSITION:

California Board of Psychology
Two individuals
Five individuals (Unless amended)

Analysis Prepared by: Kaitlin Curry / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2115 (Haney) – As Amended April 1, 2024

SUBJECT: Controlled substances: clinics.

SUMMARY: Authorizes a clinic to dispense methadone to relieve acute withdrawal symptoms when necessary while arranging for a referral to a narcotic treatment program and eases restrictions on participation in narcotic treatment programs.

EXISTING LAW:

1) Defines "dispense" as the furnishing of drugs or devices upon a prescription from a physician, nurse practitioner, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor acting within the scope of their practice. (Business and Professions Code (BPC) § 4024)

2) Defines "controlled substance" as any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code. (BPC § 4021)

3) Classifies methadone as a Schedule II controlled substance. (Health and Safety Code (HSC) § 11055(c)(14)-(15))

4) Authorizes methadone and other specified medications to be used for narcotic replacement therapy and medication-assisted treatment by licensed narcotic treatment programs. (HSC § 11839.2)

5) Requires the State Department of Health Care Services (DHCS or Department) to license narcotic treatment programs to use narcotic replacement therapy in the treatment of addicted persons whose addiction was acquired or supported by the use of a narcotic drug or drugs, not in compliance with a physician and surgeon's legal prescription. (HSC § 11839.3)

6) Defines "community clinic" as a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions that may be in the form of money, goods, or services. In a community clinic, any charges to the patient shall be based on the patient's ability to pay, utilizing a sliding fee scale. (HSC § 1204(a)(1)(A))

7) Defines "free clinic" to mean a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. In a free clinic there shall be no charges directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished. (HSC § 1204(a)(1)(B))

8) Authorizes the following clinics to purchase drugs at wholesale for administration or dispensing, under the direction of a physician and surgeon, to patients registered for care at the clinic: licensed nonprofit community clinic or free clinic; primary care clinic owned or operated by a county; a clinic operated by a federally recognized Indian tribe or tribal

organization; a clinic operated by a primary care community of free clinic that is operated on separate premises from a licensed clinic; a student health center operated by a public institution of higher education; and a nonprofit multispecialty clinic. (BPC § 4180(a)(1))

9) Requires each clinic to keep records of the kind and amounts of drugs purchased, administered, and dispensed. Records must be available and maintained for a minimum of three years for inspection by all specified personnel. (BPC § 4180(a)(2))

10) Requires each clinic location to be licensed and requires clinics to notify the BOP of address changes. (BPC § 4180(b))

11) As a condition of licensure, required each clinic to comply with all applicable laws and regulations of the CDPH relating to the drug distribution service to ensure that inventories, security procedures, training, protocol development, recordkeeping, packaging, labeling, dispensing, and patient consultation occur in a manner that is consistent with the promotion and protection of the health and safety of the public. (BPC § 4181(a))

12) Specifies that the dispensing of drugs in a clinic can only be done by a physician, pharmacist, or other person lawfully authorized to dispense drugs, and only in compliance with all applicable laws and regulations. (BPC § 4181(b))

13) Requires clinics to retain a consulting pharmacist to approve policies and procedures and to certify in writing quarterly that the clinic is, or is not, operating in compliance with the requirements of the Pharmacy Law. (BPC § 4192)

14) Prohibits a Schedule II controlled substance from being dispensed by a clinic, although a physician may dispense a schedule II drug to the extent permitted by law. (BPC § 4184)

STATE REGULATIONS:

1) Requires the medical director of a narcotic treatment program to conduct a medical evaluation, as specified, or document their review and concurrence of a medical evaluation conducted by the physician extender before admitting an applicant to detoxification or maintenance treatment. (California Code of Regulations (CCR) § 10270(a))

2) Requires applicants to have a confirmed documented history of at least one year of addiction to opioids to be accepted as patients for maintenance treatment. (CCR § 10270(d)(1))

3) Require the primary counselor at a narcotic treatment program to, upon completion of the initial treatment plan, arrange for the patient to receive a minimum of fifty minutes of counseling services per calendar month. (CCR § 10345(a))

4) Authorizes the medical director to adjust or waive any time after admission, by medical order, the minimum number of minutes of counseling services per calendar month, and shall document the rationale for the medical order to adjust or waive counseling services in the patient's treatment plan. (CCR § 10345(e))

5) Requires the primary counselor at a narcotic treatment program to evaluate and update the patient's maintenance treatment plan whenever necessary or at least once every three months from the date of admission. (CCR § 10305(f))

6) Specifies that a patient's first-day dose of methadone cannot exceed 30 milligrams unless the dose is divided and the initial portion of the dose is 30 milligrams or less and the subsequent portion is administered to the patient separately after a period of observation as prescribed by the medical director or program physician. (CCR § 10355(d)(1))

7) Specifies that the total dose of methadone for the first day shall not exceed 40 milligrams unless the medical director or program physician determines that 40 milligrams is not sufficient to suppress the patient's opioid abstinence symptoms, and documents in the patient's record the basis for his/her determination. (CCR § 10355(d)(2))

8) Specifies that methadone may only be provided to a patient as take-home medication if the medical director or program physician has determined, in their clinical judgment, that the patient is responsible in handling narcotic medications, is adhering to program requirements, and has documented their rationale in the patient's record. Their rationale must be based on consideration of the following criteria:

    a. Absence of use of illicit drugs and abuse of other substances, including alcohol;

    b. Regularity of program attendance for replacement narcotic therapy and counseling services;

    c. Absence of serious behavioral problems while at the program;

    d. Absence of known criminal activity, including the selling or distributing of illicit drugs;

    e. Stability of the patient's home environment and social relationships;

    f. Length of time in maintenance treatment;

    g. Assurance that take-home medication can be safely stored within the patient's home; and

    h. Whether the rehabilitative benefit to the patient derived from decreasing the frequency of program attendance outweighs the potential risks of diversion. (CCR § 10370(a))

9) Requires narcotic treatment programs to adhere to the following methadone take-home medication schedules:

    a. Step I Level - Day 1 through 90 of continuous maintenance treatment, the medical director or program physician may grant the patient a single dose of take-home supply of medication per week. The patient must attend the program at least six times per week for observed ingestion.

    b. Step II Level - Day 91 through 180 of continuous maintenance treatment, the medical director or program physician may grant the patient not more than a two-day take-home supply of medication per week. The patient must attend the program at least five times per week for observed ingestion.

c. Step III Level - Day 181 through 270 of continuous maintenance treatment, the medical director or program physician may grant the patient not more than a three-day take-home supply of medication per week. The patient must attend the program at least four times per week for observed ingestion.

d. Step IV Level - Day 271 through one year of continuous treatment, the medical director or program physician may grant the patient not more than a six-day take-home supply of medication per week. The patient must attend the program at least one time per week for observed ingestion.

e. Step V Level - After one year of continuous treatment, the medical director or program physician may grant the patient not more than a two-week supply of medication. The patient must attend the program at least two times per month for observed ingestion.

f. Step VI Level - After two years of continuous treatment, the medical director or program physician may grant the patient not more than a one-month take-home supply of medication. The patient must attend the program at least one time per month for observed ingestion. (CCR § 10375(a))

10) Requires the medical director or program physician to restrict a patient's take-home medication privileges by moving the patient back at least one step level on the take-home medication schedule for any of the following reasons:

a. Patients on step level schedules I through V who have submitted at least two consecutive monthly body specimens which have tested positive for illicit drugs and/or negative for the narcotic medication administered or dispensed by the program, unless the program physician invalidates the accuracy of the test results.

b. Patients on step level schedule VI who have submitted at least two monthly body specimens within the last four consecutive months which have tested positive for illicit drugs and/or negative for the narcotic medication administered or dispensed by the program, unless the program physician invalidates the accuracy of the test results.

c. Patients, after receiving a supply of take-home medication, are inexcusably absent from or miss a scheduled appointment with the program without authorization from the program staff.

d. The patient is no longer a suitable candidate for take-home medication privileges as presently scheduled, based on consideration of specified criteria. (CCR § 10390(a)(1))

11) Specifies that is a patient in maintenance treatment misses appointments for two weeks or more without notifying the program, the patient's treatment must be terminated by the medical director or program physician and the discharge must be noted in the patient's record. If the discharged patient returns for care and is accepted into the program, the patient must be readmitted as a new patient and documentation for the new readmission must be noted in the patient's record. (CCR § 10300(b))

FEDERAL REGULATIONS:

1) Authorizes a practitioner who is registered with the DEA as a narcotic treatment program and is in compliance with DEA regulations regarding treatment qualifications, security, records, and unsupervised use of narcotic drugs to administer and dispense (but not prescribe) a narcotic drug listed in any schedule to a narcotic dependent person for the purpose of maintenance or detoxification treatment. (Code of Federal Regulations (CFR) § 1306.07(a))

2) Authorizes a practitioner who is not registered with the DEA to conduct a narcotic treatment program to dispense (but not prescribe) narcotic drugs, in accordance with applicable Federal, State, and local laws related to controlled substances, to a person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both). (CFR § 1306.07(b))

3) Prohibits more than a three-day supply of narcotic drug medication from being dispensed while arrangements are being made for referral for treatment, and prohibits such emergency treatment from being renewed or extended. (CFR § 1306.07(b))

4) Authorizes a practitioner to administer or dispense (including prescribe) any Schedule III, IV, or V narcotic drug approved by the Food and Drug Administration specifically for use in maintenance or detoxification treatment to a narcotic dependent person if the practitioner complies with specified requirements. (CFR § 1306.07(d))

5) Require opioid treatment programs (OTP) to maintain current procedures designed to ensure that patients are admitted to treatment by qualified personnel who have determined, using accepted medical criteria, that the person meets diagnostic criteria for a moderate to severe OUD; the individual has an active moderate to severe opioid use disorder (OUD), or OUD in remission, or is at high risk for recurrence or overdose. (FCR § 8.12(e)(1))

6) Requires an OTP to require each patient to undergo an initial medical exam comprised of a screening examination to ensure that the patient meets criteria for admission and that there are no contraindications to treatment with medications for OUD (MOUD) and a full history and examination, to determine the patient's broader health status, with lab testing as determined to be required by an appropriately licensed practitioner. Specifies that a patient's refusal to undergo lab testing for co-occurring physical health conditions should not preclude them from access to treatment, provided such refusal does not have potential to negatively impact treatment with medications. (CFR § 8.12(f)(2)(i))

7) Require the screening examination and full examination to be completed by an appropriately licensed practitioner. If the practitioner is not an OTP practitioner, the screening examination must be completed no more than seven days prior to OTP admission. Where the examination is performed outside of the OTP, the written results and narrative of the examination, as well as available lab testing results, must be transmitted, consistent with applicable privacy laws, to the OTP, and verified by an OTP practitioner. (CFR § 8.12(f)(2)(ii))

8) Specify that a full in-person physical examination, including the results of serology and other tests that are considered to be clinically appropriate, must be completed within 14 calendar days following a patient's admission to the OTP. The full exam can be completed by a non-OTP practitioner, if the exam is verified by a licensed OTP practitioner as being true and accurate and transmitted in accordance with applicable privacy laws. (CFR § 8.12(f)(2)(iii))

9) Requires a patient's care plan to be reviewed and updated to reflect responses to treatment and recovery support services, and adjustments made that reflect changes in the context of the person's life, their current needs for and interests in medical, psychiatric, social, and psychological services, and current needs for and interests in education, vocational training, and employment services. (CFR § 8.12(f)(4)(i))

10) Specify that patient refusal of counseling cannot not preclude them from receiving MOUD. (CFR § 8.12(f)(5)(i))

11) Requires the initial dose of methadone for each new patient enrolled in an OTP to be individually determined and requires the following to be considered: the type(s) of opioid(s) involved in the patient's OUD, other medications or substances being taken, medical history, and severity of opioid withdrawal. The total dose for the first day should not exceed 50 milligrams unless the OTP practitioner finds sufficient medical rationale, including but not limited to if the patient is transferring from another OTP on a higher dose that has been verified, and documents in the patient's record that a higher dose was clinically indicated. (CFR § 8.12(h)(3)(ii))

12) Specify that OTP decisions on dispensing MOUD to patients for unsupervised use must be determined by an appropriately licensed OTP medical practitioner or the medical director. In determining which patients may receive unsupervised medication doses, the medical director or program medical practitioner must consider, among other pertinent factors that indicate that the therapeutic benefits of unsupervised doses outweigh the risks, the following criteria:

    a. Absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose, or the ability to function safely;

    b. Regularity of attendance for supervised medication administration;

    c. Absence of serious behavioral problems that endanger the patient, the public or others;

    d. Absence of known recent diversion activity;

    e. Whether take-home medication can be safely transported and stored; and

    f. Any other criteria that the medical director or medical practitioner considers relevant to the patient's safety and the public's health. (CFR § 8.12(i)(2))

13) Authorize during the first 14 days of treatment, the take-home supply of methadone to be limited to 7 days. From 15 days of treatment, the take-home supply is limited to 14 days. From 31 days of treatment, the take-home supply provided to a patient is not to exceed 28 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up and the rationale underlying the decision to provide unsupervised doses of methadone must be documented in the patient's clinical record. (CFR § 8.12(i)(3))

THIS BILL:

1) Specifies that a clinic may dispense a Schedule II controlled substance if the substance being dispensed is a narcotic drug for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment consistent with federal regulations.

2) Subjects a clinic that is dispensing a Schedule II controlled substance to specified labeling, recordkeeping, and packaging requirements.

3) Authorizes a medical evaluation of a patient prior to admittance to a detoxification or maintenance treatment to be conducted by any health care provider, if it is verified by a narcotic treatment program practitioner as true and accurate and it is transmitted in accordance with all applicable privacy laws.

4) Permits a narcotic treatment program to authorize a patient to decline laboratory testing for disease or to complete that testing within two weeks of the date of admittance to the program.

5) Prohibits a narcotic treatment program from imposing additional requirements on a patient who is pregnant.

6) Prohibits a narcotic treatment program from denying a patient maintenance treatment due to the length of time a person has been addicted to opiates.

7) Specifies that a patient receiving maintenance treatment is not precluded from receiving medication for opiate use disorder by refusing to participate in counseling services.

8) Requires a narcotic treatment program practitioner to update a patient's treatment plan annually.

9) Specifies that the initial dose of methadone provided to a patient in a narcotic treatment program cannot exceed 50 milligrams unless the practitioner finds sufficient medical rationale that a higher dose is clinically indicated, and requires the practitioner to document that rationale in the patient's records.

10) Authorizes a medical practitioner to determine whether to dispense take-home doses of narcotic replacement therapy medications, and requires the medical practitioner to consider, among other pertinent factors, all of the following criteria:

    a) The absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose, or the ability to function safely.

    b) The regularity of attendance for supervised medication administration.

    c) The absence of serious behavioral problems that endanger the patient, the public, or others.

    d) The absence of known recent diversion activity.

    e) Whether take-home medication can be safely transported and stored.

f) Any other criteria that the medical director or medical practitioner considers relevant to the patient's safety and the public's health.

11) Prohibits a decision to dispense take-home medication from being made contingent on the length of time a patient has participated in treatment. A patient eligible for take-home medication may receive up to a seven-day take-home supply of medication. After 15 days of treatment, a patient may receive up to a two-week take-home supply of medication, and after 31 days in treatment may receive a 28-day take-home supply of medication.

12) Specifies that a medical practitioner is not required to restrict a patient's take-home medication privileges if that patient's monthly bodily specimen has tested positive for illicit drugs in two consecutive months, and that a practitioner is not required to impose any requirement that the patient's monthly bodily specimen test negative for illicit drugs for any specified period of time as a condition of restoring a patient's take-home medication privileges.

13) Allows a patient to be absent from a maintenance treatment program for up to 30 days, without contacting the program.

14) Requires the DHCS to review existing regulations and remove outdated, stigmatizing language and obsolete references.

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

COMMENTS:

Purpose. The bill is sponsored by the **San Francisco Department of Public Health**. According to the author:

> We need to dismantle the barriers to methadone access, such as the regulatory restrictions, negative stigma, and a lack of understanding by the public. Untreated drug addiction has been the most devastating and deadly epidemic and ensuring that individuals suffering from opioid addiction have easy access to methadone treatment is essential in reducing the rates of overdose deaths. By fostering a more supportive environment, we can encourage those struggling with addiction to seek help without fear of judgment. We need to normalize and prioritize this effective treatment option, breaking down the barriers that prevent so many from receiving the help they desperately need. [This bill] will transform California from a state with the most restrictive methadone laws into a state that leads in accessibility for methadone treatment by providing the most meaningful update of California's methadone laws in over a decade, and bring us in line with federal methadone standards.

Background.

Overview of the Opioid Crisis. Opioids are a class of drugs prescribed and administered by health professionals to manage pain. The term "opioid" is commonly used to describe both naturally occurring opiates derived from the opium poppy as well as their manufactured synthetics. Common examples of prescription opioids include oxycodone (OxyContin, Percocet); hydrocodone (Vicodin, Norco, Lorcet); codeine; and morphine. Heroin is also an opioid, but is ineligible for lawful prescription in the United States.

In addition to providing pain relief, opioids can be used as a cough suppressant, an antidiarrheal, a method of sedation, and a treatment for shortness of breath. The majority of pharmaceutical opioids are Schedule II drugs under the federal Controlled Substances Act, considered by the federal Drug Enforcement Administration (DEA) to have a high potential for abuse that may lead to severe psychological or physical dependence. However, combination drugs containing lower doses of opioids combined with other active ingredients are typically less restricted; for example, cough syrups containing low doses of codeine are frequently classified Schedule V medications.

In October of 2017, the White House declared the opioid crisis a national public health emergency, formally recognizing what had long been understood to be a growing epidemic responsible for devastation in communities across the country. According to the Centers for Disease Control and Prevention (CDC), as many as 50,000 Americans died of an opioid overdose in 2016, representing a 28 percent increase over the previous year. The California Department of Public Health estimated that nearly 2,000 Californians died of an opioid overdose in 2016.

The nature of the country's opioid crisis has evolved over the past several years as illicitly manufactured fentanyl has replaced prescribed pain management medication as the dominant source of opioid-related overdoses. Fentanyl is a synthetic opioid that is up to 100 times stronger than morphine. Fentanyl is often pressed into pills to imitate more common (and less potent) pharmaceutical products, and other drugs can be unknowingly "laced" with fentanyl. Over 70,000 Americans died of a fentanyl overdose in 2021, including 5,961 deaths in California – approximately 83% of all opioid-related deaths in California.

The abuse of prescription drugs was historically viewed as a criminal concern analogous to street narcotics cases regularly investigated by law enforcement. In recent years, however, an expert consensus has evolved around the opinion that the opioid crisis must be addressed through the lens of public health policy. It is widely accepted that health professionals must continue to play a critical role in any meaningful solutions through safe-prescribing and the medication-assisted treatment of opioid use disorder.

Methadone. Methadone is an opioid medication that is used to treat OUD in conjunction with behavioral health therapies.[1] It reduces opioid cravings and withdrawal and limits the effects opioids. As a full opioid agonist, methadone works by activating opioid receptors in the brain, though its effects are slower and long-lasting, preventing the same euphoric effect associated with other opioids. Nonetheless, while methadone is generally safe and effective when taken as prescribed, it can be misused and overdose and death are possible. As a Schedule II drug, methadone is highly regulated. Methadone is frequently marketed under the brand names Dolophine and Methadose, among others.

Three-Day Rule. The federal Easy Medication Access and Treatment for Opioid Addiction Act, as incorporated into a short-term funding bill signed on December 11, 2020, directs the DEA to its regulations "so that practitioners . . . are allowed to dispense not more than a three-day supply of narcotic drugs to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both)." Accordingly, the DEA expanded and revised this regulation in August 2023 to allow non-physician practitioners to prescribe narcotic drugs under the "Three Day Rule" or the "72-Hour Rule."

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[1] Methadone | SAMHSA

The Three Day Rule for methadone dispensing by physicians regulates the frequency at which methadone can be dispensed to patients in opioid addiction treatment programs. According to this rule, physicians are allowed to dispense up to a 72-hour supply of methadone to patients who are stable in their treatment. This means that patients who have been consistently adherent to their treatment plan and have shown progress in their recovery may receive a three-day supply of methadone at a time, rather than needing to visit the clinic daily for their dose. Certain criteria must be met for a patient to qualify for extended take-home doses, such as negative drug screens and compliance with program requirements.

The primary goal of the Three Day Rule is to increase flexibility and convenience for patients in methadone treatment programs while ensuring the safe and effective management of their addiction. Allowing for dispensing of methadone by clinics to alleviate acute withdrawal symptoms, coupled with arrangements for referral to narcotic treatment programs and the relaxation of participation restrictions, draws on the principles of harm reduction and patient-centered care. By allowing clinics to dispense methadone for symptom relief, individuals in distress can access immediate support, potentially reducing the likelihood of relapse and overdose deaths. This approach emphasizes the importance of mitigating harm associated with opioid use while respecting individual autonomy and dignity.

This bill would allow patients in California to take full advantage of the Three Day Rule by authorizing nonprofit or free clinics to dispense methadone to relieve acute withdrawal symptoms while arrangements are being made for referral for treatment. The clinic would be required to comply with specified labeling recordkeeping, and packaging requirements, including the use of childproof containers. The author believes this authority will improve health outcomes for patients in need of treatment and improve the likelihood of linkage to a treatment program.

Opioid Treatment Program Regulations. Federal regulations on opioid treatment programs (OTPs), which include those that dispense methadone, are governed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the DEA. These regulations are designed to ensure the safe and effective provision of medication-assisted treatment (MAT) for individuals with opioid use disorder. OTPs must adhere to stringent federal requirements regarding program operations, patient care, staff qualifications, and security measures to prevent diversion and misuse of controlled substances like methadone.

Recent changes in federal regulations have focused on enhancing access to MAT and reducing barriers to treatment. One significant change includes the expansion of telehealth services for OTPs, allowing patients to receive counseling and medication management remotely, particularly beneficial during the COVID-19 pandemic. Additionally, there has been an emphasis on increasing flexibility in take-home medication doses, as demonstrated by the implementation of the 72-hour rule for methadone dispensing. These changes aim to improve treatment retention, reduce the burden on patients, and promote better outcomes in opioid addiction treatment programs, while maintaining stringent oversight to ensure the safety and effectiveness of MAT.

This bill includes provisions aimed at aligning state requirements with and the flexibility now allowed under federal law. For example, state law requires that the medical director of a treatment program "conduct a medical evaluation" of the patient, whereas the recently revised federal regulations allow for the examination to be completed by a non-OTP practitioner if verified as true and accurate by an OTP practitioner. This bill would update California law to make this and similar adjustments to California law to align with the relaxed federal regulations.

Current Related Legislation.

SB 1468 (Ochoa Bogh) requires each health professional licensing board that licenses a prescriber to develop informational and educational material regarding the federal Drug Enforcement Administration's (DEA) "Three Day Rule" in order to ensure prescriber awareness of existing medication-assisted treatment pathways to serve patients with substance use disorder. *SB 1468 is pending in the Senate Appropriations Committee.*

Prior Related Legislation.

AB 663 (Haney), Chapter 539, Statutes of 2023, allows county-operated mobile pharmacies to carry and dispense buprenorphine and buprenorphine/naloxone combination medications for the treatment of OUD and authorizes the operation of multiple mobile units within one jurisdiction.

AB 816 (Haney), Chapter 456, Statutes of 2023, authorizes a minor who is 16 years of age or older to consent to replacement narcotic abuse treatment that uses buprenorphine, as specified.

ARGUMENTS IN SUPPORT:

As the sponsor of this bill, the **City and County of San Francisco** writes in support:

> Patients face multiple barriers to accessing methadone for the treatment of OUD, as it can only be dispensed in a limited number of situations. Federal Drug Enforcement Agency (DEA) recently increased the situations when methadone can be provided and now allows clinics to dispense 72 hours of methadone while referring a person to an Opioid Treatment Program (aka methadone clinic). However, current California law does not fully align with this new DEA flexibility. AB 2115 would address this issue and allow clinics to dispense 72 hours of methadone while referring a person to a methadone clinic. This will allow people increased access to methadone for the treatment of OUD while waiting to enroll in a methadone clinic, such as on weekends and evenings. Overall, this change would lower the barrier to patients receiving opioid withdrawal management services, improve linkage to longer term treatment at methadone clinics, and reduce ongoing opioid use and overdose risk.

ARGUMENTS IN OPPOSITION:

None on file

POLICY ISSUE(S) FOR CONSIDERATION:

While there is no formal opposition to this bill, concerns have been raised that provisions in the bill relating to the Three Day Rule should be amended to ensure that methadone is dispensed safely and that a "warm hand-off" to an OTP occurs. It should be noted that because methadone is a Schedule II controlled substance, a myriad of requirements aimed at preventing diversion and abuse already apply when the drug is dispensed by a health care practitioner regardless of setting. Nevertheless, the author may wish to consider clarifying the applicability of these safeguards. The author should continue to work with all stakeholders to ensure that the language in the bill is ultimately sufficient to promote confidence in the preservation of public safety while not sacrificing the additional flexibility now afforded under federal law.

REGISTERED SUPPORT:

City and County of San Francisco *(Sponsor)*
California Society of Addiction Medicine
California State Board of Pharmacy
County of Santa Clara
Glide
Healthright 360
National Coalition to Liberate Methadone
R Street Institute
San Mateo County Board of Supervisors
Smart Justice California, a Project of Tides Advocacy
Steinberg Institute
Supervisor Joel Engardio, San Francisco Board of Supervisors
The Association for Multidisciplinary Education and Research in Substance Use and Addiction

REGISTERED OPPOSITION:

None on file

Analysis Prepared by: Kaitlin Curry / B. & P. / (916) 319-3301, Robert Sumner / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2231 (Gipson) – As Introduced February 8, 2024

NOTE: This bill is double referred and previously passed the Assembly Committee on Banking and Finance on a 7-0-2 vote.

SUBJECT: Pawnbrokers: education.

SUMMARY: Requires pawnbrokers to complete both prelicensing education and continuing education as a condition of local licensure, and establishes a California Pawnbrokers Education Council for the purpose of approving educational courses for pawnbrokers.

EXISTING LAW:

1) Defines "pawnbroker" as a person engaged in the business of receiving goods, including motor vehicles, in pledge as security for a loan. (Financial Code (FIN) § 21000)

2) Establishes various requirements and proscriptions in the practice of pawnbrokers making loans and accepting pledged goods as security for that loan. (FIN §§ 21200 – 21209)

3) Requires representatives of the pawnbroker industry to poll their members annually to gather data relating to the current financial condition of the state's pawn industry. (FIN § 21205)

4) Provides for the licensure of pawnbrokers by city chiefs of police, county sheriffs, or police commissions. (FIN § 21300)

5) Prohibits any person to act as a pawnbroker or represent themselves as a pawnbroker or pawnbrokerage business entity unless they are licensed. (FIN § 21300.1)

6) Provides that pawnbroker licenses must be renewed biannually and may be subjected to forfeiture by the licensing authority for breach of specified conditions. (FIN § 21301)

7) Requires the advertisement of services as a pawnbroker to include the pawnbroker's license number. (FIN § 21301.1)

8) Authorizes a district attorney or the Attorney General to bring an action for violations of law relating to the regulation of pawnbrokers. (FIN § 21302)

9) Requires pawnbrokers to file a $20,000 nonrevokable surety bond with their issuing authority as a condition of licensure. (FIN § 21303)

10) Requires each applicant for licensure as a pawnbroker to file a financial statement with their issuing authority confirming that they have $100,000 in either liquid assets or as a nonrevocable surety bond. (FIN § 21304)

11) Prohibits pawnbroker licenses from being transferred or assigned. (FIN § 21305)

12) States that it is the intent of the Legislature to curtail the dissemination of stolen property and to facilitate the recovery of stolen property by means of a uniform, statewide, state-administered program of regulation of persons whose principal business is the buying, selling, trading, auctioning, or taking in pawn of tangible personal property. (Business and Professions Code (BPC) § 21625)

13) Defines "secondhand dealer" to mean any person, copartnership, firm, or corporation whose business includes buying, selling, trading, taking in pawn, accepting for sale on consignment, accepting for auctioning, or auctioning secondhand tangible personal property, excluding coin dealers or participants at gun shows. (BPC § 21626)

14) Defines "tangible personal property" as all secondhand tangible personal property that bears or appears to have once beared a serial number or personalized initials or inscription and that is purchased by a secondhand dealer or a pawnbroker. Additionally defines "tangible personal property" as property received in pledge as security for a loan by a pawnbroker and property determined by the Attorney General to constitute a significant class of stolen goods according to the most recent property crime data. (BPC § 21627)

15) Establishes the California Pawn and SecondhandDealer System (CAPSS), which is a single, statewide, uniform electronic reporting system that receives secondhand dealer reports and is operated by the Department of Justice (DOJ). (BPC § 21627.5)

16) Provides for the licensure of secondhand dealers by city chiefs of police, county sheriffs, or police commissions. (BPC § 21641)

THIS BILL:

1) Establishes the Pawnbroker Education Act and makes various findings and declarations in support of requiring pawnbrokers to meet education requirements.

2) Establishes the California Pawnbroker Education Council, governed by a board of directors consisting of the following members appointed by the following entities:

    a) One member appointed by either the California Police Chiefs Association or California State Sheriffs' Association.

    b) One member appointed by the Secondhand Dealer and Pawnbroker Unit of the DOJ.

    c) Four members who are licensed pawnbrokers, appointed by a professional society, association, or other entity composed of at least 200 licensed pawnbroker established in or before 2000, and whose bylaws require its members to comply with a code of ethics.

    d) One member who is a licensed attorney who is a California resident, appointed by the professional society, association, or entity described above.

3) Provides that each member of the board of directors may serve a term of two years.

4) Authorizes the council to take reasonable actions necessary to carry out its responsibilities and duties, including, but not limited to, hiring staff, entering into contracts, and developing policies, procedures, rules, and bylaws to implement the Pawnbroker Education Act.

5) Allows for the council to establish fees sufficient to support the functions of the council and to cover the reasonable regulatory cost of administering the Pawnbroker Education Act.

6) Requires the council to develop and establish a standard course and curriculum in specified state and federal laws relating to pawnbroker transactions, including at least eight hours of prelicensing education, and eight hours of continuing education to be taken by an applicant for licensure or a licensee, or their designated representative.

7) Allows for the curriculum developed by the council to include any other training that the council deems to be relevant to the efficient and lawful operation of a pawnbroker business.

8) Requires entities that propose to offer educational courses that satisfy the prelicensing or continuing education requirements for pawnbrokers to obtain approval from the council.

9) Provides that the council shall develop policies, procedures, rules, or bylaws governing the requirements described in the Pawnbroker Education Act and the process for applying to become, approving, denying the approval of, imposing correction action upon, or withdrawing the approval of, an educational course provider.

10) Requires the council to issue a certificate to an applicant for a pawnbroker license, or a licensee applying for renewal of a pawnbroker license, who has satisfied the educational requirements of the Pawnbroker Education Act.

11) Requires the council to maintain records verifying completion of the initial prelicensing education and continuing education for a period of not less than two years.

12) Requires applicants for licensure as pawnbrokers to first complete at least eight hours of prelicensing education approved by the council and to submit to their licensing authority a certificate of completion issued by the council.

13) Requires pawnbrokers to complete at least eight hours of continuing education approved by the council and to submit to their licensing authority a certificate of completion issued by the council as a condition of renewing their licenses.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the **California Pawnbrokers Association**. According to the author:

> "AB 2231 proposes mandatory education for all pawnbrokers before receiving licensure, and continuing education every two years coinciding with the pawnbroker's license renewal. Mandatory education will establish and maintain professional standards essential to protecting both consumers and pawnbrokers. Pawnbrokers have long served as an essential service to underserved communities that are unbanked, or have insufficient credit scores, to acquire short term loans from traditional banks. Ensuring that Pawnbrokers have adequate training in laws and regulations, business practices, security, and ethics will help them service their communities to their fullest capabilities. Educated pawnbrokers are also better able to provide advice and guidance to consumers."

Background.

California has long regulated sellers of secondhand goods. In 1937, a law was enacted to require secondhand dealers to report new acquisitions of property to local law enforcement so that these items could potentially be matched with stolen goods. In 1959, this requirement was combined with a requirement that secondhand dealers wait a specified number of days before selling an item in order to provide law enforcement with time to investigate possible matches. The reporting requirement was also modified that year to consist of a daily paper report to both local law enforcement agencies and the DOJ. In 2000, legislation was passed establishing a framework for secondhand dealers to make their required reports electronically. Legislation in 2012 finally funded a new statewide electronic system known as CAPSS, operated by the DOJ and paid for through increased licensing fees obtained from secondhand dealers.

Pawnbrokers are a category of secondhand dealers who receive property in pledge as security for a loan. The Financial Code outlines a series of requirements and prohibitions in regards to how much a pawnbroker can charge for a specific loan amount, as well as when and how pledged property may be sold in the event the loan is not repaid. Statute additionally requires pawnbrokers to make various specified disclosures to pledgors during the process and sets requirements for loan contracts.

Licensure of pawnbrokers was first established through the enactment of Senate Bill 939 (Dills) in 1993. The bill represented a compromise between the Collateral Loan and Secondhand Dealers Association—the sponsors of SB 939—and representatives of law enforcement, who argued that general licensure of secondhand dealers was insufficient to ensure adequate oversight of pawnbrokers. In exchange for establishing stronger licensing requirements specific to pawnbrokers, the bill also streamlined a number of provisions in the Financial Code relating to loans made in exchange for the pledging of property.

While state law provides that the DOJ is responsible for enforcing requirements under the Financial Code relating to secondhand dealers, the licensing of pawnbrokers is primarily a responsibility of local law enforcement. Statute provides that applications for licensure are made to the chief of police, the sheriff, or, where appropriate, the police commission through forms prescribed and provided by the DOJ. The local law enforcement submits the completed application form to the DOJ, which then has up to 30 days to comment on the application. If the DOJ does not comment, statute requires the license to be granted. Fees can be charged by both the local licensing agency and by the DOJ, which pays for the CAPSS database.

To be eligible for licensure as a pawnbroker under current law, an applicant must pay the required fees and demonstrate that they have obtained a $20,000 nonrevokable surety bond and that they have $100,000 either in assets or as a posted security bond. They must also undergo a criminal history check to ascertain that they have not been convicted of any disqualifying offenses. These are the only current prelicensure requirements, and pawnbrokers may continue to renew their license as long as they meet these requirements and as long as they do not subsequently commit any misconduct.

This bill would establish new education requirements as a prerequisite for both obtaining an initial license and for renewing a license as a pawnbroker. Each would consist of eight hours of education as part of a standard course and curriculum in pawnbroker transactions. This course and curriculum would be required to include compliance with state and federal laws applicable to the pawnbroker business.

To develop and establish the standard course and curriculum, this bill would create the California Pawnbroker Education Council, governed by a board of directors comprised of representatives of the pawnbroker industry, the DOJ, and local law enforcement. The council would then issue certificates of completion to applicants and pawnbrokers seeking renewal of their licenses, which would be provided to the local licensing authority as proof of their compliance. The author believes that a council is the appropriate entity to administer the new education requirements for pawnbrokers, while still reserving for local law enforcement the principle responsibilities of licensing pawnbrokers in California.

Current Related Legislation.

AB 2412 (Reyes) would establish a California Body Contouring Council to regulate the practice of body contouring through the administration of a certification program. *This bill is pending in this committee.*

Prior Related Legislation.

SB 1317 (Bradford, Chapter 723, Statutes of 2022) eliminated the requirement that secondhand dealers report personally identifying information regarding the seller or pledger of secondhand goods to the CAPSS database, and instead required that this information to be kept on file and available upon request by law enforcement.

AB 1993 (Gipson, Chapter 184, Statutes of 2018) replaced the prior 30 day period of time in which a secondhand dealer may not sell tangible personal property upon reporting the acquisition to CAPSS with a requirement that secondhand dealers may not sell an item within five days of reporting the acquisition and then must collect and retain buyer information if the property is sold within the following two days.

AB 1751 (Low, Chapter 793, Statutes of 2016) clarified what descriptive categories may be required by the DOJ for secondhand goods reported by dealers through CAPSS.

AB 1182 (Santiago, Chapter 749, Statutes of 2015) narrowed the definition of "tangible personal property" and required the DOJ to annually update the list of items which represent a significant class of stolen goods.

AB 632 (Eggman, Chapter 169, Statutes of 2015) authorized specified unique identifying numbers to be used as the serial number reported for handheld electronic devices.

SB 782 (Hill, Chapter 318, Statutes of 2013) clarified the interests of licensed pawnbrokers and secondhand dealers relating to the seizure and disposition of property during a criminal investigation or case.

AB 391 (Pan, Chapter 172, Statutes of 2012) required secondhand dealers and coin dealers to report certain information to the DOJ through CAPSS and instituted a new $30 license fee.

SB 1520 (Schiff, Chapter 994, Statutes of 2000) created a framework for the DOJ to develop a new electronic reporting system that would eventually be CAPSS.

SB 939 (Dills, Chapter 782, Statutes of 1993) established a comprehensive licensing scheme for pawnbrokers.

ARGUMENTS IN SUPPORT:

The **California Pawnbrokers Association** (CPA) is sponsoring this bill. According to the CPA: "Pawnbrokers who are properly educated and trained are better able to assess the value of items that are pawned, detect counterfeit items commonly used as collateral, and therefore protect themselves from making a loan not supported by the collateral. Educated pawnbrokers are also better able to provide advice and guidance to consumers. Mandatory education will establish and maintain professional standards essential to protecting both consumers and pawnbrokers."

ARGUMENTS IN OPPOSITION:

None on file.

POLICY ISSUE(S) FOR CONSIDERATION:

General Issues with Nongovernmental Councils. There are currently three councils that to varying degrees serve regulatory functions pursuant to California law. The California Council for Interior Design Certification (CCIDC) was created in 1991 by Senate Bill 153 (Craven) to provide title protection for voluntarily certified interior designers. The California Tax Education Council (CTEC) was created in 1997 by Senate Bill 1077 (Greene), which replaced a licensing program for tax preparers under the Department of Consumer Affairs (DCA) with a less onerous registration program under a private nonprofit. Finally, the California Massage Therapy Council (CAMTC) was created in 2009 after multiple failed attempts to establish licensure of massage therapists by a state licensing board. While certification by CAMTC is voluntary under state law, it is frequently required as part of local ordinances, making it function similarly to a license.

Each of the three nonprofit councils currently established under the Business and Professions Code is subject to the Legislature's sunset review process. In recent years, a number of issues have been raised in the respective background papers for each entity highlighting identified deficiencies that are arguably intrinsic to the nongovernmental council model. Many of these issues relate to the inapplicability of various "good government" laws to private councils that while nongovernmental, effectively serve functions traditionally administered by government agencies in regards to licensure and oversight.

For example, an issue raised in multiple sunset background papers is that none of the three nonprofit councils are required to comply with the California Public Records Act (CPRA). The CPRA generally provides that "public records are open to inspection at all times during the office hours of the state or local agency and every person has a right to inspect any public record." The CPRA defines "state agency" as "every state office, officer, department, bureau, board, and commission or other state body or agency." This definition almost certainly does not apply to private councils, as confirmed in relevant court decisions related to similar entities.

Another law, the Bagley-Keene Open Meeting Act, requires meetings of regulatory bodies to be noticed and allow for participation by public. The intent of Bagley-Keene is "that actions of state agencies be taken openly and that their deliberation be conducted openly." The law defines "state bodies" as "a board, commission, committee, or similar multimember body that exercises any authority of a state body delegated to it by that state body." Because this definition does not expressly apply to statutorily empowered nonprofits, sunset bills for each of the existing councils have expressly required compliance with Bagley-Keene; however, there have been reported difficulties with several of these entities demonstrating compliance with those requirements.

Similarly, the Office of State Audits and Investigations at the Department of Finance generally has broad authority to inquire into the budgets of state entities. However, this authority is based on the definition of "state agency" as codified in Section 11000 of the Government Code, which includes "every state office, officer, department, division, bureau, board, and commission." A nonprofit council is not included among the specified entities falling under this statute's definition of "state agency."

It also appears that not all of the state's whistleblower laws apply to nonprofit councils. Both the California Whistleblower Protection Act and the Whistleblower Protection Act utilize the limited definition in Section 11000 of the Government Code. These laws, which protect employees and other persons who disclose improper activities by public bodies, would therefore likely also not apply to statutorily created nonprofits.

California's Administrative Procedure Act (APA) includes a variety of additional laws aimed at preserving transparency in rulemaking and due process administrative hearings by state agencies. Provisions of the APA establish entities such as the Office of Administrative Law (OAL), which oversees public participation in agency regulations, and the Office of Administrative Hearings (OAH), which adjudicates administrative disputes. The portions of the APA relating to OAL and rulemaking again utilize the Section 11000 definition of "state agency," likely its provisions inapplicable to private nonprofits; it is unclear to what extend provisions relating to OAH would apply absent express preemption or adoption in statute.

Finally, the Political Reform Act of 1974 enacted a number of safeguards to hold public decision-makers accountable and ensure that they "perform their duties in an impartial manner, free from bias caused by their own financial interests." The California Fair Political Practices Commission (FPPC) has relatively broad authority to determine who is subject to the requirements imposed by the Act. It is not entirely clear whether a nonprofit council would be considered applicable. An FPPC advisory letter (referred to as the Siegel Letter) lays out four factors in determining whether an entity must comply with the Act: (1) Whether the impetus for the formation of the entity originated with a government agency; (2) Whether the entity is substantially funded by a government agency; (3) Whether one of the entity's principle purposes is rendering services typically performed by public agencies; and (4) Whether the entity is otherwise treated as a public entity by statute. Absent further guidance by the FPPC, it is possible that because private councils likely do not fulfil each of the Siegel Letter's four factors, they would likely be ruled inapplicable to the Act.

While the potential inapplicability of each of these laws may be viewed as a substantial flaw in the private council model, it was also arguably part of the Legislature's intent in creating it. The fact that nongovernmental councils do not have to comply with various bureaucratic processes and requirements allows for more flexibility and efficiency. It has been argued that this results in those bodies operating more expeditious and at less cost to fee payers.

These advantages must then be weighed against the disadvantages. An essential component of this equation is whether professionals are required to receive permission from a council to engage in providing services, as opposed to receiving some other competitive advantage, such as title protection or the marketing advantages of certification. If a nongovernmental entity is responsible for determining whether an individual is afforded the property right of their ability to earn a living through their profession or trade, it can be argued that this responsibility is carried out with the accountability and transparency required of government agencies.

In the case of this bill, the California Pawnbrokers Education Council would not ultimately be charged with approving or denying pawnbroker licenses. This important function would still be vested in government agencies at the local level in collaboration with the DOJ. Instead, the proposed council would be serving a singular purpose: developing and approving education courses and curricula for purposes of the bill's provisions requiring applicants and licensees to regularly receive education on laws relating to pawnbrokers. While receiving a certificate of compliance from the council would be mandatory, the council would serve more as an education accreditor than a licensing entity, and it is therefore not necessarily inappropriate for it to be established as a nongovernmental entity. The author may wish to amend the bill to make this distinction clear.

AMENDMENTS:

To clarify that the California Pawnbrokers Education Council is not intended to serve as a licensing body and that this responsibility remains solely that of local government and the DOJ, add a new subdivision to Section 3 of the bill as follows:

> *Nothing in this chapter authorizes the council to approve, deny, revoke, or suspend a license required pursuant to Section 21300.*

REGISTERED SUPPORT:

California Pawnbrokers Association *(Sponsor)*

REGISTERED OPPOSITION:

None on file.

Analysis Prepared by: Robert Sumner / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2246 (Ramos) – As Amended March 18, 2024

SUBJECT: Medical Practice Act: health care providers: qualified autism service paraprofessionals.

SUMMARY: Revises the definition of "health care provider" to include a qualified autism service paraprofessional."

EXISTING LAW:

1) Defines "qualified autism service paraprofessional" to mean an unlicensed and uncertified individual who meets all of the following criteria:

    a) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.

    b) Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

    c) Meets specified education and training qualification.

    d) Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.

    e) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

    (Health and Safety Code § 1374.73(c)(5))

2) Defines "health care provider" to mean any of the following:

    a) A person who is licensed under the Medical Practice Act or the Osteopathic Act.

    b) An associate marriage and family therapist or marriage and family therapist trainee.

    c) A qualified autism service provider or qualified autism service professional certified by a national entity, as specified.

    d) An associate clinical social worker.

    e) An associate professional clinical counselor or clinical counselor trainee.

    (Business and Professions Code (BPC) § 2290.5(a)(3))

3) Defines "telehealth" to mean the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation,

treatment, education, care management, and self-management of a patient's health care. (BPC § 2290.5(a)(6))

4) Requires a health care provider, before the delivery of health care via telehealth, to inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. (BPC § 2290.5(b))

5) Specify that all laws and regulations governing professional responsibility, unprofessional conduct, and standards of practice that apply to a health care provider under the health care provider's license shall apply to that health care provider while providing telehealth services. (BPC § 2290.5(g))

6) Requires a contract between a health care service plan or health insurer and a health care provider that is issued, amended, or renewed on or after January 1, 2021, to specify that the health plan or health insurer is required to provide coverage for the cost of health care services delivered through telehealth on the same basis and to the same extent that the health plan or health insurer is responsible for coverage for the same service in-person. (Health and Safety Code § 1374.14(a); Insurance Code § 10123.855)

THIS BILL:

1) Revises the definition of "health care provider" for purposes of Division 2 of the Business and Professions Code to include a qualified autism service paraprofessional certified by a national entity, as specified.

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

COMMENTS:

Purpose. This bill is authored by the **Autism Business Association**. According to the author:

> Today, we are facing a shortage of qualified personnel who can provide the critical services our children with autism depend on. Most families are struggle to find qualified professionals in their area, especially, ones who can work within their budget. It is crucial that families maintain a level of consistent care for their loved ones with autism. [This bill] would allow paraprofessionals, experts in their field, to fill that gap. Most importantly, would allow health insurances companies to cover the services by paraprofessionals who meeting communities where there at, not just where the community can afford to be.

Background.

According to the Centers for Disease Control and Prevention, nearly 1 in 36 children are diagnosed with autism spectrum disorder (ASD), which affects the way they behave, communicate, interact, and learn.[1] While there is no cure for ASD, there are several types of treatment to support daily functioning and quality of life. These include behavioral,

[1] What is Autism Spectrum Disorder? | CDC

developmental, educational, social-relational, pharmacological, and psychological approaches as well as complementary and alternative treatments.[2] Treatment is often provided by multiple professionals and may be provided at school, in healthcare settings, within the community, at home, or some combination of those settings.

In 2011, SB 946 (Steinberg), Chapter 650, Statutes of 2011 began requiring health plans and health insurance policies to cover behavioral health therapy provided by a qualified autism service provider, a qualified autism service professional supervised by the qualified autism service provider, or a qualified autism service paraprofessional supervised by a qualified autism service provider or professional.

Qualified autism service paraprofessionals are required to have a high school diploma or the equivalent, have completed 30 hours of competency-based training designed by a certified behavior analysist, and have six months experience working with developmental disabilities. Alternatively, they may have an Associate's Degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management from an accredited community college or educational institution, and have six months of experience working with persons with developmental disabilities.[3] Qualified autism service paraprofessionals are also required to be supervised by a qualified autism service provider or professional, provide treatment and implement services pursuant to a treatment plan developed and approved by a qualified autism service provider, and be employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

Current law has, since January 1, 2021, required health care service plans and health insurance policies to cover services provided by a health care provider via telehealth in the same manner as provided for in-person services. While qualified autism service providers and professionals deemed health care providers in statue, qualified autism service paraprofessionals are not. According to the author's office, Executive Order N-43-2 temporarily required health plans and insurers to cover telehealth services provided by autism service paraprofessionals during the COVID-19 pandemic. However, since the state of emergency was lifted, the author's office reports that one of the largest national health insurance plans has stopped covering telehealth services for behavioral health treatment for individuals with ASD. By expanding the definition of health care provider to include qualified autism service paraprofessionals, this bill would require health plans and health insurance policies to cover telehealth services provided by these providers. The author and sponsor portend that this change will fill gaps and increase access to care for individuals with ASD, particularly for those who live in rural communities or who require services in a language other than English.

Current Related Legislation.

AB 2449 (Ta) of 2024 would clarify that the Qualified Applied Behavior Analysis Credentialing Board is also a national entity that may certify a qualified autism service provider, and would authorize the certification to be accredited by the American National Standards Institute. *AB 2249 is pending in the Assembly Health Committee.*

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[2] Treatment and Intervention Services for Autism Spectrum Disorder | NCBDDD | CDC
[3] CCR § 54342

Prior Related Legislation.

SB 805 (Portantino), Chapter 635, Statutes of 2023, expanded the definition of "qualified autism service professional" to include a psychological associate, an associate marriage and family therapist, an associate clinical social worker, and an associate professional clinical counselor.

SB 562 (Portantino) of 2022 would have, as it relates to this bill, revised the definition of qualified autism service professional and the training requirements for qualified autism service paraprofessional. *SB 562 was vetoed.*

AB 774 (Aguiar-Curry), Chapter 867, Statutes of 2019, added qualified autism service provider and qualified autism service professional to the definition of health care provider and required health care contracts on or after January 1, 2021, to specify that the health care service plan (health plan) or insurer is required to cover and reimburse diagnosis, consultation, or treatment delivered through telehealth on the same basis and to the same extent as in-person diagnosis, consultation, or treatment.

SB 946 (Steinberg), Chapter 650, Statutes of 2011, required, in part, health plans and health insurance policies to cover behavioral health therapy for autism.

ARGUMENTS IN SUPPORT:

As the sponsor of this bill, the **Autism Business Association** writes in support:

> [This bill] addresses a vital need for the autism community – improving accessibility to care. The provision to include qualified autism service paraprofessionals as providers who can deliver services via telehealth modalities is a progressive step. It aligns with the current healthcare innovation trends and directly tackles care accessibility issues many families face, particularly those living in remote or underserved communities. The benefits of expanding telehealth options are multifaceted. It not only supports continuity of care, where interruptions could lead to regression in progress, but also empowers families to choose the treatment modalities that work best for them. This flexibility respects people's autonomy and acknowledges diverse individual needs. In addition, telehealth expansion serves to reduce travel burdens, lower the risk of exposure to infectious diseases, and potentially lower costs for providers and families alike. It is an efficient means of providing quality care without the geographic and physical limitations attached to traditional in-person services.

ARGUMENTS IN OPPOSITION:

None on file.

REGISTERED SUPPORT:

Autism Business Association *(Sponsor)*
Autism Behavior Services Inc.
Autism Heroes
Autism Society of California
DIR/Floortime Coalition of California
Greenhouse Therapy Center

REGISTERED OPPOSITION:

None on file.

Analysis Prepared by: Kaitlin Curry / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2265 (McCarty) – As Amended March 18, 2024

SUBJECT: Animals: spaying, neutering, and euthanasia.

SUMMARY: Requires animal shelters to post both daily lists on the internet and physical notices on animal kennels for cats or dogs scheduled for euthanasia at least 24 hours prior to the scheduled euthanasia of a dog or cat; amends language declaring the policies of the state regarding the euthanasia of animals; prohibits shelters and rescue groups from giving dogs or cats to a foster unless spay or neuter surgery has been scheduled within 30 days of the animal departing the shelter; requires shelters seeking to adopt a policy, practice, or protocol that potentially conflicts with the specified laws to give notice to their local city or county body and then schedule a public hearing; and makes various additional changes to existing laws and requirements relating to animal welfare and animal shelters.

EXISTING LAW:

1) Provides that it is the policy of the state that no adoptable animal should be euthanized if it can be adopted into a suitable home, and no treatable animal should be euthanized, with specific language describing adoptable animals as those animals eight weeks of age or older that show no sign of either behavioral or temperamental defects or of disease, injury, or congenital or hereditary conditions. (Food and Agricultural Code (FAC) § 17005)

2) Exempts animals that are irremediably suffering from a serious illness or severe injury from requirements that they be held for owner redemption or adoption, and allows for newborn animals that need maternal care and have been impounded without their mothers to be euthanized without being held for owner redemption or adoption. (FAC § 17006)

3) Governs the operation of animal shelters by, among other requirements, setting a minimum holding period for stray dogs, cats, and other animals, and requiring animal shelters to ensure that those animals, if adopted, are spayed or neutered and, with exceptions, microchipped. (FAC §§ 30501 *et seq.*; §§ 31101 *et seq.*; §§ 31751 *et seq.*; §§ 32000 *et seq.*)[*]

4) Requires that a shelter must hold a stray dog for a specified period prior to adoption or euthanasia of a dog, must scan the dog for a microchip that identifies the owner of that dog, and must make reasonable efforts to contact the owner and notify them that their dog is impounded and is available for redemption. (FAC § 31108)

5) Requires that a shelter must hold a stray cat for a specified period prior to adoption or euthanasia of a cat, must scan the cat for a microchip that identifies the owner of that cat, and must make reasonable efforts to contact the owner and notify them that their cat is impounded and is available for redemption. (FAC § 31752)

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[*] *Note: Enforcement of a number of these provisions is suspended due to reimbursable state mandates on local government remaining unfunded.*

6) Requires that a rabbit, guinea pig, hamster, potbellied pig, bird, lizard, snake, turtle, or tortoise that is impounded in a shelter must be held for the same period of time, under the same requirements of care, and with the same opportunities for redemption and adoption, as cats and dogs. (FAC § 31753)

7) Requires all public animal shelters, shelters operated by societies for the prevention of cruelty to animals, and humane shelters that perform public animal control services, to provide the owners of lost animals and those who find lost animals with all of the following:

   a. Ability to list the animals they have lost or found on "Lost and Found" lists maintained by the animal shelter.

   b. Referrals to animals listed that may be the animals the owners or finders have lost or found.

   c. The telephone numbers and addresses of other animal shelters in the same vicinity.

   d. Advice as to means of publishing and disseminating information regarding lost animals.

   e. The telephone numbers and addresses of volunteer groups that may be of assistance in locating lost animals.

   (FAC § 32001)

8) Requires all public and private animal shelters to keep accurate records on each animal taken up, medically treated, or impounded, which shall include all of the following information and any other information required by the Veterinary Medical Board of California:

   a. The date the animal was taken up, medically treated, euthanized, or impounded.

   b. The circumstances under which the animal was taken up, medically treated, euthanized, or impounded.

   c. The names of the personnel who took up, medically treated, euthanized, or impounded the animal.

   d. A description of any medical treatment provided to the animal and the name of the veterinarian of record.

   e. The final disposition of the animal, including the name of the person who euthanized the animal or the name and address of the adopting party. These records shall be maintained for three years after the date on which the animal's impoundment ends.

   (FAC § 32003)

9) Establishes the Polanco-Lockyer Pet Breeder Warranty Act, which regulates the sale of dogs by breeders. (Health and Safety Code (HSC) §§ 122045 *et seq.*)

10) Provides that an animal control officer, humane officer, or peace officer, who detects a violation of law by a pet store, may issue a single notice to correct. (HSC § 122356)

11) Authorizes cities and counties to enact dog breed-specific ordinances pertaining only to mandatory spay or neuter programs and breeding requirements, provided that no specific dog breed, or mixed dog breed, shall be declared potentially dangerous or vicious under those ordinances; directs any cities or counties enacting such ordinances to measure the effect of those programs by compiling specified statistical information on dog bites, and report the information to the State Public Health Veterinarian. (HSC § 122331)

12) Provides that every person who maliciously and intentionally maims, mutilates, tortures, or wounds a living animal, or maliciously and intentionally kills an animal, is guilty of a crime. (Penal Code (PEN) § 597)

13) Requires any peace officer, humane society officer, or animal control officer to convey all injured cats and dogs found without their owners in a public place directly to a veterinarian known by the officer to be a veterinarian who ordinarily treats dogs and cats for a determination of whether the animal shall be immediately and humanely euthanized or shall be hospitalized under proper care and given emergency treatment. (PEN 597.1)

14) Provides that it is the policy of the state that no adoptable animal should be euthanized if it can be adopted into a suitable home. (PEN § 599d; Civil Code § 1834.4)

15) Enacts the Veterinary Medicine Practice Act, outlining the licensure requirements, scope of practice, and responsibilities of individuals practicing veterinary medicine in California. (Business and Professions Code (BPC) §§ 4811 *et seq.*)

16) Establishes the Veterinary Medical Board (VMB) under the jurisdiction of the Department of Consumer Affairs, responsible for enforcing the provisions of the Veterinary Medicine Practice Act, and regulating veterinarians, registered veterinary technicians, veterinary assistant substance controlled permit holders, and veterinary premises. (BPC § 4800)

17) Provides that protection of the public shall be the highest priority for the VMB in exercising its licensing, regulatory, and disciplinary functions. (BPC § 4800.1)

18) Specifies a list of prohibited activities for individuals licensed under the VMB, such as fraud, misleading advertising, and cruelty to animals; provides that the VMB may deny, revoke, or suspend a license or registration, or assess a fine, if any a person under its jurisdiction is found to have engaged in prohibited activities. (BPC §§ 4883 *et seq.*)

19) Establishes the Pet Lover's Fund within the Specialized License Plate Fund, which provides for grant funding to eligible veterinary facilities that offer low-cost or no-cost animal sterilization services. (Vehicle Code § 5168)

THIS BILL:

1) Amends language providing that it is the policy of the state that no adoptable or treatable animal should be euthanized to instead more simply provide that no animal should be euthanized if it can be adopted into a suitable home; narrower current exceptions to this state policy for animals irremediably suffering from a serious illness or severe injury, dogs determined to be vicious, or newborn animals that need maternal care and have been impounded without their mothers.

2) Redefines “adoptable animal” to mean one that, at the time of, or subsequent to impoundment, is eight weeks or older and has manifested no signs of temperamental or behavioral defect that could pose a health or safety risk, and has manifested no signs of disease, injury, congenital or hereditary condition that is currently or likely to adversely affect the health of the animal.

3) Redefines “treatable animal” to mean any animal that is not adoptable, but could become adoptable with reasonable efforts.

4) Narrows the definition of “irremediably suffering” to mean an animal that is unable to live without having severe, unremitting physical pain, even with prompt, necessary, and comprehensive veterinary care.

5) Prohibits a public animal control agency or shelter from giving a dog or cat to a foster unless the public animal control agency or shelter schedules a spay or neuter surgery for the dog or cat within five business days of the dog or cat departing the public animal control agency or shelter.

6) Requires spay or neuter surgeries to be performed within 30 business days of a dog or cat departing the shelter to be given to a foster.

7) Provides that if a foster fails to bring the dog or cat to the animal’s scheduled spay or neuter appointment, the public animal control agency or shelter shall require the foster to voluntarily return the dog or cat within seven business days of the foster receiving notification from the public animal control agency or shelter to return the dog or cat.

8) Provides that if a foster fails to bring a dog or cat to their scheduled spay or neuter appointment and the public animal control agency or shelter is unable to contact the foster, the public animal control agency or shelter shall, within 14 business days of the missed appointment, conduct a site visit to the foster’s home to confirm whether the dog or cat has been altered and, if the dog or cat is still unaltered, the public animal control agency or shelter shall confiscate the dog or cat.

9) Increases various amounts of money that must be deposited by adopters and purchasers of dogs and cats that have been certified by a veterinarian as too sick or injured to be spayed or neutered at the time of exit from the shelter or rescue.

10) Repeals existing authorization for a public animal control agency or shelter, society for the prevention of cruelty to animals shelter, humane society shelter, or rescue group to extend in writing the date by which spaying or neutering is to be completed for a dog or cat at its discretion for good cause shown.

11) Requires an agency or shelter to post a daily list of any cat or dog scheduled for euthanasia on their public website or public Facebook page up to 72 hours before a scheduled euthanasia of a dog or cat but no later than 24 hours before a scheduled euthanasia of a dog or cat.

12) Exempts agencies or shelters that do not have a public internet website or a public Facebook page from the requirement to post a daily list.

13) Requires an eligible agency or shelter to post a physical notice on the kennel of a dog or cat scheduled to be euthanized up to 72 hours before a scheduled euthanasia of a dog or cat but no later than 24 hours before a scheduled euthanasia of a dog or cat.

14) Requires the eligible agency or shelter to post the physical notice using 8.5 inch by 11 inch paper with the word EUTHANIZE appearing in size 72 font.

15) Provides that if a dog or cat is housed by an agency or shelter in an area without public access, the eligible agency or shelter shall post the physical notice in an area that is accessible to public view instead of on the kennel of that dog or cat.

16) Provides that both the daily list and the physical notice must meet all the following requirements:

    a) The agency or shelter shall provide all information in a clear and conspicuous manner.

    b) The agency or shelter shall document the reason for the scheduled euthanasia and whether the dog or cat is available for one or more of the following:

        i) Adoption.

        ii) Fostering.

        iii) Transfer to a rescue group.

    c) The agency or shelter shall clearly state the contact email and telephone number of the appropriate department or person to contact so that rescue, foster, or adoption can be immediately effectuated.

17) Defines "eligible agency or shelter" as a public animal control agency or shelter or a private entity that contracts with a public animal control agency or shelter for animal care and control services.

18) Defines "rescue group" as a for-profit or not-for-profit entity, or a collaboration of individuals with at least one of its purposes being the sale or placement of cats or dogs, or both, that have been removed from a public animal control agency or shelter, society for the prevention of cruelty to animals shelter, or humane shelter or that have been previously owned by any person other than the original breeder of that cat or dog, or both.

19) Requires a public animal control agency or shelter that seeks to adopt a policy, practice, or protocol that raises the potential for conflict with any aspect of "Hayden's Law" to first give notice to the city or county body that funds the public animal control agency or shelter and to also post a notice regarding that policy, practice, or protocol at its facility in a manner that is accessible to public view.

20) Requires the city or county body that funds the public animal control agency or shelter to, within 60 days of receiving notice, schedule a public hearing regarding the policy, practice, or protocol that raises the potential for conflict with any aspect of Hayden's Law.

21) Defines "Hayden's Law" as various provisions of the Civil Code, Penal Code, and Food and Agricultural Code enacted through SB 1785 (Hayden, Chapter 752, Statutes of 1998).

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by **Fix Our Shelters**. According to the author:

> "California's policy is that no adoptable or treatable animal should be euthanized if it can be adopted into a suitable home. Despite this goal, California still has climbing euthanasia rates, despite intake of animals into shelters has been down since the COVID-19 pandemic. AB 2265 improves public transparency and accountability throughout public animal shelters, by requiring shelters to share public notice when animals are scheduled to be euthanized, prioritize spay/neuter resources, and hold public oversight hearings to uphold state law."

Background.

Animal Welfare Laws. In 1966, Congress enacted the Animal Welfare Act (AWA) to provide standards on the humane handling, care, and treatment of animals. Enforced by the Department of Agriculture, the AWA regulates animal rights in various settings, including scientific research, public exhibitions, or transportation. California is home to a number of additional animal protection laws intended to safeguard the wellbeing and life of animals in various settings.

In terms of laws intended to protect animals from being harmed or discomforted by their owners, only certain categories of severe neglect or mistreatment are expressly unlawful. The malicious and intentional maiming, mutilation, torture, or wounding of any living animal is a crime under the Penal Code. Similarly, anyone who overdrives, overloads, overworks, tortures, torments, deprives of necessary sustenance, drink, or shelter, cruelly beats, mutilates, or cruelly kills any animal is guilty of a crime. There are also provisions in the Penal Code that provide punishment for those who severely neglect an animal and allows those animals to be seized and treated. Similarly, laws like the Lockyer-Polanco-Farr Pet Protection Act establishes animal welfare and consumer protection requirements on pet dealers and the animals they sell.

Efforts to Reduce Euthanasia of Adoptable Animals. The California State Assembly declared in 2015 that the official State Pet is the shelter pet. According to information provided by the ASPCA in 2019, approximately 6.5 million companion animals enter animal shelters in the United States every year. While animal shelters play a critical role in caring for homeless pets, the number of animals entering shelters each year often exceeds the available resources and capacity to care for them, resulting in overcrowding. One of the options that shelters may consider is euthanasia as a means of managing the number of animals in their care.

In 1998, the Legislature enacted Senate Bill 1785 by Senator Tom Hayden, which formally established that the State of California's policy is "that no adoptable animal should be euthanized if it can be adopted into a suitable home" and "that no treatable animal should be euthanized." This bill would amend those provisions to instead state that no animal should be euthanized if it can be adopted into a suitable home, with more narrow exceptions for animals irremediably suffering from a serious illness or severe injury, dogs determined to be vicious, or newborn animals that need maternal care and have been impounded without their mothers. The definition of "irremediably suffering" would additionally be narrowed to mean an animal that is unable to live without having severe, unremitting physical pain, even with prompt, necessary, and comprehensive veterinary care.

The Hayden Law additionally required shelters to hold animals for a minimum of four to six days before euthanizing them, giving owners a chance to reclaim their pets or allowing animals to be adopted. Key provisions in the Hayden Law to support that policy included requirements that animal shelters do all of the following:

- Work to increase the number of animals reunited with owners by increasing the holding period for sheltered animals.
- Establish minimum holding periods for all owner-relinquished animals.
- Postpone euthanasia for any animal until after the expiration of the minimum holding period, with exceptions only for injured or very sick.
- Release animals slated for euthanasia to rescue groups upon request.
- Provide prompt and necessary veterinary care, nutrition, and shelter.
- Maintain a system of record keeping essential for reuniting lost animals with owners, managing housing, and documenting holding times and medical care.

Much of the Hayden Law has not been implemented or enforced due to fiscal challenges. In 2000, local governments successfully obtained a decision from the Commission on State Mandates that costs incurred by cities and counties in complying with the law must be reimbursed by the state. Subsequently beginning with the Budget Act of 2009, the state has not provided funding for this reimbursement. While a proposal by Governor Jerry Brown to repeal portions of the Hayden Law in 2012 were rejected by the Legislature, animal welfare advocates have argued that the bill was effectively annulled through its lack of funding, as referenced by this resolution.

While various provisions of the Hayden Law have been suspended, many shelters reportedly still aim to comply with its requirements. This bill would require a public animal control agency or shelter that seeks to adopt a policy, practice, or protocol that raises the potential for conflict with any aspect of the Hayden Law (called "Hayden's Law" in the bill) to first give notice to the city or county body that funds the public animal control agency or shelter and to also post a notice regarding that policy, practice, or protocol at its facility in a manner that is accessible to public view. The city or county body would then be required, within 60 days of receiving notice, to schedule a public hearing regarding the policy, practice, or protocol that raises the potential for conflict with any aspect of the Hayden Law.

Since the enactment of the Hayden Law, euthanasia rates in California animal shelters have remained high. According to data from the California Department of Public Health, 158,191 dogs and cats were euthanized in 2016. While it should be noted that this number is meaningfully lower than in previous years, there has been a call for action to further reduce euthanasia rates in California. Language enacted as part of the Budget Act of 2021 established the Animal Shelter Assistance Act. This legislation provided $50 million in competitive grants for outreach, regional conferences and resources on best practices for improving animal health and care in animal shelters, and in person assessments and training for local animal control agencies or shelters, societies for prevention of cruelty to animals, and humane societies. The Budget Act also required the University of California to submit a report by March 31, 2023 on the use of funds, activities supported, a list of grantees, and analysis of the programs impact.

In February of 2022, the California for All Animals program was launched to advance marketing and outreach efforts designed to engage shelters in every region of the state that met the goals outlined in the Animal Shelter Assistance Act. $15.5 million in awards has since been awarded, along with about $12.5 million for in-person visits, trainings, outreach, and program expenses. Grant funding is prioritized for programs to increase low-cost and free spay/neuter services, access to low cost and free veterinary care to prevent owner relinquishment to animal shelters, and programs that reunite lost pets with their owners and incentivize making adoption accessible for all communities.

In its report to the Legislature dated March 22, 2023, the University of California provided an overview of the state's efforts to reduce euthanasia within animal shelters. The report noted that "over 180,000 animals still lost their lives in animal shelters two decades after SB 1785 was enacted and this trend has recently accelerated." The University of California further explained in its report:

> "Prior to the COVID-19 pandemic, programs were in place to help keep pets out of shelters, which included free and low-cost veterinary care, spay/neuter services, and supplies to keep pets in homes; however, the COVID-19 pandemic drastically reduced the availability of affordable and accessible spay/neuter services and growing economic hardship has led to an increase in animals brought to shelters. In particular, animal shelters are taking in puppies and large dogs at a rate that has not been seen in many years."

Following news reports of the tragic case of a terrier puppy named Bowie that had been euthanized at an animal shelter in Baldwin Park, California, Assemblymember Bill Essayli introduced Assembly Bill 595 in 2023. That bill would have required all animal shelters to provide public notice on their internet websites at least 72 hours before euthanizing any animal. That public notice would have been required to include information that includes, but is not limited to, the date that an animal is scheduled to be euthanized. AB 595 would also have required the California Department of Food and Agriculture (CDFA) to conduct a study on topics relating to the overcrowding of California's animal shelters and ways that the state might address animal shelter overcrowding. The bill specifically directed the CDFA to consider the feasibility of a statewide database of dogs and cats that provides public notice and information at the statewide level in the same manner that the bill would require at each individual animal shelter. AB 595 was held on the Assembly Appropriations Committee's suspense file.

This bill would establish similar requirements by requiring agencies and shelters to provide public notice before euthanizing an animal. First, the agency or shelter would have to post a daily list of any cat or dog scheduled for euthanasia on their public internet website or public Facebook page. Second, the agency or shelter would be required to post a physical notice on the kennel of a dog or cat scheduled to be euthanized using 8.5 inch by 11 inch paper with the word EUTHANIZE appearing in size 72 font.

Both the daily list and the physical notice would be required to be provided up to 72 hours before a scheduled euthanasia of a dog or cat but no later than 24 hours before a scheduled euthanasia of a dog or cat. Both the daily list and the physical notice would also be required to document the reason for the scheduled euthanasia and whether the dog or cat is available for one adoption, fostering, or transfer to a rescue group. The agency or shelter would then be additionally required to clearly state the contact email and telephone number of the appropriate department or person to contact so that rescue, foster, or adoption can be immediately effectuated.

Spaying and Neutering Surgery Requirements. In 2024, the Legislature passed Assembly Concurrent Resolution 86, introduced by Assemblymember Ash Kalra and sponsored by Social Compassion in Legislation. The resolution declared that there is a pet overpopulation crisis in California and that California's private and public shelters and the private rescue organizations that support them are overwhelmed with animals. ACR 86 resolved that allocation of adequate funding for statewide spay and neuter programs and resources for broader enforcement of state and local licensing, breeding, and spay and neuter laws is urgently needed, and that the state is encouraged to conduct a public relations campaign urging Californians to adopt shelter animals.

As part of the state's efforts to address the perceived pet overpopulation crisis, numerous efforts have been championed over the years to increase sterilization rates for dogs and cats. After a successful campaign by an advocacy organization and the VMB, a Pet Lover's License Plate program was established in 2012, and in 2014, Senate Bill 1323 (Lieu) was enacted to allocate the proceeds from purchases of this specialty license plate to fund a grant program to eligible veterinary facilities that offer low-cost or no-cost animal sterilization services under the VMB. Legislation enacted in 2015 clarified that the VMB had authority to utilize nonprofits to assist with the disbursement of grant funds, and in 2017 the Legislature shifted responsibility for the program from the VMB to the CDFA after members of the VMB raised conflict-of-interest concerns. The most recent distribution of grand funding by the CDFA in 2023 allocated approximately $488,000, with an estimated amount of $25,000 – $50,000 per award.

The Legislature additionally enacted Assembly Bill 485 (Williams) in 2015 to establish a voluntary checkoff to the state's personal income tax return to provide revenue to a Prevention of Animal Homelessness and Cruelty Fund. The checkoff is intended to fund a program through which the CDFA would allocate money to local animal control agencies and shelters to support spay and neuter activities and to prevent and eliminate dog and cat homelessness. In 2022, a total of $308,449 was contributed through the checkoff, and approximately $250,000 was awarded that year to eligible agencies, with an estimated amount of $7,500 – $22,500 per award.

Existing law states that a public animal control agency or shelter, society for the prevention of cruelty to animals shelter, humane society shelter, or rescue group shall not sell or give away to a new owner any dog that has not been spayed or neutered. This bill would similarly prohibit dogs or cats from being given to a foster unless a spay or neuter appointment has been scheduled for within 30 days. If a foster fails to bring the dog or cat to the animal's scheduled spay or neuter appointment, the public animal control agency or shelter must require the foster to voluntarily return the dog or cat. If the agency or shelter is unable to contact the foster, they must conduct a site visit to the foster's home to confirm whether the dog or cat has been altered and, if the dog or cat is still unaltered, the agency or shelter would be required confiscate the dog or cat.

Current Related Legislation.

AB 1988 (Muratsuchi) authorizes any puppy or kitten relinquished to a public or private animal shelter by the purported owner to be made immediately available for release to a nonprofit organization, animal rescue organization, or adoption organization. *This bill is pending in the Assembly Committee on Appropriations.*

AB 2133 (Kalra) would authorize registered veterinary technicians to perform cat neuter surgery, subject to specified conditions. *This bill is pending in the Assembly Committee on Appropriations.*

AB 2425 (Essayli) would require animal shelters to provide public notice on the internet that contains a list of all animals that are available for adoption or being held by the animal shelter, require the CDFA to conduct a study on animal shelter overcrowding and the feasibility of a statewide database of dogs and cats, expand the definition of "breeder," and place additional requirements on sales or transfers of dogs by breeders. *This bill is pending in this committee.*

AB 2012 (Lee) would require the California Department of Public Health (CDPH) to collect specified data from public animal shelters as part of their annual rabies control activities reporting, and authorizes the CDPH to contract out this requirement to a California accredited veterinary school. *This bill is pending in the Assembly Committee on Appropriations.*

SB 1459 (Nguyen) would, among other things, require public animal control agencies and shelters in counties with a population greater than 400,000 to publish and update specified data on their internet website, and exempt a veterinarian or registered veterinary technician from prosecution if they willfully release a cat as part of a trap, neuter, and release activity. *This bill is pending in the Senate Committee on Business, Professions, and Economic Development.*

SB 1478 (Nguyen) would require the inclusion of specified information in any order issued by a veterinarian that authorizes a registered veterinary technician to perform animal health care services on animals impounded by a public shelter. *This bill is pending in the Senate Committee on Business, Professions, and Economic Development.*

Prior Related Legislation.

AB 595 (Essayli) of 2023 would have required animal shelters to provide 72 hours public notice before euthanizing any dog, cat, or rabbit with information that includes information about the animal and that it is subject to euthanasia, and would have required the CDFA to conduct a study on animal shelter overcrowding and the feasibility of a statewide database for animals scheduled to be euthanized. *This bill was held on suspense in the Assembly Committee on Appropriations.*

AB 1881 (Santiago) of 2022 would have required every public animal control agency, shelter, or rescue group to conspicuously post or provide a copy of a Dog and Cat Bill of Rights. *This bill died on the Senate Floor.*

AB 2723 (Holden, Chapter 549, Statutes of 2022) established additional requirements on various types of public animal shelters related to microchip registration and the release of dogs and cats.

AB 702 (Santiago) of 2021 would have required local jurisdictions, animal control agencies, or the entities responsible for enforcing animal-related laws, to establish permit programs regulating the breeding of cats and dogs. *This bill died in this committee.*

AB 588 (Chen, Chapter 430, Statutes of 2019) required any shelter or rescue group in California to disclose when a dog has a bite history when it is being adopted out.

ACR 153 (Santiago, Chapter 72, 2018) urged communities in California to implement policies that support the adoption of healthy cats and dogs from shelters by 2025.

AB 2791 (Muratsuchi, Chapter 194, Statutes of 2018) permitted a puppy or kitten that is reasonably believed to be unowned and is impounded in a shelter to be immediately made available for release to a nonprofit animal rescue or adoption organization before euthanasia.

SB 1785 (Hayden, Chapter 752, Statutes of 1998) established that the State of California's policy is that no adoptable animal should be euthanized if it can be adopted into a suitable home.

ARGUMENTS IN SUPPORT:

This bill is sponsored by **Fix Our Shelters**. According to Fix Our Shelters: "Although it is the policy of our State that no adoptable animal should be euthanized, California leads the nation in the number of animals killed in shelters. If this shameful statistic is to change, the State must refocus its objectives away from untested, unproven and controversial programs and get back to basics. Shelters across our State instituted operational changes under the auspices of COVID. Many of these changes or "trends", such as 'reduced intake' protocols, advanced by UC Davis Koret Shelter Medicine Program (KSMP), conflict with State law and have jeopardized the health and safety of lost, abandoned, and sick animals. It's time for animal shelters to get back to proven, tested protocols that reduced the number of animals dying in our shelters, such as robust high-volume spay and neuter resources. It's time for common sense. It's time for OVERSIGHT AND ACCOUNTABILITY."

The **No Kill Advocacy Center** also supports this bill, writing: "Despite California being the wealthiest state in the country (if it were a country in and of itself, it would be the fourth largest economy in the world) and priding itself on being progressive, the 72-hour holding period currently in effect is the lowest of any other state, with one exception. In addition, since the holding period runs on a 24-hour cycle, much of the holding period can be used up when the shelter is closed in the evening and often on weekends. This leaves animals precious little time to get out alive. Not surprisingly, California kills more animals than any other state except Texas. Indeed, a recent report found that 'Five states account for half of all cats and dogs killed in U.S. animal shelters: California, Texas, Florida, North Carolina, and Alabama.' California joins that ignoble list precisely because animals in our shelters have so few protections. AB 2265 is an important step to remedy this."

ARGUMENTS IN OPPOSITION:

The **California Animal Welfare Association** writes in opposition to this bill in a letter that is signed by numerous animal shelters, humane societies, rescue groups, labor representatives, local governments, and other public and nonprofit organizations. The letter states: "We know that animal lovers in California are frustrated seeing us struggle and we are working with a number of authors and bill sponsors this year to address some of the core themes that have surfaced including internal factors like operational transparency and external factors like soaring pet care costs, housing availability and pet restrictions, and a critical shortage of veterinary access in nearly every community. We understand what the proponents and author of AB 2265 are trying to accomplish, unfortunately, this bill will only exacerbate the difficulties facing shelters in nearly every imaginable way and will ultimately lead to even worse overcrowding and tragic outcomes both in and out of shelters." The letter further argues that "We are in the shelters every day fighting for the animals in our care. We work tirelessly to see every cat and dog as an individual with independent needs. Lifesaving is a collaboration and CalAnimals and our shelter members welcome opportunities to have productive conversations around solutions that help create positive outcomes and greater support for animals and their people in California."

POLICY ISSUE(S) FOR CONSIDERATION:

Spay and Neuter Requirements for Fosters. Foster programs are a critical component of many public and private shelter operations across the state, freeing up space in shelters while adoptable animals are placed in a foster home. Research conducted by University of California, Davis's Koret Shelter Medicine Program (KSMP), one of the nation's only veterinary schools with a specific program focused on improving shelter outcomes, highlights reduced intake into shelters, and foster placement when possible, as specific factors that lead to improved overall outcomes in the shelter system. Foster placements are often a way shelters secure additional space while an animal is awaiting spay or neuter surgery, which is mandated before the animal can be adopted out to a new owner. Animals placed under foster care remain in the custody of the shelter, and all laws regarding sterilization and vaccination of shelter pets still apply. Fosters are also a way for shelters to expand their capacity to care for animals who may be recovering from a medical condition, or to take in young animals who are not yet mature enough to be spayed or neutered.

As written, this bill places new, arguably onerous deadlines on the scheduling of spay or neuter surgeries when an animal is placed in foster care. Under this bill, any public animal shelter must schedule an appointment for any dog or cat placed in foster care within five business days of the animal departing the shelter, and further stipulates that this appointment must be within 30 business days of the animal's departure. If the foster fails to bring the animal to the scheduled appointment, they would be required to surrender the animal back to the shelter within seven days, and if the shelter is unable to make contact with the foster, would be required to dispatch an animal control officer to the foster's home to confirm alteration and confiscate the animal if they remain unsterilized. The bill offers no exceptions to these strict requirements.

Notwithstanding civil and practical concerns around the feasibility of an animal control officer entering a private residence and physically inspecting the foster animal, it is unclear how these requirements will serve to improve outcomes in shelters or decrease animal overpopulation in the state. According to the American Veterinary Medical Association, the United States is facing a record shortage of licensed veterinarians in the workforce, an issue even more acute for California shelters. Further data from KSMP demonstrates that more than 50 percent of veterinary positions in shelters remain vacant, and 64 percent of shelters cannot adequately provide for basic medical needs, including spay and neuter. Presently, animals at shelters wait weeks or longer to receive sterilization surgeries.

Concerns have been raised that the mandates included in this bill set an improbable standard for shelters and fosters to meet when compared to the disparities in veterinary access, and will lead to further overcrowding at public shelters. Considering that foster programs are a valuable tool to increase shelter capacity while otherwise-adoptable animals await sterilization surgery, this mandate may lead to less overall animal sterilizations and could put further crowding pressure on shelters, particularly in under-resourced jurisdictions. The author may wish to remove these provisions so additional discussion can occur prior to imposing these or similar requirements.

Social Media Terminology. This bill requires that animal shelters post a daily list of any cat or dog scheduled to be euthanized, with the option to post the list on either their website or "public Facebook page." Specifying a particular brand or company in state law is not considered best practice. Additionally, such references are likely to become outdated or inapplicable. The author should consider amending this language to instead refer to a shelter's "public social media page."

Lack of Flexibility. This bill currently only provides for very limited exemptions to the 24 hour minimum requirement for shelters to provide both a daily list and physical notice. However, there may be circumstances where a shelter determines that providing the 24-hour notice is not in the best interest of either the animal scheduled to be euthanized or the general animal population at the shelter. The author may wish to provide animal shelters with discretion to determine when this is the case and to provide public notice for less than the required 24 hours. The bill could potentially require an animal shelter to document the reason for providing less than 72 hours' notice for each instance where it utilizes this exemption, with that documentation available for inspection by the public.

Criminal Penalties. Currently, violations of the notice requirements in this bill would be punishable as a misdemeanor. This is not due to specific language in the bill, but generally applicable language contained in Section 9 of the Food and Agricultural Code, which states that "unless a different penalty is expressly provided, a violation of any provision of this code is a misdemeanor." It may not be appropriate to punish shelter employees as criminals for failing to comply with the provisions of this bill. The author may therefore wish to exempt this bill from the misdemeanor provision contained in Section 9.

AMENDMENTS:

1) To remove sections of the bill establishing or modifying requirements for spay and neuter surgeries, including requirements for dogs and cats to be given to a foster, so that discussions among stakeholders may continue and be considered in future legislation, strike Sections 3 through 10 of the bill.

2) To replace references to a specific website with more neutral terminology, strike the phrase "public Facebook page" as it appears in Section 11 of the bill and replace it with the phrase "public social media page."

3) To authorize an animal shelter to provide the required daily list or physical notice for less than 24 hours if the animal shelter determines that doing so is in the best interest of the animal or the general animal population at the shelter, insert a new subdivision in Section 11 of the bill as follows:

   (1) An animal shelter may provide the daily list described in subdivision (a) or the physical notice described in subdivision (b) for less than 24 hours if the animal shelter determines that doing so is in the best interest of the animal scheduled for euthanasia or the general animal population at the animal shelter.

   (2) For each instance where an animal shelter provides a daily list or public notice for less than 24 hours pursuant to paragraph (1), the animal shelter shall document the reason and shall keep it on file and available for public inspection for at least three years.

4) To clarify that violations of the bill's notice requirements do not constitute a crime punishable as a misdemeanor, add language providing that Section 9 does not apply to that section of the bill.

REGISTERED SUPPORT:

Fix Our Shelters *(Sponsor)*
All Beings Cooperative
Angel's Furry Friends Rescue
Animal Rescues for Change
ATSC Pets B4 Profit
Be Kind TNR
Beau's Bridge Club
Buckstop Animal Sanctuary
Coco Precious Furbaby Rescue
Community Cats United
Dachshunds and Friends Rescue
Elevation Animal Rescue
Fixfinder, Inc
Foster Tales
German Shepherd Rescue of Orange County
Giselle's Legacy All Breed Rescue & Sanctuary
Hi 5 Dog Rescue
Howard's Hound Haven
Humane Cat Trapping
Humboldt Humane
Idyllwild Animal Rescue Friends
K9 Protectors Inc.
Lake Tahoe Wolf Rescue
LapCats
Layla's Animal Cause
Loomis Bed & Biscuit Inn
Lucky Pup Dog Rescue
Martina Animal Rescue
Melita's Dream Animal Rescue
No Kill Advocacy Center
NorCal Bully Breed Rescue
Norsled – Northern California Sled Dog Rescue
Proactive Animal Sheltering
Resilient Dog Rescue
Reunion Rescue
Rocket Dog Rescue
Second Chance Cocker Rescue
Simbas Paws Dog Rescue
Southern California Pomeranian Rescue
STAR Stitch in Time Rescue
Sunset Oaks Equestrian Center
TEAH Rescue
The Animal Pad
Thompson River Animal Care Shelter
68 individuals

REGISTERED OPPOSITION:

Actors and Others for Animals
American Society for The Prevention of Cruelty to Animals (ASPCA)
Angel City Pit Bulls
ASAP Cats
Bakersfield Police Department – Animal Control
Bakersfield SPCA
Barstow Humane Society
Berkeley-East Bay Humane Society
Best Friends Animal Society
Butte Humane Society
Calaveras Humane Society
California Animal Welfare Association
California Society for The Prevention of Cruelty to Animals
California State Association of Counties
California Teamsters Public Affairs Council
Carmel Police Department Animal Control
Central California Animal Disaster Team
City of Burbank Animal Shelter
City of Carpinteria
City of Chula Vista
City of Fresno
City of Huron
City of Lodi, Police Department – Animal Services
City of Loma Linda
City of Rancho Cordova
City of Rancho Cucamonga
City of Rancho Cucamonga Animal Center
City of Shafter Animal Control Services
City of Shasta Lake Animal Shelter
City of Stockton Animal Shelter
Colusa County Animal Services
County Health Executives Association of California
County of Monterey Animal Services
County of Monterey Health Department
County of San Bernardino
County of San Diego
Delta Humane Society SPCA of San Joaquin County
East Bay SPCA
Eastern Madera County Humane Society (SPCA)
El Dorado County Animal Services
Elk Grove Animal Services
Fieldhaven Feline Center
Fontana Police Department Animal Services
Forgotten Felines of Sonoma County
Friends of Colusa County Animal Shelter
Friends of Madera Animal Shelter
Friends of the Alameda Animal Shelter

Front Street Animal Shelter – City of Sacramento
Haven Humane Society
Hawaiian Humane Society
High Sierra Animal Rescue
House Rabbit Society
Human Society Silicon Valley
Humane Society of Imperial County
Humane Society of San Bernardino Valley
Humane Society of Sonoma County
Humane Society of The Sierra Foothills
Humane Society of The United States
Humane Society of Truckee-Tahoe
Humane Society of Ventura County
Inland Valley Humane Society & SPCA
Inyo County Animal Services
Joybound People & Pets
Kern County Animal Services
Lake County Animal Care and Control
League of California Cities
Long Beach Animal Care Services
Manteca Police Department – Animal Services
Marin Humane
Mendocino County Animal Care Services
Michelson Center for Public Policy
National Animal Care & Control Association
Nevada County Animal Control/ NCSO H.E.A.R.T.T.
Oakland Animal Services
Palo Alto Animal Control
Palo Alto Humane Society
Pasadena Humane Society
Paws for Life K9 Rescue
Peninsula Humane Society & SPCA
Pets in Need
Pets Lifeline
Placer SPCA
Rancho Coastal Humane Society
Ridgecrest Animal Shelter
Riverside Humane Society
Rottweiler Rescue of Los Angeles
Sammie's Friends
San Diego Humane Society and SPCA
San Francisco SPCA
San Gabriel Valley Humane Society
San Mateo County Board of Supervisors
Santa Barbara Humane Society
Santa Cruz County Animal Shelter
Santa Cruz SPCA
SEAACA Animal Control
Selma Animal Services

Shadow's Fund
Siskiyou Humane Society
Solano County Sheriff's Office Animal Care Division
Sonoma County Animal Services
SpcaLA
SPCA Monterey County
Stray Cat Alliance
Sutter Animal Services Authority
Town of Apple Valley
Town of Paradise Animal Control and Shelter
Trinity County Sheriff's Office – Animal Control
Tulare Animal Services
Tuolumne County Animal Control
Urban Counties of California
Valley Humane Society
Ventura County Animal Services
Westminster Police Department – Animal Control Unit
Wolf Connection
Woods Humane Society
Yolo County Animal Services
71 individuals, including 66 veterinarians

Analysis Prepared by: Robert Sumner / B. & P. / (916) 319-3301, Edward Franco / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2425 (Essayli) – As Amended April 1, 2024

SUBJECT: Bowie's Law: animals: adoption, shelter overcrowding, and breeding.

SUMMARY: Requires animal shelters to provide public notice on the internet that contains a list of all animals that are available for adoption or being held by the animal shelter, requires the Department of Food and Agriculture (CDFA) to conduct a study on animal shelter overcrowding and the feasibility of a statewide database of dogs and cats, expands the definition of "breeder," and places additional requirements on sales or transfers of dogs by breeders.

EXISTING LAW:

1) Governs the operation of animal shelters by, among other requirements, setting a minimum holding period for stray dogs, cats, and other animals, and requiring animal shelters to ensure that those animals, if adopted, are spayed or neutered and, with exceptions, microchipped. (Food and Agricultural Code (FAC) §§ 30501 *et seq.*; §§ 31101 *et seq.*; §§ 31751 *et seq.*; §§ 32000 *et seq.*)[*]

2) Requires that a shelter must hold a stray dog for a specified period prior to adoption or euthanasia of a dog, must scan the dog for a microchip that identifies the owner of that dog, and must make reasonable efforts to contact the owner and notify them that their dog is impounded and is available for redemption. (FAC § 31108)

3) Requires that a shelter must hold a stray cat for a specified period prior to adoption or euthanasia of a cat, must scan the cat for a microchip that identifies the owner of that cat, and must make reasonable efforts to contact the owner and notify them that their cat is impounded and is available for redemption. (FAC § 31752)

4) Requires that a rabbit, guinea pig, hamster, potbellied pig, bird, lizard, snake, turtle, or tortoise that is impounded in a shelter must be held for the same period of time, under the same requirements of care, and with the same opportunities for redemption and adoption, as cats and dog. (FAC § 31753)

5) Requires all public animal shelters, shelters operated by societies for the prevention of cruelty to animals, and humane shelters that perform public animal control services, to provide the owners of lost animals and those who find lost animals with all of the following:

    a. Ability to list the animals they have lost or found on "Lost and Found" lists maintained by the animal shelter.

    b. Referrals to animals listed that may be the animals the owners or finders have lost or found.

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[*] *Note: Enforcement of a number of these provisions is suspended due to reimbursable state mandates on local government remaining unfunded.*

c. The telephone numbers and addresses of other animal shelters in the same vicinity.

d. Advice as to means of publishing and disseminating information regarding lost animals.

e. The telephone numbers and addresses of volunteer groups that may be of assistance in locating lost animals.

(FAC § 32001)

6) Requires all public and private animal shelters to keep accurate records on each animal taken up, medically treated, or impounded, which shall include all of the following information and any other information required by the Veterinary Medical Board of California:

a. The date the animal was taken up, medically treated, euthanized, or impounded.

b. The circumstances under which the animal was taken up, medically treated, euthanized, or impounded.

c. The names of the personnel who took up, medically treated, euthanized, or impounded the animal.

d. A description of any medical treatment provided to the animal and the name of the veterinarian of record.

e. The final disposition of the animal, including the name of the person who euthanized the animal or the name and address of the adopting party. These records shall be maintained for three years after the date on which the animal's impoundment ends.

(FAC § 32003)

7) Provides that it is the policy of the state that no adoptable animal should be euthanized if it can be adopted into a suitable home. (Penal Code § 599d; Civil Code § 1834.4)

8) Establishes the Polanco-Lockyer Pet Breeder Warranty Act, which regulates the sale dogs by dog breeders. (Health and Safety Code (HSC) §§ 122045 *et seq.*)

9) Requires every dog breeder to deliver to each purchaser of a dog a specified written disclosure and record of veterinary treatment. (HSC § 122050)

10) Requires dog breeders to maintain a written record on the health, status, and disposition of each dog for a period of not less than one year after disposition of the dog. (HSC § 122055)

11) Prohibits a dog breeder from knowingly selling a dog that is diseased, ill or has a condition, which requires hospitalization or nonelective surgical procedures. (HSC § 122060)

12) Requires every breeder who sells a dog to provide the purchaser at the time of sale, and a prospective purchaser upon request, with a written notice of rights, including conditions to return a dog and be eligible to receive a refund for an animal or reimbursement for veterinarian fees. (HSC § 122100)

13) Authorizes cities and counties to enact dog breed-specific ordinances pertaining only to mandatory spay or neuter programs and breeding requirements, provided that no specific dog breed, or mixed dog breed, shall be declared potentially dangerous or vicious under those ordinances; directs any cities or counties enacting such ordinances to measure the effect of those programs by compiling specified statistical information on dog bites, and report the information to the State Public Health Veterinarian. (HSC § 122331)

THIS BILL:

1) Defines "animal shelter" as a public animal control agency or shelter, society for the prevention of cruelty to animals shelter, or humane society shelter.

2) Requires an animal shelter to public notice in a conspicuous location on its internet website or a third-party internet website that contains a list of all animals that are available for adoption or that are being held.

3) Exempts from the public notice requirement an animal that is irremediably suffering from a serious illness or severe injury, newborn animals that need maternal care and have been impounded without their mothers, and dogs with a documented history of vicious or dangerous behavior.

4) Provides that violations of the bill's requirements shall not constitute a misdemeanor.

5) Requires the CDFA to conduct a study on the overcrowding of California's animal shelters, the ways in which the state might address animal shelter overcrowding, and the feasibility of a statewide database of dogs and cats that provides public notice and information at the statewide level about animals available for adoption, including, but not limited to, by pursuing a public-private partnership.

6) Requires the CDFA to submit a report on its study findings on or before January 1, 2027.

7) Expands the definition of a "dog breeder" or "breeder" for purposes of the Polanco-Lockyer Pet Breeder Warranty Act from persons or entities that sell, transfer, or give away all or part of three or more litters or 20 or more dogs during the preceding 12 months to persons or entities that sell, transfer, or give away all or part of two or more litters or 10 or more dogs during the preceding 12 months.

8) Requires breeders to have a microchip device implanted in the dog, before that dog reaches eight weeks of age, that identifies the breeder, and requires the breeder to register the identity of the new owner with the microchip registry company as the primary owner on the microchip device upon sale or transfer of the dog.

9) Exempts from the bill's microchipping requirements a dog determined to be medically unfit for the microchipping procedure by a licensed veterinarian because the animal has a physical condition that would be substantially aggravated by the procedure.

10) Requires breeders to provide information on the transference of ownership, including the microchip company information, the microchip number and any other relevant identifiers, and any other information necessary for a new owner to subsequently update the microchip registration as necessary.

11) Prohibits a dog from being sold or otherwise transferred by a breeder, whether for compensation or otherwise, until it has been immunized against common diseases and has a documented health check from a licensed veterinarian.

12) Expressly states that the Polanco-Lockyer Pet Breeder Warranty Act does not prohibit a city or county from adopting or enforcing a more restrictive breed-specific ordinance.

13) Provides that the act establishing the provisions in this bill shall be known as Bowie's Law.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by **Social Compassion in Legislation**. According to the author:

> "I am proud to be authoring AB 2425, Bowie's Law, which will mandate new dog breeder standards for enforcement, provide a publicly available database of adoptable animals in every shelter, and require a comprehensive study on the solutions to shelter overcrowding. This is multifaceted approach to the tragedy of our current system that results in thousands of otherwise healthy animals being euthanized each year due to a lack of shelter resources. Among those animals was a puppy named Bowie, who was put down shortly before he was scheduled to be adopted by an animal rescue. AB 2425 will move California toward a world where no other adoptable animal meets Bowie's fate."

Background.

Efforts to Reduce Euthanasia at California Animal Shelters. The California State Assembly declared in 2015 that the official State Pet is the shelter pet. According to information provided by the ASCPA in 2019, approximately 6.5 million companion animals enter animal shelters in the United States every year. While animal shelters play a critical role in caring for homeless pets, the number of animals entering shelters each year often exceeds the available resources and capacity to care for them, resulting in overcrowding. One of the options that shelters may consider is euthanasia as a means of managing the number of animals in their care.

In 1998, the Legislature enacted Senate Bill 1785 by Senator Tom Hayden, which formally established that the State of California's policy is "that no adoptable animal should be euthanized if it can be adopted into a suitable home" and "that no treatable animal should be euthanized." The Hayden Law required shelters to hold animals for a minimum of four to six days before euthanizing them, giving owners a chance to reclaim their pets or allowing animals to be adopted. Key provisions in the Hayden Law to support that policy included requirements that animal shelters do all of the following:

- Work to increase the number of animals reunited with owners by increasing the holding period for sheltered animals.

- Establish minimum holding periods for all owner-relinquished animals.

- Postpone euthanasia for any animal until after the expiration of the minimum holding period, with exceptions only for injured or very sick.

- Release animals slated for euthanasia to rescue groups upon request.

- Provide prompt and necessary veterinary care, nutrition, and shelter.

- Maintain a system of record keeping essential for reuniting lost animals with owners, managing housing, and documenting holding times and medical care.

Much of the Hayden Law has not been implemented or enforced due to fiscal challenges. In 2000, local governments successfully obtained a decision from the Commission on State Mandates that costs incurred by cities and counties in complying with the law must be reimbursed by the state. Subsequently beginning with the Budget Act of 2009, the state has not provided funding for this reimbursement. While a proposal by Governor Jerry Brown to repeal portions of the Hayden Law in 2012 was rejected by the Legislature, animal welfare advocates have argued that the bill was effectively annulled through its lack of funding.

Since the enactment of the Hayden Law, euthanasia rates in California animal shelters have remained high. According to data from the California Department of Public Health, 158,191 dogs and cats were euthanized in 2016. While it should be noted that this number is meaningfully lower than in previous years, there has been a call for action to further reduce euthanasia rates in California.

Language enacted as part of the Budget Act of 2021 established the Animal Shelter Assistance Act. This legislation provided $50 million in competitive grants for outreach, regional conferences and resources on best practices for improving animal health and care in animal shelters, and in person assessments and training for local animal control agencies or shelters, societies for prevention of cruelty to animals, and humane societies. The Budget Act also required the University of California to submit a report by March 31, 2023 on the use of funds, activities supported, a list of grantees, and analysis of the programs impact.

In February of 2022, the California for All Animals program was launched to advance marketing and outreach efforts designed to engage shelters in every region of the state that met the goals outlined in the Animal Shelter Assistance Act. $15.5 million in grant awards has since been awarded, along with $12.5 million for in-person visits, trainings, outreach, and program expenses. Grant funding is prioritized for programs to increase low-cost and free spay/neuter services, access to low cost and free veterinary care to prevent owner relinquishment to animal shelters, and programs that reunite lost pets with their owners and incentivize making adoption accessible for all communities.

In its report to the Legislature dated March 22, 2023, the University of California provided an overview of the state's efforts to reduce euthanasia within animal shelters. The report noted that "over 180,000 animals still lost their lives in animal shelters two decades after SB 1785 was enacted and this trend has recently accelerated." The University of California further explained:

> "Prior to the COVID-19 pandemic, programs were in place to help keep pets out of shelters, which included free and low-cost veterinary care, spay/neuter services, and supplies to keep pets in homes; however, the COVID-19 pandemic drastically reduced the availability of affordable and accessible spay/neuter services and growing economic hardship has led to an increase in animals brought to shelters. In particular, animal shelters are taking in puppies and large dogs at a rate that has not been seen in many years."

Bowie. In December of 2022, the *Los Angeles Times* reported that a terrier puppy named Bowie had been euthanized at an animal shelter in Baldwin Park, California. The article reported that Bowie had been at the shelter for more than three weeks, during which time he "exhibited extreme fear and fearful aggression." While Bowie was featured on the agency's website as available for rescue, the notice did not specifically mention that he would be euthanized if no one adopted him.

According to the *Times* article, a rescue group called Underdog Heroes reached out to the agency inquiring about adopting Bowie, but somehow the communication was not received or relayed to the appropriate individuals at the agency. Bowie was put down shortly thereafter, reportedly at the decision of one employee. This led to outcry among animal advocates, who believed that Bowie was unnecessarily euthanized due to inadequate efforts by the agency to find him a home.

Several weeks later, the Los Angeles County Board of Supervisors voted to order the agency to investigate the dog's death "in collaboration with rescue partners and animal welfare stakeholders." In addition, the Board of Supervisors voted approved a motion directing the Los Angeles County Department of Animal Care and Control Services to provide a five-year plan to reduce the number and percentage of animals who are euthanized.

The author of this bill introduced a prior bill in 2023, Assembly Bill 595, in direct response to the incident that occurred in Los Angeles County, and formally titled the legislation "Bowie's Law." That bill would have required all animal shelters to provide public notice on their internet websites at least 72 hours before euthanizing any animal. That public notice would have been required to include information that includes, but is not limited to, the date that an animal is scheduled to be euthanized. The bill would also have required the CDFA to conduct a study on topics relating to the overcrowding of California's animal shelters and ways that the state might address animal shelter overcrowding. The bill specifically directed the CDFA to consider the feasibility of a statewide database of dogs and cats that provides public notice and information at the statewide level in the same manner that the bill would require at each individual animal shelter. AB 595 was held on the Assembly Appropriations Committee's suspense file.

This bill, also formally titled Bowie's Law, would similarly require animal shelters to provide public notice about animals available for adoption. However, there is no longer a 72 hour requirement in the bill, nor is there specific reference to an animal being subject to euthanasia. Instead, the bill would more simply require that notice be posted in a conspicuous location on the shelter's internet website or a third-party internet website that contains a list of all animals that are available for adoption or that are being held by the shelter.

Animal Breeding. California regulates the sale of dogs by dog breeders through the Polanco-Lockyer Pet Breeder Warranty Act. Under the Warranty Act, "dog breeders" are defined as a person, firm, partnership, corporation, or other association that has sold, transferred, or given away all or part of three or more litters or 20 or more dogs during the preceding 12 months that were bred and reared on the premises of the person, firm, partnership, corporation, or other association. Broadly, the Warranty Act allows a consumer to receive a refund or reimbursement should they purchase a sick pet, or a pet that is found to have a hereditary or congenital condition requiring surgery or hospitalization. The Warranty Act further regulates California dog breeders by requiring breeders to provide specific written disclosures, including the breeder's name, address, information on the dog, and signed statements that the dog has no known diseases or illnesses, as well as a notice of the purchaser's rights to obtain a refund or reimbursement.

Professional breeders are generally recognized as responsible breeding operations who adhere to strict animal health, safety, and breeding standards; maintain active membership in their kennel clubs, and conduct extensive research on breed lineage, health risks, and canine or feline obstetrics. Professional breeders comply with all existing state laws when selling an animal, and ensure that contracts meet existing requirements on health guarantees such as the ones outlined in the Polanco-Lockyer Pet Breeder Warranty Act.

Commercial breeders—sometimes referred to "puppy mills" or "kitten factories"—generally refer to commercial, high-volume breeding facilities that mass produce animals for retail sale. Although commercial breeders are required to abide by the federal Animal Welfare Act (AWA), with some operations even licensed under the United States Department of Agriculture, there is limited oversight and enforcement of the requirements. According to several animal welfare groups, mills often rear animals in squalid and inhumane conditions, with certain facilities having long and documented histories of repeated violations of the AWA. Over the years, public scrutiny and subsequent legislative action has been placed curbing the sale of animals coming from large-scale commercial operations. AB 485 (O'Donnell) was enacted in 2017 to prohibit pet store operators from selling a live cat, dog, or rabbit unless the animal is offered through a public animal control agency or shelter, specified nonprofit, or animal rescue or adoption organization. That bill attempted to address both overcrowding in California animal shelters and reduce sales from out-of-state puppy mills.

"Backyard breeder" is an informal catch-all term referring to breeders with little experience or knowledge in the practice of animal breeding. While such breeders are not necessarily unethical, breeding without the training, knowledge, or even support of a kennel club can lead to genetic issues and put the health and safety of the animal and their offspring at risk. Untrained breeders may have various reasons for breeding an animal, from making extra income, or having extra puppies or kittens for their own family. Over the years, local jurisdictions have reported untrained breeders selling sick or injured animals who were raised in inhumane conditions, though it is unclear to what extend these individuals are responsible for other issues relating to animal overcrowding and welfare.

This bill would amend the Polanco-Lockyer Pet Breeder Warranty Act to expand the definition of "breeder" or "dog breeder" to encompass more individuals and entities who would be required to comply with that act. The bill would lower the threshold for the number of dog litters sold, transferred, or given away per 12 month period from three litters to two litters. Similarly, it would lower the threshold of individual dogs sold, transferred, or given away per 12 period from 20 dogs to 10 dogs. Those newly captured breeders—many of whom may be hobbyist or incidental breeders—would then have to comply with new requirements under the Warranty Act.

Additionally, this bill would add to the requirements for all breeders under the Warranty Act. First, this bill would require breeders to have a microchip device implanted in each dog they sell or transfer that identifies the breeder, unless a licensed veterinarian determines the dog is medically unfit for the microchipping procedure. Breeders would then be required to register the identity of the new owner of the dog once the animal is sold or otherwise transferred, and would be required to provide information on the transference of ownership, including the microchip company information, the microchip number and any other relevant identifiers, and any other information necessary for a new owner to subsequently update the microchip registration as necessary.

Second, this bill would prohibit a breeder from selling or otherwise transferring a dog, whether for compensation or otherwise, unless the dog has been immunized against common diseases and has a documented health check from a licensed veterinarian. Currently, animal shelters are similarly required to vaccinate and microchip dogs prior to adopting them out. The author believes that these same requirements should be applied to breeders.

Current Related Legislation.

AB 2265 (McCarty) would require animal shelters to post both daily lists on the internet and physical notices on animal kennels for cats or dogs scheduled for euthanasia at least 24 hours prior to the animal is scheduled to be euthanized; would amend language declaring the policies of the state regarding the euthanasia of animals; would prohibit shelters and rescue groups from giving a dog or cat to a foster unless spay or neuter surgery has been scheduled within 30 days; requires shelters seeking to adopt a policy, practice, or protocol that potentially conflicts with the Hayden Law to give notice to their local government and then schedule a public hearing; and makes various additional changes to existing laws and requirements relating to animal welfare and animal shelters.

AB 1988 (Muratsuchi) authorizes any puppy or kitten relinquished to a public or private animal shelter by the purported owner to be made immediately available for release to a nonprofit organization, animal rescue organization, or adoption organization. *This bill is pending in the Assembly Committee on Appropriations.*

AB 2133 (Kalra) would authorize registered veterinary technicians to perform cat neuter surgery, subject to specified conditions. *This bill is pending in the Assembly Committee on Appropriations.*

AB 2012 (Lee) would require the California Department of Public Health (CDPH) to collect specified data from public animal shelters as part of their annual rabies control activities reporting, and authorizes the CDPH to contract out this requirement to a California accredited veterinary school. *This bill is pending in the Assembly Committee on Appropriations.*

SB 1459 (Nguyen) would, among other things, require public animal control agencies and shelters in counties with a population greater than 400,000 to publish and update specified data on their internet website, and exempt a veterinarian or registered veterinary technician from prosecution if they willfully release a cat as part of a trap, neuter, and release activity. *This bill is pending in the Senate Committee on Business, Professions, and Economic Development.*

SB 1478 (Nguyen) would require the inclusion of specified information in any order issued by a veterinarian that authorizes a registered veterinary technician to perform animal health care services on animals impounded by a public shelter. *This bill is pending in the Senate Committee on Business, Professions, and Economic Development.*

Prior Related Legislation.

AB 595 (Essayli) of 2023 would have required animal shelters to provide 72 hours public notice before euthanizing any dog, cat, or rabbit with information that includes information about the animal and that it is subject to euthanasia, and would have required the CDFA to conduct a study on animal shelter overcrowding and the feasibility of a statewide database for animals scheduled to be euthanized. *This bill was held on suspense in the Assembly Committee on Appropriations.*

AB 1881 (Santiago) of 2022 would have required every public animal control agency, shelter, or rescue group to conspicuously post or provide a copy of a Dog and Cat Bill of Rights. *This bill died on the Senate Floor.*

AB 2723 (Holden, Chapter 549, Statutes of 2022) established additional requirements on various types of public animal shelters related to microchip registration and the release of dogs and cats.

AB 702 (Santiago) of 2021 would have required local jurisdictions, animal control agencies, or the entities responsible for enforcing animal-related laws, to establish permit programs regulating the breeding of cats and dogs. *This bill died in this committee.*

AB 588 (Chen, Chapter 430, Statutes of 2019) required any shelter or rescue group in California to disclose when a dog with a bite history when it is being adopted out.

ACR 153 (Santiago, Chapter 72, 2018) urged communities in California to implement policies that support the adoption of healthy cats and dogs from shelters by 2025.

AB 2791 (Muratsuchi, Chapter 194, Statutes of 2018) permitted a puppy or kitten that is reasonably believed to be unowned and is impounded in a shelter to be immediately made available for release to a nonprofit animal rescue or adoption organization before euthanasia.

SB 1785 (Hayden, Chapter 752, Statutes of 1998) established that the State of California's policy is that no adoptable animal should be euthanized if it can be adopted into a suitable home.

ARGUMENTS IN SUPPORT:

Social Compassion in Legislation (SCIL) is sponsoring this bill. According to SCIL: "By ensuring that all animal shelters are posting their adoptable animals online, we can ensure that those looking to add a pet to their family are able to see the many wonderful pets available without having to necessarily travel to the shelter first. The easier it is for potential adopters to find the animal right for their family, the more animals will be adopted. Additionally, posting online helps animal rescues know who is available and where their help is needed most." SCIL further argues that "ensuring that breeders also properly inoculate the dogs they sell will cut down on new pet owners from incurring expensive veterinary bills early in the animal's life, which can lead to the owner surrendering the animal to a shelter."

ARGUMENTS IN OPPOSITION:

The **American Kennel Club** (AKC) opposes this bill unless amended. According to the AKC, "AKC is a strong defender of policies that promote responsible pet ownership and protecting the health and welfare of dogs." However, AKC argues that the bill "tacitly assumes that small scale, hobby dog breeders are contributing to poor conditions in California's animal shelters. While the AKC is not opposing the idea that breeders should offer contracts with some consumer protection or keep their dogs in humane conditions (as is already *required* under state law), this new definition indicates a significant shift in who the state believes should be regulated." The AKC additionally raises concerns that the bill "could see dogs vaccinated prematurely in ways that are not in accordance with veterinary recommendations."

POLICY ISSUE(S) FOR CONSIDERATION:

Immunization requirements on breeders. This bill places new requirements on breeders who intend to sell or transfer a dog under the Polanco-Lockyer Pet Breeder Warranty Act, including new mandates regarding microchipping and immunization against diseases. However, concerns have been raised that as written, mandates under this bill could conflict with other established laws and best practices in veterinary medicine. While some immunizations, such as parvovirus, are recommended for puppies as early as six weeks of age, others, such as rabies, are often not given until three months, with their final round of vaccines typically administered around four months. In fact, current law under the Health and Safety Code mandates that owners can only obtain a license for their dog after they are four months of age. In addition, there may be certain breed-specific limitations or additional care. The author should amend this bill to ensure that all required immunizations are in accordance with veterinary recommendations for the age and breed of the dog being sold or transferred.

AMENDMENTS:

To ensure that immunizations administered to dogs being sold or otherwise transferred by a breeder are consistent with laws and best practices in veterinary medicine, subdivision (b) in Section 5 of the bill should be amended as follows:

> *(b) A dog shall not be sold or otherwise transferred by a breeder, whether for compensation or otherwise, until it has been immunized against common diseases in accordance with veterinary recommendations for the age and breed of the dog and has a documented health check from a California-licensed veterinarian.*

REGISTERED SUPPORT:

Social Compassion in Legislation *(Sponsor)*
A Passion for Paws – Akita Rescue
Animal Solutions
Barks of Love Animal Rescue
Better Together Forever
Catmosphere Laguna Foundation
Cultivate Empathy for All
Fix Our Shelters
Foods by Jude
Greater Los Angeles Animal Spay Neuter Collaborative
Gurrs and Purrs Rescue
Hanaeleh
Humboldt Humane
Kesar and Cardi
Latino Alliance for Animal Care Foundation
Little Hill Sanctuary
Los Angeles Democrats for The Protection of Animals
Love Leo Rescue
Motherlode Feral Cat Alliance
NY 4 Whales
Outta the Cage
PAAW – People Advocating for Animal Welfare

Poison Free Malibu
Preetirang Sanctuary
Project Minnie
Sacramento Vegan Society
Saving Imperial Rescue
Start Rescue
Take Me Home
Terra Advocati
The Animal Coalition Group
The Animal Rescue Mission
The Canine Condition
Tippedears
UnchainedTV
Westside German Shepherd Rescue
Women United for Animal Welfare
1,256 individuals

REGISTERED OPPOSITION:

American Kennel Club
The Animal Council

Analysis Prepared by: Robert Sumner / B. & P. / (916) 319-3301, Edward Franco / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2526 (Gipson) – As Amended April 8, 2024

SUBJECT: Nurse anesthetists.

SUMMARY: Creates a general anesthesia (GA) permit under the Dental Board of California (DBC) that authorizes a certified registered nurse anesthetist (CRNA) to administer deep sedation (DS) and GA in any dental office and authorizes a GA-permitted CRNA to select and order anesthesia, as defined, upon the request of a dentist.

EXISTING STATE LAW:

1) Regulates the practice of nursing through the licensure of registered nurses (RNs) under the Nursing Practice Act. (Business and Professions Code (BPC) §§ 2700-2838.4)

    a) Establishes the Board of Registered Nursing (BRN) until January 1, 2027, within the Department of Consumer Affairs (DCA) to administer and enforce the Nursing Practice Act. (BPC § 2701)

    b) Defines the RN scope of practice as functions, including basic healthcare, that help people cope with or treat difficulties in daily living that are associated with their actual or potential health or illness problems, and that require a substantial amount of scientific knowledge or technical skill. (BPC § 2725)

    c) Includes within the scope of RN practice all of the following:

        i) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures. (BPC § 2725(b)(1))

        ii) Direct and indirect patient care services, including the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist. (BPC § 2725(b)(2))

        iii) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries. (BPC § 2725(b)(3))

        iv) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with "standardized procedures," or the initiation of emergency procedures. (BPC § 2725(b)(4))

    d) Defines "standardized procedures" as either of the following:

i) Policies and protocols developed by a licensed health facility through collaboration among administrators and health professionals including physicians and nurses. (BPC § 2725(c)(1))

ii) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system that is not a licensed health facility. (BPC § 2725(c)(2))

e) Defines "nurse anesthetist" as a licensed RN who has met standards for certification from the BRN, which must consider the standards of the National Board of Certification and Recertification for Nurse Anesthetists, or a successor national professional organization approved by the BRN. (BPC § 2826(a))

f) Authorizes a CRNA to provide anesthesia services in (1) an acute care facility if approved by the acute care facility administration and the appropriate committee, and at the discretion of the physician, dentist or podiatrist, and (2) in a dental office, the dentist holds a GA permit. (BPC § 2827)

2) Regulates the practice of medicine through the licensure of physician and surgeons under the Medical Practice Act and establishes the Medical Board of California (MBC) until January 1, 2028, to administer and enforce the act. (BPC §§ 2000-2529.6)

3) Regulates the practice of dentistry through the licensure of dentists and dental auxiliaries under the Dental Practice Act and establishes the DBC until January 1, 2025, to administer and enforce the act. (BPC §§ 1600-1976)

a) Regulates the use of DS and GA in dentistry. (BPC §§ 1646-1646.13)

b) Defines "deep sedation" as a drug-induced depression of consciousness during which (1) patients cannot be easily aroused but respond purposefully following repeated or painful stimulation; (2) the ability to independently maintain ventilatory function may be impaired; (3) patients may require assistance in maintaining a patent airway; and (4) spontaneous ventilation may be inadequate; but (5) Cardiovascular function is usually maintained. (BPC § 1646(a))

c) Defines "general anesthesia" as a drug-induced loss of consciousness during which (1) patients are not arousable, even by painful stimulation; (2) the ability to independently maintain ventilatory function is often impaired; (3) patients often require assistance in maintaining a patent airway; (4) positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function; and (5) cardiovascular function may be impaired. (BPC § 1646(b))

d) Requires a dentist to possess (1) either a current license in good standing, a permit in oral and maxillofacial surgery, or a special teaching permit and (2) a DBC-issued GA permit to administer or order the administration of DS or GA on an outpatient basis for dental patients. (BPC § 1646.1(a))

e) Requires a dentist to be physically within the dental office at the time of ordering, and during the administration of, GA or DS. (BPC § 1643.1(c))

f) Requires a dentist to possess a pediatric endorsement of their GA permit to administer or order the administration of DS or GA to patients under seven years of age. (BPC § 1643.1(b))

g) Requires, for patients under 13 years of age, all of the following:

   i) The presence of the operating dentist and at least two additional personnel throughout the procedure involving DS or GA. (BPC § 1643.1(d)(1))

   ii) If the operating dentist is the permitted anesthesia provider, then both of the following:

      (1) The operating dentist and at least one of the additional personnel maintain current certification in Pediatric Advanced Life Support (PALS) or other DBC-approved training in pediatric life support and airway management, and the additional certified personnel is solely dedicated to monitoring the patient and is be trained to read and respond to monitoring equipment including, but not limited to, pulse oximeter, cardiac monitor, blood pressure, pulse, capnograph, and respiration monitoring devices. (BPC § 1643.1(d)(2)(A))

      (2) The operating dentist is responsible for initiating and administering any necessary emergency response. (BPC § 1643.1(d)(2)(B))

   iii) If a dedicated permitted anesthesia provider is monitoring the patient and administering DS or GA, both of the following:

      (1) The anesthesia provider and the operating dentist, or one other trained personnel, must be present throughout the procedure and must maintain current certification in PALS and airway management or other DBC-approved training in pediatric life support and airway management. (BPC § 1643.1(d)(3)(A))

      (2) The anesthesia provider is be responsible for initiating and administering any necessary emergency response and the operating dentist, or other trained and designated personnel, must assist the anesthesia provider in emergency response. (BPC § 1643.1(d)(3)(B))

h) Requires a dentist who desires to administer or order the administration of DS or GA to apply to the DBC on an application form prescribed by the DBC. The dentist must submit an application fee and produce evidence showing that they have successfully completed a minimum of one year of advanced training in anesthesiology and related academic subjects approved by the DBC, or equivalent training or experience approved by the DBC, beyond the undergraduate school level. (BPC § 1646.2(a))

i) Requires the application for a permit to include documentation that equipment and drugs required by the DBC are on the premises. (BPC § 1646.2(b))

j) Authorizes a dentist to apply for a pediatric endorsement for the GA permit by providing proof of successful completion of all of the following:

i) A Commission on Dental Accreditation (CODA)-accredited or equivalent residency training program that provides competency in the administration of DS and GA on pediatric patients. (BPC § 1646.2(c)(1))

ii) At least 20 cases of DS or GA to patients under seven years of age in the 24-month time period directly preceding application for a pediatric endorsement to establish competency, both at the time of initial application and at renewal. The applicant or permit holder must maintain and be able to provide proof of the cases upon request by the DBC for up to three permit renewal periods. (BPC § 1646.2(c)(2))

iii) Current certification in Advanced Cardiac Life Support (ACLS) and PALS or other DBC-approved training in pediatric life support and airway management for the duration of the permit. (BPC § 1646.2(c)(3))

k) Authorizes applicants for a pediatric endorsement who otherwise qualify for the pediatric endorsement but lack sufficient cases of pediatric sedation to patients under seven years of age to administer DS and GA to patients under seven years of age under the direct supervision of a GA permit holder with a pediatric endorsement. The applicant may count the cases toward the 20 cases required to qualify for the applicant's pediatric endorsement. (BPC § 1646.2(d))

l) Requires a physical evaluation and medical history to be taken before the administration of DS or GA. (BPC §1646.3(a))

m) Requires any dentist holding a permit to maintain medical history, physical evaluation, DS, and GA records as required by the DBC. (BPC § 1646.3(b))

n) Requires, prior to the issuance or renewal of a permit for the use of DS or GA, and authorizes the DBC to additionally require, an onsite inspection and evaluation of the licentiate and the facility, equipment, personnel, and procedures utilized by the licentiate; requires the permit of any dentist who has failed an onsite inspection and evaluation to be automatically suspended 30 days after the date on which the board notifies the dentist of the failure, unless within that time period the dentist has retaken and passed an onsite inspection and evaluation; requires every dentist issued a GA permit to have an onsite inspection and evaluation at least once every five years; and requires the refusal to submit to an inspection to result in automatic denial or revocation of the permit. (BPC § 1646.4(a))

o) Authorizes the DBC to contract with public or private organizations or individuals expert in dental outpatient GA to perform onsite inspections and evaluations, but prohibits the DBC from delegating its authority to issue permits or to determine the persons or facilities to be inspected. (BPC § 1646.4(b))

p) Authorizes a physician and surgeon to administer DS or GA in the office of a licensed dentist for dental patients, without regard to whether the dentist possesses a GA permit, if all of the following conditions are met:

i) The physician and surgeon possesses a current license in good standing. (BPC § 1646.9(a)(1))

ii) The physician and surgeon holds a valid GA permit issued by the DBC. (BPC § 1646.9(a)(2))

iii) The physician and surgeon meets the requirements patients under 13 years of age. (BPC § 1646.9(a)(3))

q) Requires a physician and surgeon applicant for a GA permit to apply to the DBC on an application form prescribed by the DBC and submit all of the following:

i) The payment of an application fee. (BPC § 1646.9(b)(1))

ii) Evidence satisfactory to the MBC showing that the applicant has successfully completed a postgraduate residency training program in anesthesiology that is recognized by the American Council on Graduate Medical Education. (BPC § 1646.9(b)(2))

iii) Documentation demonstrating that all equipment and drugs required by the DBC are on the premises for use in any dental office in which they administer DS or GA. (BPC § 1646.9(b)(3))

iv) Information relative to the current membership of the applicant on hospital medical staffs. (BPC § 1646.9(b)(4))

r) Requires, prior to issuance or renewal of a physician GA permit, and authorizes the DBC to additionally require, an onsite inspection and evaluation of the facility, equipment, personnel, including, but not limited to, the physician and surgeon, and procedures utilized. At least one of the persons evaluating the procedures utilized by the physician and surgeon must be a licensed physician and surgeon expert in outpatient DS or GA who has been authorized or retained under contract by the DBC for this purpose. (BPC § 1646.9(c))

s) Requires the permit of a physician and surgeon who has failed an onsite inspection and evaluation to be automatically suspended 30 days after the date on which the DBC notifies the physician and surgeon of the failure unless within that time period the physician and surgeon has retaken and passed an onsite inspection and evaluation; requires every physician and surgeon issued a GA permit to have an onsite inspection and evaluation at least once every five years; and requires refusal to submit to an inspection to result in automatic denial or revocation of the permit. (BPC § 1646.9(d))

t) Authorizes a physician and surgeon who additionally meets the requirements for a pediatric endorsement to provide DS or GA to a child under seven years of age to apply for the endorsement, and authorizes a physician and surgeon without sufficient cases to obtain an endorsement to qualify for the endorsement via supervised cases. (BPC § 1646.9(e))

u) Includes in the definition of unprofessional conduct for a dentist the failure to report to the DBC in writing within seven days any of the following: (A) the death of the licensee's patient during the performance of any dental or dental hygiene procedure; (B) the discovery of the death of a patient whose death is related to a dental or dental hygiene procedure performed by the licensee; or (C) except for a scheduled hospitalization, the

removal to a hospital or emergency center for medical treatment of any patient to whom oral conscious sedation, conscious sedation, or GA was administered, or any patient as a result of dental or dental hygiene treatment, unless removal to a hospital or emergency center is the normal or expected treatment for the underlying dental condition. (BPC § 1680(z)(1))

4) Prohibits the operation of an outpatient setting unless the setting is one of several authorized settings. (HSC § 1248.1)

   a) Defines "outpatient setting" as any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes. (Health and Safety Code (HSC) § 1248(b)(1))

   b) Includes as an authorized outpatient settings those used by a dentist or physician and surgeon in compliance with the GA and moderate sedation requirements of the Dental Practice Act. (HSC § 1248.1(f))

EXISTING FEDERAL LAW:

1) Regulates the manufacturing, importing, exporting, distributing, and dispensing of controlled substances under the Controlled Substances Act of 1970. (Title 21, U.S. Code (USC) §§ 800-971)

2) Establishes five schedules of drugs and other substances, known as schedules I, II, III, IV, and V, based on potential for abuse, medical utility, and dependence. (21 USC §§ 811-814)

3) Defines "controlled substance" as a drug or other substance, or immediate precursor, included in schedule I, II, III, IV, or V. (21 USC § 802(6))

4) Defines "administer" as the direct application of a controlled substance to the body of a patient or research subject by (A) a practitioner (or, in their presence, by their authorized agent), or (B) the patient or research subject at the direction and in the presence of the practitioner. (21 USC § 802(2))

5) Defines "dispense" as delivering a controlled substance to an ultimate user or research subject by, or pursuant to the lawful order of, a practitioner, including the prescribing and administering of a controlled substance and the packaging, labeling or compounding necessary to prepare the substance for such delivery. (21 USC § 802(10))

6) Requires every person who dispenses, or who proposes to dispense, any controlled substance, to register with the U.S. Drug Enforcement Administration (DEA). (21 USC § 822(a)(2); Title 28, Code of Federal Regulations (CFR) § 0.100; 21 CFR § 1301.11)

7) Authorizes controlled substance registrants to possess, manufacture, distribute, or dispense the substances or chemicals to the extent authorized by their registration type. (21 USC § 822(b); 21 CFR § 1301.13)

8) Defines "mid-level practitioner" as an individual practitioner, other than a physician, dentist, veterinarian, or podiatrist, who is licensed, registered, or otherwise permitted by the United States or the jurisdiction in which they practice, to dispense a controlled substance in the course of professional practice, including health care providers such as nurse practitioners, nurse midwives, CRNAs, clinical nurse specialists and physician assistants who are authorized to dispense controlled substances by the State in which they practice. (21 CFR § 1300.1)

9) Establishes exemptions to the registration requirement, including: (1) an agent or employee of any registered manufacturer, distributor, or dispenser of any controlled substance if the agent or employee is acting in the usual course of their business or employment; (2) an individual practitioner who is an agent or employee of a non-mid-level practitioner registered to dispense controlled substances when acting in the normal course of business or employment; and (3) an individual practitioner who is an agent or employee of a registered hospital or other institution when acting in the normal course of business or employment. (21 USC § 822; 21 CFR § 1301.22)

THIS BILL:

1) Authorizes a CRNA to administer GA or DS in the office of a licensed dentist to dental patients without regard to whether the dentist possesses a GA permit if both of the following conditions are met:

    a) The CRNA holds a valid GA permit issued by the DBC.

    b) The CRNA meets the existing requirements for patients under 13 years of age.

2) Requires a CRNA applicant for a GA permit to apply to the DBC on an application form prescribed by the DBC and submit all of the following:

        i) Payment of an application fee.

        ii) Evidence satisfactory to the DBC and the BRN showing that the applicant has successfully completed an accredited CRNA program approved by the BRN.

        iii) Documentation demonstrating that all equipment and drugs required by the DBC are on the premises for use in any dental office in which the CRNA administers GA or deep sedation.

3) Requires, prior to issuance or renewal of a CRNA GA permit, and authorizes the DBC to additionally require, an onsite inspection and evaluation of the facility, equipment, and personnel, including, but not limited to, the CRNA and procedures utilized, and requires at least one of the people evaluating the procedures utilized by the CRNA to be a CRNA expert in outpatient general anesthesia or deep sedation who has been authorized or retained under contract by the DBC for that purpose.

4) Requires a CRNA who has failed an onsite inspection and evaluation to have their permit automatically suspended for 30 days after the date on which the DBC notifies the CRNA of the failure unless within that time period the CRNA has retaken and passed an onsite inspection and evaluation.

5) Requires a CRNA who is issued a GA permit to undergo an onsite inspection and evaluation at least once every five years.

6) Requires a CRNA's refusal to submit to an inspection to result in automatic denial or revocation of the permit.

7) Authorizes a CRNA who additionally meets the requirements for a pediatric endorsement to provide GA or DS to a child under seven years of age to apply to the DBC for the endorsement.

8) Authorizes a CRNA without sufficient cases to obtain a pediatric endorsement to qualify for the endorsement via supervised cases.

9) Authorizes a CRNA to administer GA or DS in any dental office if in accordance with the DBC permit requirements and the RN scope of practice.

10) Defines "order" as the process of directing a licensed individual, pursuant to their statutory authority, to directly administer a drug or to dispense, deliver, or distribute a drug for the purpose of direct administration to a patient, under instructions of the CRNA to provide prescription drugs.

11) Defines "prescription drugs" as Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act.

12) Defines "select" as the decisionmaking process of choosing a drug, dosage, route, and time of administration.

13) Grants a CRNA who is registered with the DEA the "prescriptive authority" to select, order, or administer prescription drugs upon a request issued by a dentist for purposes of DS and GA to administer anesthesia for diagnostic, operative, or therapeutic procedures in an outpatient dental setting.

14) Requires a CRNA in outpatient dental settings to prescribe prescription drugs based on their level of professional education, training, and certification by the National Board of Certification and Recertification for Nurse Anesthetists, or a successor national professional organization approved by the BRN.

15) Specifies that a CRNA may only prescribe prescription drugs in a dental setting for an individual whom the CRNA has, at the time of the prescription, established a client or patient record.

16) Requires a CRNA upon registration or renewal of registration with the DEA to complete the required training as set forth by the agency.

17) Specifies that nothing in the Nursing Practice Act affects the authority of a CRNA to select, order, or administer prescription drugs for the delivery of perioperative anesthesia services beyond the outpatient dental setting.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the *California Association of Nurse Anesthesiology*. According to the author, "General anesthesia plays a crucial role in dental care, especially for pediatric patients and those with developmental disabilities, who often face challenges in receiving timely treatment. Consequently, many of these individuals require intensive restorative procedures under deep sedation or general anesthesia. However, accessing such care can be problematic due to a shortage of providers offering these services. An LAO study highlighted the issue, revealing long waitlists of up to three years in some cases at hospitals and oral surgery centers. Consequently, children and patients with disabilities often endure oral pain for extended periods of time. To address these challenges, this bill seeks to increase the number of anesthesia providers available to provide these services. This bill would allow Certified Registered Nurse Anesthetists to obtain a general anesthesia permit from the Dental Board of California and allow them to order anesthesia medications to administer in the dental office. This would enable the dentist to offer in-office anesthesia services provided by a licensed anesthesia provider while the dentist focuses on providing high-quality dental care. This would increase access to care for some of California's most vulnerable populations while maintaining stringent safety standards, with the goal of minimizing risks and maximizing patient outcomes. This bill embodies an unwavering commitment to prioritizing patient safety and increasing access to quality dental care."

Background. CRNAs are advanced practice RNs who specialize in anesthesia services. As RNs, CRNAs are licensed to perform health care functions that require a substantial amount of scientific knowledge or technical skill, including direct and indirect patient care, disease prevention and restorative measures, administration of medication and therapeutic agents upon order of a physician, dentist, podiatrist, or specified clinical psychologists, skin tests, immunizations, blood withdrawal, patient assessment, analysis, planning, and treatment implementation, and laboratory tests.

In addition to the base training required of an RN, CRNAs must obtain a minimum of a master's degree from a CRNA educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs. CRNAs generally practice in all settings where anesthesia is provided but may only provide anesthesia services in dental settings if the dentist has a GA permit or there is an anesthesiologist with a GA permit.

Dental Anesthesiology. Anesthesiology is the medical practice of inducing anesthesia, which is a temporary state of controlled loss of sensation or awareness for purposes of pain management or other perioperative care. There are varying levels of anesthesia, with higher levels of anesthesia presenting a higher risk of serious complications. DS and GA are the highest levels of anesthesia.

Anesthesia can be useful for facilitating dental care in averse populations, such as patients with anxiety or special needs. However, due to the safety risks of anesthesia, existing law establishes requirements on dental offices where dental anesthesia is practiced, including requiring dentists who wish to administer or order another provider to administer DS or GA in their office to obtain a permit. Anesthesiologists, the physician providers of anesthesia, must also apply for a GA permit. CRNAs may administer DS or GA upon the order of a GA-permitted dentist or physician.

The DBC reported 949 active dental GA permits and 153 physician GA permits at the end of fiscal year (FY) 2022-23.

Harm Data. Existing law requires dentists to report the death of the licensee's patient during the performance of any dental procedure, the discovery of the death of a patient whose death is related to a dental procedure performed by the licensee, or the removal to a hospital or emergency center for medical treatment of any patient to whom oral conscious sedation, conscious sedation, or GA was administered, or any patient as a result of dental treatment, unless removal to a hospital or emergency center is the expected treatment for the underlying dental condition.

Between January 1, 2017, and August 1, 2023, the DBC received 516 incident reports, and of the 516 incident reports, the DBC determined that:

- 215 reports related to incidents in which oral conscious sedation, moderate sedation, DS, or GA was administered, and the patient was subsequently hospitalized.

- 28 reports related to incidents in which oral conscious sedation, moderate sedation, DS, or GA was administered, and the patient died during or shortly after the dental procedure.

According to the DBC:

> Of the 28 reports of death during or shortly after a dental procedure in which sedation/anesthesia was administered, the Board found 1 report of an incident in which general anesthesia or deep sedation was administered to a pediatric patient resulting in a death during a dental procedure. A summary of the reported death is as follows:
>
> On June 12, 2017, the patient presented for dental rehabilitation under general anesthesia, which was administered by a dental anesthesiologist in a dental office. During the procedure, the patient experienced a life-threatening cardiac rhythm that required emergency medication and defibrillation. The incident was reported to the Board on June 15, 2017. The case was assigned to an investigator on June 15, 2017. The investigative report and all records were sent to an anesthesia expert, who determined that the attending dentist did not deviate from the standard of care in the dentist's care and treatment of the patient. On February 1, 2018, the case was closed with no violation.

Pediatric Dental Anesthesia. Pediatric dental anesthesia is being discussed in the DBC's sunset review this year.[1] The existing requirements for pediatric dental anesthesia are the result of a bill (SB 501 (Glazer), Chapter 929, Statutes of 2018) following the death of a child undergoing dental work under anesthesia. Specifically, that bill created a new process for the DBC to issue a GA permit (that may include a pediatric endorsement) as well as moderate and pediatric minimal sedation permits to applicants based on their level of experience and training and established new requirements for DS or GA administered to patients under thirteen years of age.

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[1] The sunset review process provides an opportunity for the DCA, the Legislature, the boards, and interested parties and stakeholders to discuss the performance of the boards, and make recommendations for improvements. Each year, the Assembly Business and Professions Committee and the Senate Business, Professions, and Economic Development Committee hold joint sunset review oversight hearings to review the boards and bureaus. For more information, see the background paper for the DBC's 2024 Sunset Review, accessible at: https://abp.assembly.ca.gov/jointsunsethearings.

In its sunset report, the DBC reports that it is still working to implement the provisions of SB 501 and continues to identify areas in the Dental Practice Act where technical changes may be necessary, including the following:

- Implementation of the new GA and sedation permits.
- Fees for GA and sedation permits.
- Ambiguities in the GA and sedation permits for physicians and surgeons.
- Outdated language for Oral Conscious Sedation for Adults certificates.
- Continuing education requirements and expiration dates for Pediatric Minimal Sedation Permits.
- Physical presence requirements when administering or ordering the administration of general anesthesia or sedation.
- Confidentiality concerns over submission of patient case information.
- Pediatric Minimal Sedation Permit requirements for physical evaluation and medical history.
- The definition of "good standing" and moving the good standing requirement to the sections on permit applications.
- Which kind of permit (and endorsement, if applicable) a permit holder should have, if not already specified.
- Medical recordkeeping requirement consistency.
- Ensuring patient safety and compliance with minimal sedation administration requirements by requiring that all minimal sedation procedures, including those performed to obtain a minimal sedation permit, in a private dental office meet established requirements for minimal sedation permit holders.

The DBC reported that there were 60 active pediatric endorsements at the end of FY 2023-24.

Current Related Legislation. SB 1453 (Ashby), which is pending in the Senate Business, Professions and Economic Development Committee, is the sunset review bill for the DBC.

Prior Related Legislation. SB 889 (Ochoa-Bogh) of 2022 would have established the CRNA GA permit aspect of this bill. SB 889 died pending a hearing in the Senate Business, Professions and Economic Development Committee.

SB 652 (Bates) of 2021 would have extended the requirements for dental patients under 13 years of age, specifically that an operating dentist and at least two additional personnel be present throughout a procedure involving deep sedation or general anesthesia, and that the dentist and one additional personnel maintain current certification in Advanced Cardiac Life Support (ACLS), to all patients regardless of age. SB 652 died pending a hearing in this committee.

SB 501 (Glazer), Chapter 929, Statutes of 2018, among other things, revised the requirements for the administration of various levels of outpatient dental sedation into what is currently required, including training, permitting, pediatric endorsement, physical evaluation, onsite inspection, and unprofessional conduct.

ARGUMENTS IN SUPPORT:

The *California Association of Nurse Anesthesiology* (sponsor) writes in support:

> Increased hospital wait times for dental care with general anesthesia lead to more patient complications. Often, patients will not seek dental care of any kind unless sedation or general anesthesia is available. This situation is compounded for pediatric patients who are unable to cooperate due to their developmental stage or intellectual disabilities and cannot tolerate effective dental care without the services of an anesthesia professional.
>
> Since 2021, there has been a progressive increase in delinquent and canceled general anesthesia permits. This trend reflects an increased need for dental anesthesia providers. Patients frequently avoid seeking dental care altogether due to the high cost of anesthesia, even when it is available. This situation in California has led to an unacceptable and inequitable lack of dental care for low-income patients, which has persisted for decades, creating major morbidity, illness, and even fatalities….
>
> Many Californians need anesthesia for dental care, and those dentists who desire anesthesia services from a CRNA can do so without the regulatory burden of obtaining a permit themselves. This allows the dentist to focus on providing dental care, while the CRNA is solely responsible for the anesthesia, and physiologic well-being of the patient. In addition, under [this bill], a CRNA would be authorized to order the necessary medications to provide this service. This prescriptive authority would only be authorized in a dental setting for these procedures. At the national level, CRNAs with prescriptive authority are eligible to apply for and obtain an individual DEA number. Liability and responsibility for anesthesia lies with the anesthesia provider, regardless of whether they are a physician anesthesiologist or CRNA.
>
> California CRNAs practice independently everywhere anesthesia is needed in the state. The dental outpatient setting, which is in need of anesthesia services, is the only place where a permit is required. CRNAs have been independent anesthesia providers in California since 2009. In fact, CRNAs are the sole anesthesia providers in 4 California counties. The impression that CRNAs operate solely as members of a physician-led care team is inaccurate and outdated. CRNAs are fully independent providers of anesthesia services and work in care team models only by choice. Also antiquated is the belief that liability lies with the ordering physician or dentist. CRNAs have accepted full liability for the administration of anesthesia since the inception of our licensure.
>
> CRNAs have advanced training and expertise in providing safe anesthesia in all settings, for all types of anesthesia for patients of all ages and medical complexities, with a proven safety record. In fact, CRNAs meet and exceed all the

safety requirements the Dental Board requests of their current permit holders for General Anesthesia and Pediatric Endorsement. CRNAs are safe, experienced, and dedicated anesthesia providers who are qualified to contribute their services to the dental care community that needs our help.

ARGUMENTS IN OPPOSITION:

The *California Association of Oral Maxillofacial Surgeons* (CALAOMS) writes in opposition:

> The Legislature approved SB 501 by Senator Glazer in 2018, which strengthened the requirements for the delivery of deep sedation/general anesthesia (DS/GA) to pediatric patients. That bill — which took effect January 1, 2022 — requires practitioners treating patients under the age of 13 to operate under a team delivery approach, with at least three individuals present during the administration of DS/GA….
>
> CALAOMS supports and seeks to apply these same SB 501 standards to patients of all ages - creating one standard for the delivery of DS/GA in the dental office and eliminating conflicting standards that could lead to confusion. These changes would not only streamline the delivery of anesthesia, but they would also bring California into compliance with the nationally recognized American Dental Association, American Association of Oral and Maxillofacial Surgeons, and American Society of Anesthesiologists' standards for the administration of office-based dental anesthesia.

The *California Society of Anesthesiologists* write in opposition:

> … we provide the following rationale as to how dangerous it would be to allow Certified Registered Nurse Anesthetists (CRNAs) to independently prescribe and order sedation and anesthesia in dental offices, as proposed by [this bill].
>
> First, all liability and responsibility for any anesthetic being ordered or administered in a dental office, must be maintained with the ordering dentist and/or anesthesiologist and the qualified dentist and/or anesthesiologist administering that anesthesia. Under existing law, CRNAs are already eligible to obtain a GA permit for administration of anesthesia in dental offices but they would need to have an "order" from an anesthesiologist or qualified dentist who has obtained the GA permit and pediatric endorsement from the Dental Board of California (hereafter; Board), if administering anesthesia to children under seven….
>
> It is inconceivable why we would allow CRNAs, who are not currently eligible to even obtain a DEA license in the state of California, to independently order and prescribe medication that will render a patient lifeless and unable to control any life-saving motor skills. Furthermore, many children and young adults receiving dental care under anesthesia in dental offices are often those with special needs and disabilities requiring a more complex level of care from a medical doctor (i.e. anesthesiologist).

> Nowhere else in California can you order or administer a level of anesthesia where the patient loses all forms of life-saving motor skills without that facility being state licensed, nationally accredited or Medicare certified. [This bill] would bypass these regulations for CRNAs in dental offices, which are solely intended to protect patient safety. These regulations and state oversight are in place to ensure that the facility is equipped with the necessary equipment, staffing, safety protocols, regular inspections, emergency transfer agreements, etc….
>
> Although undergoing anesthesia is now safer than ever before, there still remains the potential for complications and side-effects that may occur during procedures, especially in dental offices. Anesthesiologists and dentists with a GA permit and pediatric endorsement (when necessary) from the California Dental Board have the advanced training and expertise to help minimize these risks by vigilantly monitoring for any problems, immediately responding to complications, exercising medical judgment, and making split-second decisions that save lives. Although CRNAs are also an important part of the healthcare system and provide high quality care in many settings and situations in a physician-led anesthesia care team model. However, CRNA training is not the same as physicians, and therefore their skills and capabilities are not the same.

The *California Medical Association* is opposed to this bill unless it is amended, writing:

> This bill would bypass current California facility requirements where general anesthesia is currently being administered by Certified Registered Nurse Anesthetists (CRNAs) and physicians. This bill would allow for CRNAs to independently prescribe and order sedation and anesthesia in dental offices. Which would create substantial patient safety concerns with the proposed expansion in this measure.
>
> We respectfully request that all language relating to CRNAs independently prescribing or dispensing anesthesia in dental offices be struck from this bill. We are also concerned with the language regarding CRNAs ordering anesthesia in dental offices but are committed to working with all stakeholders involved to resolve those concerns.

POLICY ISSUES FOR CONSIDERATION:

1) *"Independent" Practice*. Multiple statutory restrictions prevent CRNAs from administering DS or GA in a dental office if the dentist is not GA-permitted and there is no GA-permitted physician. The restrictions also limit CRNAs from administering DS or GA without a dentist or physician assuming responsibility for the administration of the anesthesia. This bill establishes the new CRNA GA permit and "prescriptive authority" with the goal of allowing CRNAs to provide DS and GA via their own GA permit, independent of dentist or physician responsibility or delegation.

   The first statutory restriction is that the Dental Practice Act restricts the provision of DS and GA by any provider in a dental office, requiring the provider who will administer the anesthesia to obtain a GA permit. Only dentists and physicians may currently obtain the permit. This bill adds CRNAs to the list of providers who may obtain the permit.

The second restriction is that the Nursing Practice Act requires the dentist to hold a GA permit if a CRNA provides services in a dental office and GA is being administered. This bill deletes that restriction.

The third restriction is that the RN scope of practice in the Nursing Practice Act, which still applies to CRNAs, only authorizes the administration of medication or therapeutic agents in a dental setting "ordered by and within the scope of licensure of" a physician or dentist. Although not currently defined in statute, an order is generally used as a mechanism for delegating something, such as the treatment of a condition or performance of tests, to another provider. When giving an order, the ordering provider has determined the medical necessity of the order. Even if DS or GA could be provided in a dental office without a GA permit, the CRNA if the dentist is unwilling or unqualified to order a CRNA to administer the anesthesia, then the CRNA cannot.

This bill addresses the scope restriction in two ways. First, it authorizes a GA-permitted CRNA to administer GA or DS in a dental office "notwithstanding any other law." It also defines the terms "select," and "order" in the Nursing Practice Act and grants a CRNA "prescriptive authority" to directly "select, order, or administer" anesthesia upon the "request" of a dentist.

The fourth restriction is that, even if a CRNA could administer without an order from a dentist or physician, CRNAs do not have a DEA registration allowing them to obtain the anesthesia, and a dentist is unlikely to purchase the anesthesia on the CRNA's behalf if they are not willing to assume the responsibility of the anesthesia through an order. The authorizations under this bill, including the ability to administer GA or DS independent of an order from a dentist or physician, meet the definition of "dispense" under the federal Controlled Substances Act of 1970, requiring GA-permitted CRNAs to register with the DEA.

The opposition argues that the independence granted under this bill presents patient safety concerns, specifically that CRNAs, although qualified to provide anesthesia services, are not qualified to do so outside of licensed facilities or upon the order of a qualified dentist or physician. The sponsor argues that dental cases are of lower complexity than those in licensed facilities and that CRNAs are trained to identify patients who are not suitable for DS or GA in a dental setting.

The ability to utilize a CRNA in dental settings varies across the US:[2]

a) 22 states authorize CRNAs to provide services without regard to a dental permit.

b) 25 states, including CA, and the District of Columbia authorize CRNAs to provide services if the provider has a dental permit.

c) 3 states do not authorize CRNAs to practice in dental offices.

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[2] American Association of Nurse Anesthesiology, Dental Permit Map, https://www.aana.com/wp-content/uploads/2023/07/CRNA-Dental-Board-Permit-Map.png (accessed April 12, 2024).

2) *Prescriptive Authority*. CRNAs are currently not authorized to prescribe, which is the act of issuing an order for the dispensing of drugs or devices to a patient. This bill does not authorize the act of "prescribing," but instead grants CRNAs "prescriptive authority" to "select, order, or administer prescription drugs." However, in the dental settings where CRNAs would practice, they would not be prescribing or dispensing medications outside of the administration of the anesthesia. Any pre- or post-operative care medications would be prescribed by the operating dentist.

   In addition, the bill authorizes a CRNA to "order" when providing DS and GA services at the request of a dentist. However, there are no licensees who would be able to execute the order other than another CRNA or other licensee already authorized to administer, dispense, deliver, or distribute the anesthesia within their scope of practice. Therefore, the prescriptive authority under this bill is not necessary to accomplish the goals of the bill.

   Currently, the ability for CRNAs to prescribe varies across the US:[3]

   a) 16 states and the District of Columbia authorize full, independent prescribing.

   b) 20 states authorize limited prescribing under physician supervision, limited schedules, or both.

   c) 14 states, including, CA authorize no prescribing.

3) *Three Provider Model*. CALAOMS is opposed to this bill because it believes the requirement on the use of DS or GA for patients under 13 years of age under SB 501 should be applied to the general population. In the DBC's response to the issue during its sunset review, the DBC wrote, "DBC is willing to consider the expansion of the pediatric staffing of anesthesia in dental office standards to the adult population. However, there does not appear to be an identifiable problem justifying the increased regulation. Since the last Sunset bill there have been no pediatric deaths related to general anesthesia and deep sedation in dentistry reported."

IMPLEMENTATION ISSUES:

1) *Unnecessary Requirements and Declarations*. This bill contains provisions that are not necessary or may have no effect, including:

   a) Requiring CRNAs to prescribe based on their competence, but this bill does not authorize prescribing.

   b) Requiring CRNAs to only prescribe if there is an established client or patient record.

   c) Requiring CRNAs to complete any training required by the DEA, but if registration is conditioned on that training, then the provision is duplicative of the DEA's requirements.

   d) Declaring that nothing in the Nursing Practice Act affects the authority of a CRNA to select, order, or administer prescription drugs for the delivery of perioperative anesthesia

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[3] American Association of Nurse Anesthesiology, Prescriptive Authority Map, https://www.aana.com/wp-content/uploads/2023/04/CRNA-Prescriptive-Authority-1.png (accessed April 12, 2024).

services beyond the outpatient dental setting, but nothing in the act (or this bill) would have that effect.

2) *Definition of "Request."* This bill conditions the administration of DS or GA by a permitted CRNA on a "request" issued by a dentist but does not define it. Because the term "request" is intended to be something other than an "order" in the context of the assessment of the patient and overall liability of the DS and GA services provided, the author may wish to clarify the distinction if this bill passes this committee.

3) *Ongoing Discussions*. As noted above, the implementation of the permitting requirements established under SB 501 is being discussed as part of the DBC's sunset review, including potential changes to the physician GA permit, which the language under this bill is modeled after. If this bill passes this committee, the author may wish to continue to work with this committee, the Senate Business, Professions and Economic Development Committee, the DBC, and relevant stakeholders to avoid conflicts.

AMENDMENTS:

1) *Prescriptive Authority.* Delete the new "prescriptive authority" and accompanying definitions as follows:

On pages 6-7, strike lines 27-19:

~~**SEC. 3.** Section 2831.5 is added to the Business and Professions Code, to read:~~

~~**2831.5.** (a) As used in this section, the following definitions apply:~~

~~"Order" means the process of directing a licensed individual, pursuant to their statutory authority, to directly administer a drug or to dispense, deliver, or distribute a drug for the purpose of direct administration to a patient, under instructions of the certified registered nurse anesthetist to provide prescription drugs.~~

~~"Prescription drugs" includes Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code).~~

~~"Select" means the decisionmaking process of choosing a drug, dosage, route, and time of administration.~~

~~(b) (1) A certified registered nurse anesthetist who is licensed pursuant to this article and is registered with the federal Drug Enforcement Agency shall have prescriptive authority to select, order, or administer prescription drugs upon a request issued by a dentist under Article 2.75 (commencing with Section 1646) of Chapter 4 to administer anesthesia for diagnostic, operative, or therapeutic procedures in an outpatient dental setting.~~

~~(2) A certified registered nurse anesthetist under paragraph (1) shall prescribe prescription drugs based on their level of professional education, training, and certification by the National Board of Certification and Recertification for Nurse~~

~~Anesthetists, or a successor national professional organization approved by the board.~~

~~(c) A certified registered nurse anesthetist shall only prescribe prescription drugs under subdivision (b) for an individual whom the certified registered nurse anesthetist has, at the time of the prescription, established a client or patient record.~~

2) *Independent Practice*. Add additional guardrails but maintain the goals of the bill, including administration of DS and GA without a dentist or physician order and the ability to purchase anesthesia under a DEA registration as follows:

a) Maintain the ability to administer DS or GA pursuant to the GA permit at the request, rather than the order of, a dentist without a GA permit.

b) Keep the requirement to register with the DEA.

c) Clarify that the CRNA may only practice within their individual competence.

d) Require a referral plan for complex cases and emergencies.

e) Require CRNAs to refuse DS or GA for patients not suited for it.

f) Require CRNAs to maintain DBC standards for facilities, equipment, personnel, and procedures as a condition of their RN license, in addition to the GA permit.

g) Clarify that the DBC is not required to enforce the Nursing Practice Act:

On page 6, after line 21:

(b) General anesthesia or deep sedation administered in a dental office *at the request of a dentist* by a nurse anesthetist shall be in accordance ~~with both of~~ the following:

(1) Article 2.75 (commencing with Section 1646) of Chapter 4.

(2) ~~Paragraph (2) of subdivision (b) of Section 2725.~~ *(A) If administering general anesthesia or deep sedation to dental patients in the office of a licensed dentist who does not possess a permit issued pursuant to Article 2.75 (commencing with Section 1646) of Chapter 4, the nurse anesthetist shall do all of the following:*

(i) Register with the United States Drug Enforcement Administration.

(ii) Practice within the scope of their clinical and professional education and training.

(iii) Establish a plan for referral of complex cases and emergencies.

(iv) Decline or refer a patient with a preexisting disease or condition that is not optimized and may adversely interact with general anesthesia or deep sedation.

(v) Ensure that the facilities, equipment, personnel, and procedures utilized by the nurse anesthetist meet the Dental Board of California's onsite inspection requirements under subdivision (c) of Section 1646.14. Failure of an onsite inspection constitutes unprofessional conduct and is grounds for disciplinary action by the board.

(B) This paragraph shall not be construed to require the Dental Board of California to enforce the requirements of this paragraph or verify compliance with this paragraph for purposes of Section 1646.14.

3) *Conforming Change*. Cross-reference the new requirements in the Nursing Practice Act in the Dental Practice Act as follows:

On page 5, between lines 5 and 11:

1646.14. (a) Notwithstanding any other law, including, but not limited to, Sections 1646.1 and 1647.2, a certified registered nurse anesthetist licensed pursuant to Chapter 6 (commencing with Section 2700) and certified as a nurse anesthetist pursuant to Article 7 (commencing with Section 2825) of Chapter 6 may administer general anesthesia or deep sedation in the office of a licensed dentist to dental patients without regard to whether the dentist possesses a permit issued pursuant to this article, if both of the following conditions are met:

(1) *The nurse anesthetist meets the requirements of paragraph (2) of subdivision (b) of Section 2827.*

(2) The nurse anesthetist holds a valid general anesthesia permit issued by the Dental Board of California pursuant to subdivision (b).

~~(2)~~ *(3)* The nurse anesthetist meets the requirements of subdivision (d) of Section 1646.1.

4) *Unnecessary Requirements and Declarations*. Delete sections 4 and 5 of the bill:

On page 7, strike lines 20-39 and page 8, strike lines 1-14:

~~**SEC. 4.** Section 2833 of the Business and Professions Code is amended to read:~~

~~**2833.** (a) Each certificate issued pursuant to this article shall be renewable biennially, and each person holding a certificate under this article shall apply for a renewal of their certificate and pay the biennial renewal fee required by Section 2830.7 every two years on or before the last day of the month following the month in which their birthday occurs, beginning with the second birthday following the date on which the certificate was issued, whereupon the board shall renew the certificate.~~

~~(b) Each certificate not renewed in accordance with this section shall expire but may within a period of eight years thereafter be reinstated upon payment of the biennial renewal fee and penalty fee required by Section 2830.7 and upon submission of proof of the applicant's qualifications as may be required by the~~

~~board. During the eight-year period, no examination shall be required as a condition for the reinstatement of any expired certificate that has lapsed solely by reason of nonpayment of the renewable fee. After the expiration of the eight-year period the board may require, as a condition of reinstatement, that the applicant pass an examination as it deems necessary to determine their present fitness to resume the practice of nurse anesthesia.~~

~~(c) Upon registration or renewal of registration with the federal Drug Enforcement Agency, a certified registered nurse anesthetist shall complete the required training as set forth by the agency.~~

~~**SEC. 5.** Section 2833.3 of the Business and Professions Code is amended to read:~~

~~**2833.3.** (a) Nothing in this article shall be construed to limit a certified nurse anesthetist's ability to practice nursing.~~

~~(b) Nothing in this chapter shall affect the authority of a certified registered nurse anesthetist licensed pursuant to this article to select, order, or administer prescription drugs for the delivery of perioperative anesthesia services beyond the outpatient dental setting.~~

REGISTERED SUPPORT:

California Association of Nurse Anesthetists (sponsor)
American Nurses Association/California
14 individual dentists

REGISTERED OPPOSITION:

California Association of Oral and Maxillofacial Surgeons
California Society of Anesthesiologists
California Medical Association (unless amended)

Analysis Prepared by: Vincent Chee / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2566 (Wilson) – As Amended April 8, 2024

SUBJECT: Healing arts: counseling.

SUMMARY: Codifies the Counseling Compact (Compact) to facilitate the practice of counseling across state lines for licensees who have authorization.

EXISTING LAW:

1) Establishes the Board of Behavioral Sciences (BBS or board) under the Department of Consumer Affairs (DCA) for purposes of implementing and enforcing the Licensed Marriage and Family Therapist Act, the Educational Psychologist Practice Act, the Licensed Professional Clinical Counselor Act, and the Clinical Social Worker Practice Act. (Business and Professions Code (BCP) § 4989.12)

2) Specifies that protection of the public shall be the highest priority for the board in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (BPC § 4990.16)

3) Defines "professional clinical counseling" as the application of counseling interventions and psychotherapeutic techniques to identify and remediate cognitive, mental, and emotional issues, including personal growth, adjustment to disability, crisis intervention, and psychosocial and environmental problems, and the use, application, and integration of the coursework and training, as required by law. Further specifies that "professional clinical counseling" includes conducting assessments for the purpose of establishing counseling goals and objectives to empower individuals to deal adequately with life situations, reduce stress, experience growth, change behavior, and make well-informed, rational decisions. (BPC § 4999.20)

4) Authorizes a person who holds a license in another jurisdiction of the United States as a professional clinical counselor to provide professional clinical counseling services in California for a period not to exceed 30 consecutive days in any calendar year, if specified conditions are met. (BPC § 4999.23)

5) Prohibits any person from practicing or advertising professional clinical counseling services without a license issued by the BBS and payment of a license fee. (BPC § 4999.30)

6) Requires applicants for licensure or registration to begin graduate study on or after August 1, 2012, to possess a 60-semester unit, or equivalent, master's or doctoral degree that meets specified requirements, including being obtained from an accredited or approved institution. (BPC § 4999.33)

7) Requires applicants to complete a minimum of 3,000 postdegree supervised experience hours performed over a period of not less than two years. (BPC § 499.46(c))

8) Requires every applicant for a license as a professional clinical counselor to take one or more examinations, as determined by the board, to ascertain their knowledge, professional skills, and judgment in the utilization of appropriate techniques and methods of professional clinical counseling. (BPC § 4999.52)

9) Requires an applicant for licensure as a licensed professional clinical counselor (LPCC) to pass a California law and ethics examination and a clinical examination administered by either the board or the National Clinical Mental Health Counselor Examination, to be determined by the board. (BPC § 4999.53)

10) Authorizes the BBS to issue a license to a person who, at the time of submitting an application for a license, holds a license in another jurisdiction of the United States as a professional clinical counselor at the highest level for independent clinical practice if specified requirements are met. (BPC § 4999.60)

11) Requires, on or after January 1, 2021, an applicant for licensure as a professional clinical counselor to show that they have completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention. (BPC § 4999.66)

12) Requires, on or after July 1, 2023, an applicant for licensure as a professional clinical counselor to show that they have completed a minimum of three hours of training or coursework in the provision of mental health services via telehealth, which shall include law and ethics related to telehealth. (BPC § 4999.67)

13) Prohibits the BBS from renewing any license unless the applicant certifies that they have completed at least 36 hours of approved continuing education in or relevant to the field of professional clinical counseling in the preceding two years, as determined by the board. (BPC § 4999.76)

14) Specifies that any person who violates any of the provisions of the Licensed Professional Clinical Counselor Act is guilty of a misdemeanor punishable by imprisonment in a county jail not exceeding six months, or by a fine not exceeding $2,500, or by both that fine and imprisonment. (BPC § 4999.86)

15) Authorizes the board to refuse to issue any license, or may suspend or revoke the license of any licensed professional clinical counselor, as specified. (BPC §§ 4999.90 – 4999.91)

16) Authorizes the BBS to assess fees relating to the licensure of professional clinical counseling, as specified. (BPC § 4999.120)

17) Requires boards under the DCA to expedite the initial licensure process for an applicant who has served as an active duty member of the Armed Forces of the United States and was honorably discharged. (BPC § 115.4)

18) Requires boards under the DCA to expedite the licensure process for an applicant who is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders; and who holds a current license in another state in the profession or vocation for which they are seeking a license from the board. (BPC § 115.5)

19) Requires boards under the DCA to grant temporary licenses to applicants who are married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces and who holds a current, active, and unrestricted license in another state. (BPC § 115.6)

THIS BILL:

1) Codifies the entirety of the Compact, including provisions that do all of the following:

   a) Establish a joint public agency known as the Counseling Compact Commission (Commission), and confer upon it enumerated powers and duties.

   b) Authorize each Member State to select one delegate to sit on the Commission.

   c) Specify that each delegate on the Commission may have one vote.

   d) Authorize the Commission to levy on and collect an annual assessment from each Member State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff.

   e) Require the Commission to develop, maintain, operate, and use a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individual in Member States and require Member States to provide specified data for inclusion in the database.

   f) Require a state to meet the following criteria to participate in the Compact:

      i) License and regulate Licensed Professional Counselors.

      ii) Require licensees to pass a nationally recognized exam approved by the Commission.

      iii) Require licensees to have a 60 semester-hour (or 90 quarter-hour) master's degree in counseling or 60 semester-hours (or 90 quarter-hours) of graduate course work including in specified topic areas.

      iv) Require licensees to complete supervised postgraduate professional experience as defined by the Commission.

      v) Have a mechanism in place for receiving and investigating complaints about licensees.

   g) Enumerate requirements for Member States as a condition of participation in the Compact.

   h) Authorize Member States to charge a fee for granting a Privilege to Practice, defined as a legal authorization that is equivalent to a license permitting the practice of Professional Counseling in Member States.

   i) Specify that nothing in the Compact affects the requirements established by a Member State for the issuance of a single state license.

j) Require a licensee to meet specified criteria to exercise a Privilege to Practice in a Member State.

k) Specify that the Privilege to Practice is valid until the expiration date of the Home State license.

l) Require a licensee providing Professional Counseling in a Remote State under the Privilege to Practice to adhere to the laws and regulations of the Remote State.

m) Specify that a licensee providing Professional Counseling services in a Remote State is subject to that state's regulatory authority and authorizes a Remote State to revoke a license's Privilege to Practice in the Remote State, as specified.

n) Require Member States to recognize the right of a Licensed Professional Counselor to practice Professional Counseling in any Member State via telehealth under a Privilege to Practice as provided in the Compact and rules adopted by the Commission.

o) Authorize a Remote State to take adverse action against a Licensed Professional Counselor's Privilege to Practice within that Member State.

p) Authorize a Member State to recover from the affected Licensed Professional Counselor the costs of investigations and dispositions of cases resulting from any adverse action taken against that Licensed Professional Counselor.

q) Specify that if a Home State takes adverse action against a Licensed Professional Counselor's license, then the Licensed Professional Counselor's Privilege to Practice in all other Member States must be deactivated until all encumbrances have been removed from the state license.

r) Require the executive, legislative, and judicial branches of state government in each Member State to enforce the Compact and take all actions necessary and appropriate to effectuate the Compact's purpose and intent.

s) Authorize any Member State to withdraw from the Compact by enacting a statute repealing the provisions of the Compact and specify that a Member State's withdrawal would not take effect until six months after the enactment of the repealing statute.

t) Authorize the Compact to be amended by Member States, but no amendment would become effective and binding until it is enacted into the laws of all Member States.

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

COMMENTS:

Purpose. This bill is sponsored by the **California Association for Licensed Professional Clinical Counselors.** According to the author:

> The goal of [this bill] is to eliminate barriers to practice for licensed professional clinical counselors and eliminate barriers to treatment for clients, by establishing a licensing compact which will ensure cooperation among compact member states in regulating the counseling profession. The Counseling Compact is an occupational licensure interstate

compact - which is a statutorily established agreement among states with uniform licensing standards for a profession to recognize valid licenses for that profession by any state that has enacted the agreement. The compact provides greater access to mental health care in California, removes barriers to practice without sacrificing public protection, helps address healthcare workforce shortages, and allows California LPCCs to provide greater continuity of care to patients who travel or relocate, provides seamless ability for military personnel and spouses who relocate to practice, preserves and strengthens the regulatory oversight of the Board of Behavioral Sciences. The Compact does not impact the scope of practice in any state. Licensed Counselors practicing under the Compact in another state must comply with the counseling Laws and Standards in that state in which they are practicing. Professional Counselors (LPCCs in California) are licensed in all 50 states with consistent licensing requirements. The Compact does not affect the BBS authority to protect public health and safety or regulate the LPCC profession.

Background.

Board of Behavioral Sciences. The BBS is responsible for licensing and regulating Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Educational Psychologists, and LPCCs. Additionally, the Board registers Associate Clinical Social Workers, Associate Marriage and Family Therapists, and Associate Professional Clinical Counselors. Cumulatively, the Board is responsible for the oversight of over 120,000 licensees and registrants, including, as it relates to this bill, roughly 2,300 LPCCs. Its mission is to "protect and serve Californians by setting, communicating, and enforcing standards for safe and competent mental health practice."[1] The BBS has authority to take disciplinary action against LPCCs who violate the Licensed Professional Clinical Counselor Act. It may cite and fine licensees for minor violations as well as seek license suspension or revocation for more egregious violations. The board is self-funded through license, application, and examination fees, and receives no General Fund revenue.

Applicants for an LPCC license are required to obtain a qualifying master's degree, complete a minimum of 3,000 hours of post-degree supervised experience, pass both the California Law and Ethics Exam as well as the National Clinical Mental Health Counseling Examination, undergo a criminal background check, and pay various fees. During the BBS's most recent sunset review in 2020, the BBS reported that it was meeting its established application processing timeframe of 60 business days for LPCC applications.

The BBS currently has a licensure endorsement process which is referred to as "Licensure by Credential."[2] An out-of-state licensee can qualify for a license by credential if they have held a license as a Professional Clinical Counselor in another United States jurisdiction, the license is current and has been active and unrestricted for at least two years immediately before the date of application, the license is at the highest level of licensure for independent clinical practice in that jurisdiction, they have a master's or doctoral degree from a qualifying accredited or approved institution, they have completed additional specified coursework (e.g. 12 hours in California law and ethics), they undergo a criminal history background check, and they pass the California Law

[1] About the Board of Behavioral Sciences
[2] Overview and Discussion of the Social Work Interstate Licensing Compact and the Counseling Interstate Licensing Compact

and Ethics Examination. The "Licensure by Credential" process was established via SB 679 (Bates), Chapter 380, Statutes of 2019, after the BBS established a License Portability Committee to review the potential barriers to licensure for out-of-state applicants. Approximately 2,500 out-of-state licensees have successfully applied to licensure using this streamlined approach.

Interstate Licensing Compacts. An interstate licensing compact represents a legally binding agreement between multiple states to facilitate cross-state practice for licensed professionals without requiring them to obtain full licensure in each participating state. To participate in such a compact, a state must adopt model statutory language provided by a compact organization. Typically, a practitioner must already hold a license in their home state before seeking authorization to practice in a compact member state. California currently does not participate in any licensing compacts related to the healing arts professions.

Counseling Compact. The American Counseling Association began coordinating with the National Center for Interstate Compacts in 2019 to create a multistate compact for Licensed Professional Counselors. The Compact was finalized in 2020 and has since been enacted. Under the Compact, a Licensed Professional Counselor must be licensed by their Home State and is required to request a Privilege to Practice for each Compact Member State they plan to practice in. Member States may require Licensed Professional Counselors to pay a fee and pass an exam demonstrating their knowledge of the Remote State's laws governing the practice of professional counseling. Licensed Professional Counselors are required to abide by the laws and regulations of the Member State in which they are providing counseling services. Member States may take revoke a Licensed Professional Counselor's Privilege to Practice, but only a Licensed Professional Counselor's Home State may take action against their license. To date, 34 states have joined the Compact and several others are currently considering doing so.

This bill would require California to join the Compact. According to the author and sponsors of this bill, California's membership in the Compact would increase access to mental health care and ensure continuity of care when clients or counselors relocate or travel to other states.

Current Related Legislation.

AB 1328 (Gipson) would enact the Cosmetology Licensure Compact to facilitate California's participation in a multistate licensing program whereby cosmetologists can receive reciprocity to practice in other states that have adopted the Cosmetology Licensure Compact and vice versa. *AB 1328 is pending in the Senate Business, Professions, and Economic Development Committee.*

AB 2051 (Bonta) would codify the Psychology Interjurisdictional Compact to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state lines for licensees who have authorization. *AB 2051 is pending in this committee.*

AB 3232 (Dahle) would enact the Nurse Licensure program, under which the Board of Registered Nursing and the Board of Vocational Nursing and Psychiatric Technicians would be authorized to issue a multistate license to practice in all party states. *AB 3232 is pending in this committee.*

ARGUMENTS IN SUPPORT:

As the sponsor of this bill, the **California Association for Licensed Professional Clinical Counselors**, writes in support:

> The Counseling Compact provides greater access to mental health care in California, removes barriers to practice without sacrificing public protection, helps address healthcare workforce shortages, and allows California LPCCs to provide greater continuity of care to patients who travel or relocate, provides seamless ability for military personnel and spouses who relocate to practice, preserves and strengthens the regulatory oversight of the Board of Behavioral Sciences. The broad goal of the Counseling Compact is to eliminate barriers to practice for licensed counselors and barriers to treatment for clients, by ensuring cooperation among member states in regulating the counseling profession.

ARGUMENTS IN OPPOSITION:

None on file

POLICY ISSUE(S) FOR CONSIDERATION:

Sufficiency of Existing Laws. While one of the potential benefits of joining a state licensing compact is to expedite licensure for active duty service members of the United States Armed Forces and military spouses, the federal Servicemembers Civil Relief Act already authorizes service members or their spouses who currently hold a valid license in good standing in another state to practice in California within the same profession or vocation, if they are required to relocate to California because of military orders.[3] Additionally, the BBS expedites the licensure process for military veterans who were honorably discharged, as well as domestic partners of active duty servicemembers.

Delegation of Authority. By joining the Compact, California would be delegating all authority to a multistate commission to determine and enforce licensing requirements for out-of-state Licensed Professional Counselors to provide counseling services to Californians. Moreover, with just one voting member on the Commission—equal to all other Member States—California's representation would be vastly disproportionate to the number of licensees California would contribute to the compact. By a simple majority vote, the Commission would have the ability to make decisions at odds with California's position.

Fairness. LPCCs licensed by the BBS are required to complete specified education and training requirements, including supervised professional experience and continuing education. However, Licensed Professional Counselors from another Member State whose qualifications may be less than what this state has deemed appropriate and necessary for licensure would have the same ability to provide professional counseling services in California.

Consumer Protection. Considering the varying the licensing requirements for Licensed Professional Counselors, joining the Compact could make Californians susceptible to consumer harm.

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[3] Federal Professional License Portability and State Registration - California Department of Consumer Affairs

IMPLEMENTATION ISSUES:

Equity for California Licensees. To exercise the Privilege to Practice under the terms and provisions of the Compact, Licensed Professional Counselors are required to have a valid United States Social Security Number (SSN) or National Practitioner Identifier. However, applicants for licensure in California may provide a SSN, Individual Taxpayer Identification Number, or Federal Employer Identification Number on an application for a LPCC license.[4] California LPCCs who do not have a SSN may be excluded from participating in the Compact despite being otherwise qualified.

Ease of Leaving the Counseling Compact. In the same way that legislation is required to join the Compact, so too is legislation required to leave the Compact. In the event that California joined and subsequently wanted to leave the Compact, doing so would be subject to affirmative action on behalf of the Legislature and would not take effect until six months after the enactment of such a law.

AMENDMENTS:

Considering the policy and implementation concerns above, the author has agreed to amend to bill to make its enactment contingent upon approval by the BBS.

REGISTERED SUPPORT:

California Association for Licensed Professional Clinical Counselors *(Sponsor)*
Ata Action
Kaiser Permanente
Steinberg Institute

REGISTERED OPPOSITION:

None on file

Analysis Prepared by: Kaitlin Curry / B. & P. / (916) 319-3301

[4] Request for Initial License Issuance

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2578 (Flora) – As Amended March 21, 2024

SUBJECT: Nursing: students in out-of-state nursing programs.

SUMMARY: Authorizes an unlicensed nursing student who is enrolled in an out-of-state distance education nursing program to provide supervised nursing services that are incidental to the course of study for purposes of gaining clinical experience.

EXISTING LAW:

1) Regulates the practice of nursing under the Nursing Practice Act. (Business and Professions Code (BPC) §§ 2700-2838.4)

2) Establishes the Board of Registered Nursing (BRN) within the Department of Consumer Affairs (DCA) to administer and enforce the Nursing Practice Act until January 1, 2027. (BPC § 2701)

3) Prohibits the practice of nursing without holding a license which is in an active status issued under the Nursing Practice Act, except as otherwise provided, and specifies that every licensee may be known as a registered nurse (RN) and use the title "R.N." (BPC § 2732)

4) Requires an applicant for licensure as an RN to complete the education requirements established by the BRN in a program in this state approved by the BRN or in a school of nursing outside of this state which, in the opinion of the BRN, offers an education that meets the BRN's requirements. (BPC § 2736)

5) Defines "an approved school of nursing" or "an approved nursing program" as one that (1) has been approved by the BRN, (2) gives the course of instruction approved by the BRN, covering not less than two academic years, (3) is affiliated or conducted in connection with one or more hospitals, and (4) is an institution of higher education. (BPC § 2786(a))

6) Requires the BRN to determine by regulation the required subjects of instruction for licensure as an RN and (1) include the minimum units of theory and clinical experience necessary to achieve essential clinical competency at the entry level of an RN and (2) require all programs to provide clinical instruction in all phases of the educational process, except as specified. (BPC § 2786(c))

7) Authorizes a student to render nursing services if those services are incidental to the course of study of one of the following:

    a) A student enrolled in a BRN-approved pre-licensure program or school of nursing. (BPC § 2729(a))

    b) A nurse licensed in another state or country taking a BRN-approved continuing education course or a post-licensure course. (BPC § 2729(b))

8) Requires a nursing program to obtain approval from the BRN for the use of any agency or facility for clinical experience, and requires the program to take into consideration the impact that an additional group of students would have on students of other nursing programs already assigned to the agency or facility. (California Code of Regulations, Title 16, § 1427)

9) Prohibits an institution of higher education or a private postsecondary school of nursing, or an entity affiliated with the institution or school of nursing, from making a payment to any clinical agency or facility in exchange for clinical experience placements for students enrolled in a nursing program offered by or affiliated with the institution or private postsecondary school of nursing, as specified. (BPC § 2786.4)

10) Defines an "out-of-state private postsecondary educational institution" as a private entity without a physical presence in this state that offers distance education to California students for an institutional charge, regardless of whether the institution has affiliated institutions or institutional locations in California. (Education Code § 94850.5)

THIS BILL:

1) Authorizes a student who is a resident of this state and enrolled in a pre-licensure distance education nursing program based at an out-of-state private postsecondary educational institution to provide nursing services to gain clinical experience in a clinical setting if the following are met:

   a) The program is accredited by a programmatic accreditation entity recognized by the United States Department of Education.

   b) The BRN has not otherwise approved the program.

   c) The student placement does not impact any students already assigned to the agency or facility.

   d) The program does not make payments to any clinical agency or facility in exchange for clinical experience placements for students enrolled in a nursing program offered by or affiliated with the institution or private postsecondary school of nursing.

   e) The program qualifies graduates for licensure under the Nursing Practice Act.

   f) The program maintains minimum faculty to student ratios required of BRN-approved programs for in-person clinical experiences.

   g) The program pays a one-time fee of $100 to the BRN for each student who participates in clinical experience placements in the state.

2) Requires a student providing services under this bill to be supervised by an RN while rendering nursing services.

3) Prohibits a clinical agency or facility from offering clinical experience placements to an out-of-state private postsecondary educational institution if the placements are needed to fulfill the clinical experience requirements of an in-state student enrolled in a BRN-approved nursing program.

4) Specifies that, for purposes of the authorization under this bill, "out-of-state private postsecondary educational institution" means a private entity without a physical presence in this state that offers distance education to California students for an institutional charge, regardless of whether the institution has affiliated institutions or institutional locations in California.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the *Nightingale Education Group*. According to the author, "[This bill] recognizes that for some California residents, online distance nursing education is the best option to pursue a nursing degree…. The reality for these students is that they are forced to find another state, where they can move to for a number of weeks, to fulfill on-ground practical components of their education. This has to be done at their own expense, forcing them to take time away from their families and their home, in order to complete their nursing degree. Further, these students develop relationships with these health facilities outside of the State and often results in their leaving the State of California to become a nurse in another State when California needs as many nurses as possible…. Many students choose not to further their education because of limited options in their area. With blended distance education programs, students can enroll in colleges and universities hundreds or thousands of miles from home. Having a strong local nursing workforce is imperative to improving patient care and access across the state and to decreasing the state's healthcare financial burdens. [This bill] provides an immediate, long-lasting, and much desired solution for creating and keeping a strong nursing workforce of local California nurses."

Background. Nursing education generally contains two components, classroom theory and clinical experience. Clinical experience is supervised, hands-on experience providing patient care, providing an opportunity to apply theory to practice. In California, both theory and clinical experience are required for licensure as an RN.

To allow students to gain clinical experience, existing law exempts students from licensing requirements while providing nursing services through a BRN-approved education program. There is no exemption for students enrolled in non-BRN-approved nursing education programs, including students who live in California but attend distance-learning nursing education programs based in other states.

However, students who attend out-of-state programs must have their education evaluated for equivalency with state requirements, including clinical experience. Those who do not meet the requirements will be denied or considered deficient and required to complete additional remedial education or training.

As a result, the in-state students enrolled in non-BRN-approved distance programs must move to other states during their course of study to obtain the required clinical experience if they wish to immediately qualify for licensure in California upon graduation. This bill seeks to avoid requiring those students to move or travel by expanding the license exemption, though specifically limited to students enrolled in non-BRN-approved distance education nursing programs that are also accredited.

BRN. The BRN is a licensing entity within DCA and is responsible for administering and enforcing the Nursing Practice Act, which is the chapter of laws that establishes the BRN and outlines the regulatory framework for the practice, licensing, education and discipline of RNs and advanced practice registered nurses. The BRN is also one of the few licensing boards that actively approve and regulate educational programs that offer the degrees necessary for licensure. In-state programs that offer a course of instruction leading to an RN license must seek approval from the BRN to operate. At the end of fiscal year 2021-22, the BRN reported a total of 152 approved RN programs, including 91 Associate Degree in nursing (ADN) programs, 48 Bachelor of Science in nursing (BSN) programs, and 13 Entry-level Master's (ELM) programs.

Prior Related Legislation. AB 1292 (Flora) of 2023 was substantially similar to this bill. AB 1292 was held on the Assembly Appropriations Committee suspense file.

AB 1577 (Low) of 2023 would have required hospitals that offer pre-licensure clinical training slots to work in good faith with community college nursing programs to meet their clinical training needs. AB 1577 died pending a hearing in the Senate Health Committee.

AB 2684 (Berman), Chapter 413, Statutes of 2022, which was the BRN's 2022 Sunset Review bill,[1] made several changes to address the lack of clinical placements, including establishing a lower 500 minimum number of clinical experience hours, authorizing clinical placements to take place in the academic term immediately following theory, prohibiting nursing schools and programs from paying for clinical placements, and requiring the BRN to utilize data from available regional or individual institution databases in collecting information related to the number of clinical placement slots available to nursing students.

AB 2288 (Low), Chapter 282, Statutes of 2020, in response to the COVID-19 pandemic, authorized the director of an approved nursing program, during a state of emergency, to make requests to the BRN for the following: 1) the use of a clinical setting without meeting specified requirements; 2) the use of preceptorships without having to maintain specified written policies; 3) the use of clinical simulation up to 50% for medical-surgical and geriatric courses; 4) the use of clinical simulation up to 75% for psychiatric-mental health nursing, obstetrics, and pediatrics courses; and 5) allowing clinical placements to take place in the academic term immediately following theory.

AB 1015 (Blanca Rubio), Chapter 591, Statutes of 2021, required the BRN to incorporate regional forecasts into its biennial analyses of the nursing workforce, develop a plan to address regional areas of shortage identified by its nursing workforce forecast, as specified, and annually collect, analyze, and report information related to the number of clinical placement slots that are available and the location of those clinical placement slots within the state.

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[1] The sunset review process provides an opportunity for the DCA, the Legislature, the boards, and interested parties and stakeholders to discuss the performance of the boards, and make recommendations for improvements. Each year, the Assembly Business and Professions Committee and the Senate Business, Professions, and Economic Development Committee hold joint sunset review oversight hearings to review the boards and bureaus. For more information, see the background paper on the BRN's 2022 Sunset Review, accessible at: https://abp.assembly.ca.gov/jointsunsethearings.

ARGUMENTS IN SUPPORT:

Nightingale Education Group (sponsor) writes in support:

> Nightingale Education Group is the parent company of Nightingale College, a distance education nursing college headquartered in Salt Lake City, Utah. Nightingale College was established in 2011 and currently serves thousands of pre-licensure nursing students across the country, including over 3,000 California residents.
>
> [This bill] recognizes that for many California residents, distance nursing education is the best, or only, option for pursuing a nursing degree. By amending the nurse practice act to allow California residents enrolled in accredited distance nursing education programs to participate in clinical rotations at California facilities (conducted by California licensed registered nurses), the Legislature will allow these California residents to complete their online nursing education while simultaneously participating in their required hands-on training in their local communities, providing them much-needed experience and exposure to California healthcare systems and removing the need for costly out-of-state travel. [This bill] assures quality and cooperation from distance nursing education programs by mandating full accreditation by a USDOE recognized nursing education accrediting entity and by requiring programs to work together with California healthcare facilities to determine availability for local clinical rotations.
>
> Under the current nursing regulations, the reality for many California residents is that they are forced, while enrolled in distance education programs domiciled outside of California, to fulfill clinical experiential learning requirements in other states, where they are required to relocate for several weeks each semester to fulfill the mandatory on-ground practical components of their education. This creates a costly and cumbersome reality where students must travel at their own expense, leaving their families, homes, and employment, for weeks at a time every semester for the duration of their nursing program. Additionally, during these travel rotations, these students are developing relationships with, and actively being recruited by, healthcare facilities in other states, which often results in the students leaving California after graduation, further adding to California's already drastic nursing shortage.

ARGUMENTS IN OPPOSITION:

None on file

POLICY ISSUE FOR CONSIDERATION:

Lack of Clinical Placements. During the BRN's 2022 Sunset Review, both this committee and the Senate Business, Professions and Economic Development Committee raised, and continue to work on, the issue of the availability of clinical placements for nursing students. The availability of student placements for clinical experiences is based on the willingness of clinical facilities, such as hospitals or clinics, to accept and teach students.

While there are no requirements that clinical facilities accept students, many willingly accept students because it is necessary for the workforce and can help with recruitment. However, the facilities must have staff that is qualified to teach and supervise students. As a result, clinical placements are often difficult to find. Unfortunately, students who are unable to obtain their clinical placements before the end of the term either have to drop out or receive an incomplete. Under either circumstance, the student would have to repeat the course.

This bill may complicate that problem by authorizing nursing students who are enrolled in out-of-state distance education programs to compete for already limited clinical placements. To reduce the chance that a student enrolled in an in-state program is displaced from a clinical placement, this bill contains language previously recommended by this committee requiring clinical facilities to give preference to students enrolled in an in-state program.

REGISTERED SUPPORT:

Nightingale Education Group (sponsor)

REGISTERED OPPOSITION:

None on file

Analysis Prepared by: Vincent Chee / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2651 (Bains) – As Introduced February 14, 2024

SUBJECT: Alcohol drug counselors.

SUMMARY: Establishes a licensing program for "Licensed Alcohol Drug Counselors" and creates the Licensed Alcohol Drug Counselor Board to administer and enforce the program.

CONTENTS

EXISTING LAW REGARDING SUBSTANCE USE COUNSELING:

1) Prohibits unfair, dishonest, deceptive, destructive, fraudulent, or discriminatory practices under the Unfair Practices Act. (Business and Professions Code (Business and Professions Code (BPC) §§ 17000-17101)

2) Establishes the Department of Consumer Affairs (DCA) within the Business, Consumer Services, and Housing Agency. (BPC § 100)

3) Provides for the licensure and regulation of various professions and vocations by boards, bureaus, and other entities within the DCA. (BPC §§ 22, 100-144.5)

4) Regulates the practice of medicine through the licensure of physician and surgeons under the Medical Practice Act and establishes the Medical Board of California to administer and enforce the act. (BPC §§ 2000-2529.6)

    a) Prohibits the practice, attempt to practice, advertisement of, or holding out as practicing any system or mode of treating the sick or afflicted, or diagnosis, treatment, operation for, or prescription for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of doing so a valid, unrevoked, or unsuspended medical license or being otherwise authorized under state law to perform the medical act. (BPC § 2052)

5) Regulates the practice of psychology through the licensure of psychologists under the Psychology Licensing Law and establishes the Board of Psychology to administer and enforce the law. (BPC § 2901)

    a) Defines the practice of psychology as rendering or offering to render to individuals, groups, organizations, or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations. (BPC § 2903(a))

6) Regulates and licenses marriage and family therapists (LMFTs) under the Licensed Marriage and Family Therapist Act, educational psychologists (LEPs) under the Educational Psychologist Practice Act, clinical social workers (LCSWs) under the Clinical Social Worker

Practice Act, and professional clinical counselors (LPCCs) and the Licensed Professional Clinical Counselor Act. (BPC §§ 4980-4989, 4989.10-4989.70, 4991-4998.5, 4999.10-4999.129)

a) Establishes the Board of Behavioral Sciences (BBS) within the Department of Consumer Affairs to administer and enforce the LMFT, LEP, LCSW, and LPCC practice acts. (BPC §§ 4990-4990.42)

b) Defines the practice of marriage and family therapy as the application of psychotherapeutic and family systems theories, principles, and methods in the delivery of services to individuals, couples, or groups to assess, evaluate, and treat relational issues, emotional disorders, behavioral problems, mental illness, alcohol, and substance use, and to modify intrapersonal and interpersonal behaviors. (BPC § 4980.02)

c) Defines the practice of education psychology as the performance of any of the following professional functions regarding academic learning processes or the educational system or both: (1) educational evaluation; (2) diagnosis of psychological disorders related to academic learning processes; (3) administration of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors; (4) interpretation of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors; (5) providing psychological counseling for individuals, groups, and families; (6) consultation with other educators and parents on issues of social development and behavioral and academic difficulties; (7) conducting psychoeducational assessments for the purposes of identifying special needs; (8) developing treatment programs and strategies to address problems of adjustment; (9) coordinating intervention strategies for the management of individual crises. (BPC § 4989.14)

d) Defines the practice of clinical social work as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate, satisfying, and productive social adjustments, and includes within the application of social work principles and methods counseling and using applied psychotherapy of a nonmedical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping communities to organize, to provide, or to improve social or health services; doing research related to social work; and the use, application, and integration of the LCSW coursework and experience. (BPC § 4996.9)

e) Defines "professional clinical counseling" as the application of counseling interventions and psychotherapeutic techniques to identify and remediate cognitive, mental, and emotional issues, including personal growth, adjustment to disability, crisis intervention, and psychosocial and environmental problems, and the use, application, and integration of the LPCC coursework and training, including conducting assessments to establish counseling goals and objectives to empower individuals to deal adequately with life situations, reduce stress, experience growth, change behavior, and make well-informed, rational decisions. (BPC § 4999.20)

7) Establishes the state's role in alleviating issues related to the problematic use of substances under the Department of Health Care Services (DHCS). (Health and Safety Code (HSC) §§ 11760-11872)

   a) Defines "alcohol or other drug program" or "program" as a business entity with a physical location in the State of California that provides one or more of the following services to clients: (1) treatment services, (2) recovery services, (3) detoxification services, or (4) medications for addiction treatment; but not a licensed healing arts practitioner. (HSC § 11832.2)

   b) Prohibits any person, firm, partnership, association, or local government entity from establishing, operating, managing, conducting, or maintaining an alcohol or other drug program within this state without first obtaining a program certification from the DHCS. (HSC § 11832.7)

   c) Grants the DHCS the sole authority in state government to establish the minimum qualifications of an alcohol or other drug program administrator and staff who provide any of the services requiring program certification. (HSC § 11832.10)

   d) Defines "alcoholism or drug abuse recovery or treatment facility" or "facility" as any premises, place, or building that provides residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. (HSC § 11834.02)

   e) Prohibits any person, firm, partnership, association, corporation, or local governmental entity from operating, establishing, managing, conducting, or maintain an alcoholism or drug abuse recovery or treatment facility to provide recovery, treatment, or detoxification services within this state without first obtaining a facility license from the DHCS. (HSC § 11834.30)

   f) Grants the DHCS the sole authority in state government to establish the appropriate minimum qualifications of the licensee or designated administrator, and the staff of a provider of any of the services requiring a facility license. (HSC § 11834.27)

   g) Defines "incidental medical services" as services that are in compliance with the community standard of practice and are not required to be performed in a licensed outpatient clinic or licensed inpatient facility to address medical issues associated with either detoxification from alcohol or drugs or the provision of alcoholism or drug abuse recovery or treatment services, including all of the following categories of services: (1) obtaining medical histories; (2) monitoring health status to determine whether the health status warrants transfer of the patient in order to receive urgent or emergent care; (3) testing associated with detoxification from alcohol or drugs; (4) providing alcoholism or drug abuse recovery or treatment services; (5) overseeing patient self-administered medications; (6) treating substance abuse disorders, including detoxification; but not the provision of general primary medical care. (HSC § 11834.026)

   h) Authorizes a licensed alcoholism or drug abuse recovery or treatment facility to permit incidental medical services to be provided to a resident at the facility premises by, or under the supervision of, one or more physicians and surgeons licensed by the Medical

Board of California or the Osteopathic Medical Board who are knowledgeable about addiction medicine, or one or more other health care practitioners acting within the scope of practice of their license and under the direction of a physician and surgeon, and who are also knowledgeable about addiction medicine, as specified. (HSC § 11834.026)

i) Requires the DHCS to adopt the American Society of Addiction Medicine treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for licensed facilities and require a licensee to maintain those standards with respect to the level of care to be provided by the licensee. (HSC § 11834.015)

j) Grants the DHCS the sole authority in state government to determine the qualifications, including the appropriate skills, education, training, and experience of personnel working within alcohol or other drug program. (HSC §11833(a))

k) Requires any person providing counseling services within a substance use recovery or treatment program to be registered with, or certified by, a certifying organization approved by the DHCS. (HSC §11833(c)(1))

l) Defines "certified AOD counselor" as an individual certified by a certifying organization approved by the DHCS. (California Code of Regulations (CCR), Title 9, § 13005(a)(2))

m) Defines "registrant" as an individual registered with any certifying organization to obtain certification as an AOD counselor. (CCR, tit. 9, § 13005(a)(8))

n) Identifies 10 certifying organizations as DHCS-approved, establishes the method for other certifying organizations to become approved, and establishes the requirements for maintaining approval. (CCR, tit. 9, § 13035)

o) Prohibits the DHCS from approving a certifying organization that does not, before registering or certifying an individual, contact other DHCS-approved certifying organizations to determine whether the individual has ever had their registration or certification revoked or has been removed from a postgraduate practicum for an ethical or professional violation. (HSC §11833(c)(2))

p) Exempts the following individuals from the registration requirement:

   i) A graduate student affiliated with university programs in psychology, social work, marriage and family therapy, or counseling, who is completing their supervised practicum hours to meet postgraduate requirements. (HSC §11833(d)(1)(A))

   ii) An associate registered with the Board of Behavioral Sciences. (HSC §11833(d)(1)(B))

   iii) A licensed professional, as defined by the DHCS. (HSC §11833(d)(1)(C))

q) Requires the DHCS to determine the required core competencies for registered and certified counselors working within a substance use recovery and treatment program (HSC § 11833(b))

r) Specifies that the core competencies must include: (A) Knowledge of the current Diagnostic and Statistical Manual of Mental Disorders; (B) Knowledge of the American

Society of Addiction Medicine (ASAM) criteria and continuum of ASAM levels of care, or other similar criteria and standards as approved by the department; (C) Cultural competence, including for people with disabilities, and its implication for treatment; (D) Case management; (E) Utilization of electronic health records systems; (F) Knowledge of medications for addiction treatment; (G) Clinical documentation; (H) Knowledge of co-occurring substance use and mental health conditions; (I) Confidentiality; (J) Knowledge of relevant law and ethics; (K) Understanding and practicing professional boundaries; (L) Delivery of services in the behavioral health delivery system. (HSC § 11833(b)(2))

s) Requires a certifying organization to, if a counselor's registration or certification has been previously revoked or the individual has been removed from a postgraduate practicum for an ethical or professional conduct violation, deny the registration request and send the counselor a written notice of denial specifying the counselor's right to appeal the denial. (HSC § 11833(e))

t) Authorizes the DHCS to conduct periodic reviews of certifying organizations to determine compliance with all applicable laws and regulations and to take actions for noncompliance, including revocation of approval. (HSC § 11833(f))

EXISTING LAW REGARDING NEW REGULATION OF A PROFESSION:

1) Establishes requirements and procedures for legislative oversight of state board formation and licensed professional practice. (Government Code (GOV) §§ 9148-9148.8)

2) Requires, before consideration by the Legislature of legislation creating a new state board or legislation creating a new category of licensed professional, that the author or sponsor of the legislation develop a plan for the establishment and operation of the proposed state board or new category of licensed professional. (GOV § 9148.4)

3) The plan must include all of the following:

   a) A description of the problem that the creation of the specific state board or new category of licensed professional would address, including the specific evidence of need for the state to address the problem. (GOV § 9148.4 (a))

   b) The reasons why this proposed state board or new category of licensed professional was selected to address this problem, including the full range of alternatives considered and the reason why each of these alternatives was not selected. (GOV § 9148.4(b))

   c) Alternatives to be considered include, but are not limited to, the following:

      i) No action taken to establish a state board or create a new category of licensed professional. (GOV § 9148.4(b)(1))

      ii) The use of a current state board or agency or the existence of a current category of licensed professionals to address the problem, including any necessary changes to the mandate or composition of the existing state board or agency or current category of licensed professionals. (GOV § 9148.4(b)(2))

iii) The various levels of regulation or administration available to address the problem. (GOV § 9148.4(b)(3))

iv) Addressing the problem by federal or local agencies. (GOV § 9148.4(b)(4))

d) The specific public benefit or harm that would result from the establishment of the proposed state board or new category of licensed professionals, the specific manner in which the proposed state board or new category of licensed professionals would achieve this benefit, and the specific standards of performance which shall be used in reviewing the subsequent operation of the board or category of licensed professional. (GOV § 9148.4(c))

e) The specific source or sources of revenue and funding to be utilized by the proposed state board or new category of licensed professional in achieving its mandate. (GOV § 9148.4(d))

f) The necessary data and other information required in this section shall be provided to the Legislature with the initial legislation and forwarded to the policy committees in which the bill will be heard. (GOV § 9148.4(e))

4) Authorizes the appropriate policy committee of the Legislature to evaluate the plan prepared in connection with a legislative proposal to create a new state board and provides that, if the appropriate policy committee does not evaluate a plan, then the Joint Sunset Review Committee shall evaluate the plan and provide recommendations to the Legislature. (GOV § 9148.8)

THIS BILL:

1) Establishes definitions as follows:

a) Defines “board” as the LADC Board.

b) Defines “certifying organization” as a certifying organization approved by the DHCS, but makes an erroneous cross-reference to the DHCS’s mandate on quality assurance for treatment facilities.

c) Defines “intern” as an unlicensed person who meets the educational requirements for licensure and is registered with the board.

d) Defines “Licensed Alcohol Drug Counselor” as a person licensed by the board to use the title “Licensed Alcohol Drug Counselor,” conduct an independent practice of alcohol drug counseling, and provide supervision to other alcohol drug counselors.

e) Defines “trainee” as an unlicensed person who is currently enrolled in a course of education that is designed to qualify the individual as an LADC and who has completed no fewer than 12 semester units or 18 quarter units of coursework in a qualifying educational program.

Administration

2) Creates the board within the DCA as follows:

a) Comprises the board of the following 10 members:

   i) Five members appointed by the Governor as follows:

      (1) Three members representing each certifying organization. If there are more than three certifying organizations, the certifying organizations rotate on and off of the board according to the date of approval by the DHCS, with the most recent appointed last so as not to exceed three members.

      (2) Until licenses are issued, the remaining Governor vacancies are filled by members who are alcohol drug addiction counselors certified by a certifying organization.

      (3) Once the board begins issuing licenses, the remaining vacancies are filled by members who are LADCs with at least five years of experience in their profession.

   ii) Five public members who are not LADCs or certified by a certifying organization, appointed as follows:

      (1) Three members appointed by the Governor.

      (2) One member appointed by the Senate Committee on Rules.

      (3) One member appointed by the Speaker of the Assembly.

   iii) One member, appointed by the Governor, who is a licensed physician and surgeon and who specializes in addiction medicine.

b) Requires board members to reside in California.

c) Specifies that each member of the board is appointed for a term of four years and that each member holds office until the appointment and qualification of their successor or until one year from the expiration date of the term for which they were appointed, whichever occurs first.

d) Specifies that a vacancy on the board is filled by appointment for the unexpired term by the authority who appointed the member whose membership was vacated.

e) Requires the board, on or before June 1 of each calendar year, to elect a chairperson and a vice chairperson from its membership.

f) Requires the board to appoint an executive officer and specifies the following:

   i) The position as a confidential position and is it from civil service under the California Constitution.

   ii) The executive officer serves at the pleasure of the board.

   iii) The executive officer must exercise the powers and perform the duties delegated by the board and vested in them under this bill.

iv) The board, with the approval of the director, must fix the salary of the executive officer.

v) The executive officer and chairperson may call meetings of the board and any duly appointed committee at a specified time and place and defines "call meetings" as setting the agenda, time, date, or place for any meeting of the board or any committee.

g) Authorizes the board to employ personnel as it deems necessary to carry out its duties, within budget limitations.

h) Requires the board to keep an accurate record of all of its proceedings and a record of all applicants for licensure and all individuals to whom it has issued a license.

i) Grants the duty of administering and enforcing the LADC licensing laws to the board and its executive officer, and grants all the powers and subjects them to all the responsibilities vested in, and imposed upon, the head of a department under state law.

j) Requires the board to, in order to carry out the provisions of this bill, do all of the following:

i) Adopt rules and regulations to implement this chapter on or before December 31, 2027.

ii) Issue licenses and register interns and trainees.

iii) Establish procedures for the receipt, investigation, and resolution of complaints against licensees, interns, and trainees.

iv) Take disciplinary action against a licensee, intern, or trainee where appropriate, including, but not limited to, censure or reprimand, probation, suspension, or revocation of the license or registration, or imposition of fines or fees.

v) Establish continuing education requirements for licensees.

vi) Establish criteria to determine whether the curriculum of an educational institution satisfies the licensure requirements imposed by this chapter.

vii) Establish parameters of unprofessional conduct for licensees that are consistent with generally accepted ethics codes for the profession.

viii) Establish reinstatement procedures for an expired or revoked license.

ix) Establish supervisory requirements for interns.

x) Establish a process for approving supervised work experience hours earned by applicants that were obtained while certified by an approved certification organization, prior to completion of a master's degree.

xi) Align licensure requirements to the Substance Abuse and Mental Health Services Administration's career ladder for substance use disorder counselors.

xii) Establish procedures for approving reciprocity for licenses obtained in other states or nations.

xiii) Consult the public, especially people in recovery, providers of substance use disorder services, and organizations that certify substance use disorder counselors before adopting regulations and standards related to the above mandates.

k) Authorizes the board to do the following:

i) Collaborate with the Department of Health Care Access and Information concerning workforce development strategies that impact behavioral health professions.

ii) Assist the relevant legislative policy committee in reviewing and making determinations regarding sunrise review applications for emerging behavioral health license or certification programs.

iii) Refer complaints about licensed and certified behavioral health workers to appropriate agencies and private organizations and catalog complaints about unlicensed behavioral health workers.

3) Establishes a scope of practice around alcohol drug counseling as follows:

a) Authorizes an LADC to engage in the practice of alcohol drug counseling.

b) Defines "practice of alcohol drug counseling" as performing any of the following for the purpose of treating substance use disorder:

i) Clinical evaluation, including screening, assessment, and diagnosis of substance use disorders.

ii) Treatment planning for substance use disorders, including initial, ongoing, continuity of care, discharge, and planning for relapse prevention.

iii) Referral, service coordination, and case management in the areas of substance use disorder and co-occurring disorders.

iv) Counseling, therapy, trauma-informed care, and psychoeducation with individuals, families, and groups in the area of substance use disorder.

v) Client and family education on substance use disorders.

vi) Documentation, including admission summaries, progress notes, problem lists, changes in level of care, discharge summaries, and other relevant data.

vii) Clinical supervisory responsibilities for interns, trainees, and nonlicensed practitioners, including registered and certified alcohol drug counselors.

c) Limits an LDAC, unless otherwise licensed, from performing the acts listed as part of the "practice of alcohol drug counseling" except for the purpose of treating a substance use disorder.

d) Clarifies that the LDAC scope of practice does not constrict or limit a licensed physician and surgeon, a licensed registered nurse, a licensed psychologist, a licensed marriage and family therapist, or licensed clinical social worker from performing any of the LDAC scope of practice, provided that the individual does not use the title "Licensed Alcohol Drug Counselor."

Licensure

4) Establishes the requirements for licensure as follows:

a) Authorizes the board to, for a period not to exceed five years from the time the board commences issuing licenses, issue a license to an applicant who satisfies the following requirements:

i) Completion of an application for a license.

ii) Payment of the fees prescribed by the board.

iii) Either of the following:

(1) Possession of a master's degree in alcohol drug counseling or related counseling master's degree.

(2) The requirements of the International Certification & Reciprocity Consortium to sit for the Advanced Alcohol & Other Drug Counselor written examination at the time of the examination.

iv) Passing the International Certification & Reciprocity Consortium Advanced Alcohol Drug Counselor written examination or another equivalent examination, as determined by the board.

b) Authorizes the board to, no later than five years from the time the board commences approving licenses, issue a license to an applicant who satisfies the following requirements:

i) Completion of an application for a license.

ii) Payment of the fees prescribed by the board.

iii) Possesses a doctoral or master's degree in alcohol drug counseling meeting the requirements of [these requirements or the above requirements] and obtained from a school, college, or university approved by the Bureau for Private Postsecondary Education or accredited by the National Addiction Studies Accreditation Commission, the California Consortium of Addiction Programs and Professionals, or a regional or national institutional accrediting agency that is recognized by the United States Department of Education.

(1) Specifies that the board makes the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval.

iv) Completion of a supervised practicum from an educational institution approved by the board.

v) Passing a written examination approved by the board.

vi) Documentation of either of the following:

(1) The applicant, at the time of application, is certified by a certifying organization.

(2) The applicant has completed 2,000 hours of postgraduate supervised work experience.

Education

5) Establishes the educational requirements for licensure as follows:

a) Requires a doctoral or master's degree in alcohol drug counseling to at minimum contain the following:

i) The degree contains not fewer than 60 semester or 90 quarter units of instruction that include, but are not limited to, 27 semester or 40.5 quarter units in the following academic content hours:

(1) Pharmacology and physiology of addiction, including any of the following subjects:

(a) Examination of the effects of alcohol and similar legal psychoactive drugs on the body and behavior.

(b) Damage to the body and behaviors.

(c) Damage to the brain, liver, and other organs.

(d) Tolerance, cross-tolerance, and synergistic effects.

(e) Physiological differences between males and females.

(f) Disease model, including neurobiological signs and symptoms.

(2) Clinical evaluation and psychopathology, including any of the following subjects:

(a) Initial interviewing process.

(b) Biopsychosocial assessment.

(c) Differential diagnosis.

(d) Diagnostic summaries.

(e) Cooccurring disorders, referral processes, and the evaluation of clients using placement criteria, including the American Society of Addiction Medicine patient placement criteria or other validated clinical tools, to determine the

most appropriate level of care for the client and eligibility for admission to a particular alcohol and other drug abuse treatment program.

(3) Counseling psychotherapy for addiction, including any of the following subjects:

(a) Introduction to counseling.

(b) Introduction to techniques and approaches.

(c) Crisis intervention.

(d) Individual counseling focused on addiction.

(e) Group counseling.

(f) Family counseling as it pertains to addiction treatment.

(4) Case management, including any of the following subjects:

(a) Community resources.

(b) Consultation.

(c) Documentation.

(d) Resources for people who are HIV positive.

(5) Client education, including any of the following subjects:

(a) Addiction recovery.

(b) Psychological client education.

(c) Biochemical and medical client education.

(d) Sociocultural client education.

(e) Addiction recovery and psychological family education.

(f) Biomedical and sociocultural family education.

(g) Community and professional education.

(6) Professional responsibility, including any of the following subjects:

(a) Ethical standards, legal aspects, cultural competency, professional growth, personal growth, dimensions of recovery, clinical supervision, and consultation.

(b) Community involvement.

(c) Operating a private practice.

b) Requires the degree to contain no fewer than 6 semester units or 9 quarter units of supervised fieldwork.

c) Requires licensees to attest to the board every two years, on a form prescribed by the board, that they have completed continuing education coursework that is offered by a board-approved provider and that is in or relevant to the field of alcohol drug counseling. The board may require licensees to take specific coursework, including, but not limited to, coursework concerning supervisory training, as a condition of license renewal.

d) Authorizes the board to audit the records of a licensee to verify the completion of the continuing education requirement.

e) Requires a licensee to maintain records of completion of required continuing education coursework for a minimum of five years and shall make these records available to the board for auditing purposes upon request.

f) Specifies that the continuing education attestation is not subject to penalty of perjury.

6) Establishes license renewal requirements as follows:

a) Requires the board to renew an unexpired license of a licensee who meets the following qualifications:

i) The licensee has applied for renewal on a form prescribed by the board and paid the required renewal fee.

ii) The licensee attests compliance with continuing education requirements pursuant to an erroneous cross reference, but the attestation is not subject to penalty of perjury.

iii) The licensee has notified the board whether they have been subject to, or whether another board has taken, disciplinary action since the last renewal.

b) Authorizes the board to renew an expired license of a former licensee who meets the following qualifications:

i) The former licensee has applied for renewal on a form prescribed by the board within three years of the expiration date of the license.

ii) The former licensee has paid the renewal fees that would have been paid if the license had not been delinquent.

iii) The former licensee has paid all delinquency fees.

iv) The former licensee attests compliance with continuing education requirements, including for the time the license was expired, but the attestation is not subject to penalty of perjury.

v) The former licensee notifies the board whether they have been subject to, or whether another board has taken, disciplinary action against the former licensee since the last renewal.

c) Specifies that a license that is not renewed within three years after its expiration may not be renewed, restored, reinstated, or reissued, but the former licensee may apply for and obtain a new license if all of the following are satisfied:

i) No fact, circumstance, or condition exists that, if the license were issued, would justify its revocation or suspension.

ii) The former licensee pays the fees that would be required if they were applying for a license for the first time.

iii) The former licensee meets the corresponding requirements for licensure as an LDAC at the time of application.

d) Specifies that a suspended license is subject to expiration and may be renewed as provided in this article, but the renewal does not entitle the licensee, while it remains suspended and until it is reinstated, to engage in the activity for which the license related, or in any other activity or conduct in violation of the order or judgment by which it was suspended.

e) Specifies that a revoked license is subject to expiration, but it may not be renewed. If it is reinstated after its expiration, the licensee must, as a condition precedent to its reinstatement, pay a reinstatement fee in an amount equal to the renewal fee in effect on the last regular renewal date before the date on which it is reinstated, plus the delinquency fee, if any, accrued at the time of its revocation.

7) Establishes inactive status requirements as follows:

a) Authorizes an LDAC to apply to the board to request that their license be placed on inactive status. A licensee who holds an inactive license must pay a biennial fee of one-half of the active renewal fee and is be exempt from continuing education requirements, but is still otherwise subject to the licensing requirements and may not engage in the practice of alcohol drug counseling in this state.

b) Authorizes a licensee on inactive status who has not committed any acts or crimes constituting grounds for denial of licensure to, upon their request, have their license placed on active status. A licensee requesting their license to be placed on active status at any time between a renewal cycle shall pay one-half of the renewal fee.

Enforcement

8) Establishes license denial requirements specific to criminal history as follows:

a) Requires the board to, before issuing a license, review the state, national, and federal criminal history of the applicant.

b) Requires the board to deny, suspend, delay, or set aside a person's license application if, at the time of the board's determination, the person has a criminal conviction or criminal charge pending, relating to an offense for which the circumstances substantially relate to actions as an LDAC.

c) Requires an applicant who has a criminal conviction or pending criminal charge to request the appropriate authorities to provide information about the conviction or charge directly to the board in sufficient specificity to enable the board to make a determination as to whether the conviction or charge is substantially related to actions as an LDAC.

d) Authorizes the board to, after a hearing or review of documentation demonstrating that the applicant meets all of the following criteria for a waiver, waive the requirements relating to the denial, suspension, delaying, or setting aside of a person's license application:

i) Either of the following:

(1) For waiver of a felony conviction, more than five years has elapsed since the date of the conviction, and at the time of the application, the applicant is not incarcerated, on work release, on probation, on parole, on postrelease community supervision, or serving any part of a suspended sentence and the applicant is in substantial compliance with all court orders pertaining to fines, restitution, or community service.

(2) For waiver of a misdemeanor conviction or violation, at the time of the application, the applicant is not incarcerated, on work release, on probation, on parole, on postrelease community supervision, or serving any part of a suspended sentence and the applicant is in substantial compliance with all court orders pertaining to fines, restitution, or community service.

ii) The applicant is capable of practicing LDAC services in a competent and professional manner.

iii) Granting the waiver will not endanger the public health, safety, or welfare.

e) Specifies that a past criminal conviction does not serve as an automatic exclusion for licensure, and requires the board to evaluate the circumstances leading to conviction and determine if the person meets the capability and endangerment conditions for a waiver in determining approval or denial of the application.

9) Establishes title protection as follows:

a) Prohibits a person from using the title of "Licensed Alcohol Drug Counselor" unless the person has applied for and obtained a license from the board.

b) Makes a violation of the title requirement punishable by an administrative penalty not to exceed $10,000.

10) Establishes exclusions from the licensing program as follows:

a) Specifies that the requirements under this bill do not constrict, limit, or withdraw the Medical Practice Act, the Nursing Practice Act, the Psychology Licensing Law, the Licensed Marriage and Family Therapist Act, or the Clinical Social Worker Practice Act.

b) Specifies that a person employed or volunteering at a certified outpatient treatment program or licensed residential treatment facility is not required to obtain a license.

11) Establishes practice requirements as follows:

a) Requires a licensee to display their license in a conspicuous place in the licensee's primary place of practice.

b) Prohibits an LDAC who conducts a private practice under a fictitious business name from using any name that is false, misleading, or deceptive and requires the LDAC to inform the patient, prior to the commencement of treatment, of the name and license designation of the owner or owners of the practice.

c) Requires a licensee or registrant to give written notice to the board of a name change within 30 days after each change, giving both the old and new names and requires a copy of the legal document authorizing the name change, such as a court order or marriage certificate, to be submitted with the notice.

12) Establishes unprofessional conduct requirements as follows:

a) Authorizes the board to refuse to issue a registration or license, or to suspend or revoke the license or registration of any registrant or licensee, if the applicant, licensee, or registrant has been guilty of unprofessional conduct.

b) Specifies that unprofessional conduct includes, but is not limited to, all of the following:

i) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant and further specifies the following:

(1) The record of conviction is conclusive evidence only of the fact that the conviction occurred.

(2) The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant.

(3) A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant is deemed to be a conviction.

(4) The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

ii) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

iii) Administering to themselves any controlled substance or using any of the dangerous drugs specified under the Pharmacy Law, or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license, or to any other person, or to the public, or to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license, or the conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of a substance referred to in this subdivision after becoming licensed.

(1) Requires the board to deny an application for a registration or license or revoke the license or registration of a person who uses or offers to use drugs in the course of performing alcoholism and drug abuse counseling services.

iv) Gross negligence or incompetence in the performance of alcoholism and drug abuse counseling services.

v) Violating, attempting to violate, or conspiring to violate the licensing laws or a regulation adopted by the board.

vi) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of their education, professional qualifications, or professional affiliations to a person or entity.

vii) Impersonation of another by a licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use their license or registration.

viii) Aiding or abetting, or employing, directly or indirectly, an unlicensed or unregistered person to engage in conduct for which a license or registration is required.

ix) Intentionally or recklessly causing physical or emotional harm to a client.

x) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

xi) Engaging in sexual relations with a client or a former client within two years following termination of services, soliciting sexual relations with a client, committing an act of sexual abuse or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of an alcoholism and drug abuse counselor.

xii) Failure to maintain confidentiality, except as otherwise required or permitted by law, of any information that has been received from a client in confidence during the course of treatment or any information about the client that is obtained from tests or other means.

xiii) Before the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

xiv) Paying, accepting, or soliciting consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration is in relation to professional counseling services actually provided by the licensee. Two or more licensees may still collaborate in a case or cases, but a fee may not be charged for that collaboration, except when proper disclosure of the fee has been made.

xv) Advertising in a manner that is false, misleading, or deceptive.

xvi) Conduct in the supervision of a registered intern by a licensee that violates the licensing laws or rules or regulations adopted by the board.

xvii) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience, which may not be construed to expand the scope of the LDAC.

xviii) Permitting a registered intern, trainee, or applicant for licensure under one's supervision or control to perform, or permitting the registered intern, trainee, or applicant for licensure to hold themselves out as competent to perform, professional services beyond the registered intern's, trainee's, or applicant for licensure's level of education, training, or experience.

xix) The violation of a statute or regulation governing the training, supervision, or experience required by the licensing laws.

xx) Failure to maintain records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

xxi) Failure to comply with the child abuse reporting requirements of the Child Abuse and Neglect Reporting Act.

xxii) Failure to comply with the mandatory reporting requirements for elder and dependent adult abuse.

xxiii) Willful violation of requirements for patient access to health records.

13) Establishes license denial and disciplinary procedures as follows:

a) Authorizes the board to deny an application, or may suspend or revoke a license or registration, for any of the following:

i) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action imposed by another state or territory or possession of the United States, or by any other governmental agency, on a license, certificate, or registration to practice alcoholism and drug abuse counseling or any other healing art. It also constitutes unprofessional conduct. A certified copy of the disciplinary action decision or judgment is conclusive evidence of that action.

ii) Revocation, suspension, or restriction by the board of a license, certificate, or registration to practice as a marriage and family therapist, clinical social worker, or educational psychologist shall also constitute grounds for disciplinary action for unprofessional conduct against the licensee or registrant under this chapter.

iii) Written documentation from the DHCS demonstrating that the DHCS has ruled that a certification should be revoked by a private certifying organization.

b) Requires the board to revoke a license upon a decision made in accordance with the procedures set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code that contains any finding of fact that the licensee or registrant engaged in any act of sexual contact, as defined in Section 729, when that act is with a patient, or with a former patient when the relationship was terminated primarily for the purpose of engaging in that act. The revocation shall not be stayed by the administrative law judge or the board.

14) Requires all enforcement proceedings to be held in accordance with the Administrative Procedure Act.

Revenue

15) Authorizes the board to establish fees for licensure.

16) Limits the total amount of fees that may be collected to the reasonable regulatory cost to the board for administering the licensing laws.

17) Limits the license fee for an original license and license renewal, for the first 10 years of operation or until the board is self-funded, whichever is later, to no more than $200.

Operation

18) Makes the operation of the provisions of this bill contingent on appropriation by the Legislature of funds allocated to the state from any of the following:

a) Current or future substance use disorder workforce expansion funds received by the Department of Health Care Access and Information.

b) Current or future substance use disorder workforce expansion funds received by the DHCS.

c) Current or future allocations from the Opioid Settlement Fund.

d) State opioid response grant funding.

e) Other funding provided to the state to address addiction and overdose.

f) Adult use of marijuana funding.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the California Consortium of *Addiction Programs and Professionals, California Council of Community Behavioral Health Agencies,* and the *California Society of Addiction Medicine*. According to the author, "As Californians die from opioid deaths in record numbers, they lack the most essential item in the continuum of care for treating substance use disorder: access to licensed, independent drug and alcohol counselors who can treat the disease at the earliest stage of its progression. It is imperative that California employ every tool at its disposal to reduce the impact of the opioid epidemic and the burgeoning stimulant epidemic. California is one of only a handful of populous states that do not license alcohol drug counselors. This glaring gap in our treatment system means that people must become sick enough to warrant expensive inpatient or intensive outpatient care before they can enter treatment. Additionally, those who seek care in the unregulated outpatient market also lack basic consumer protection, making them vulnerable to unscrupulous actors, incompetent treatment, and patient brokering that in extreme cases can lead to human trafficking. California currently faces an urgent lack of qualified alcohol-drug counselors, so much so that some programs are now unable to comply with regulations for minimum staffing requirements. The lack of a license has exacerbated the workforce crisis."

Background. According to the American Society of Addiction Medicine:

> Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.
>
> Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

One of the treatments for addiction medicine is counseling. Generally state law requires a license to practice counseling. However, substance use counselors are authorized to provider services DHCS-certified in alcohol drug programs.

Substance Use Counselor Certification. To meet current counselor requirements, individuals must be registered with or certified by a DHCS-approved certifying organization, of which there are currently three. Counselor certification is based upon the *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, published by the federal Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment. In order for a certifying organization to issue certification, applicants must meet requirements established in regulations, which include completion of at least 155 hours of formal classroom education, as defined; have documented completion of at least 160 hours of supervised alcohol or other drug program counseling and 2,080 or more hours of work experience; and received a score of at least 70% on an approved exam. Certification is valid for two years and a counselor is required to complete 40 hours of continuing education every two years for renewal. Regulations allow for individuals who are registered with a certifying organization to provide counseling services while working toward completion of certification requirements. Regulations also exempt licensed professionals (such as physicians licensed by the Medical Board of California, psychologists licensed by the Board of Psychology, those licensed

by or registered as an intern with the Board of Behavioral Sciences or the Board of Psychology) from certification for providing substance use counseling services at facilities and programs under DHCS's jurisdiction.

Peer Support Specialists. Peer support specialists are individuals who self-identify as having lived experience with the process of recovery from mental illness, substance use, or both, and who understand and model the process of recovery and healing while offering moral support and encouragement to people who need it. Moral support and encouragement have proven to result in greater compliance with treatment services, better health function, lower usage of emergency departments, fewer medications and prescriptions, and a higher sense of purpose and connectedness on the part of the consumer. Peer support specialists are not certified or registered substance use counselors.

Drug Medi-Cal Organized Delivery System (DMC-ODS). DMC-ODS is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal-eligible individuals with SUDs. Medi-Cal adult members whose county of residence participates in DMC-ODS, and Medi-Cal members under age 21 in all counties, are able to receive DMC-ODS services consistent with this BHIN's medical necessity of services criteria, access criteria, assessment criteria, and level of care determination criteria.

DMC-ODS provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in SUD treatment, and increased coordination with other systems of care.

DMC-ODS services must be medically necessary. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. A qualified licensee must make the medical necessity determination. A certified substance use counselor who is not also licensed is not authorized to make the determination.

Prior Related Legislation. AB 1055 (Bains) of 2023 was substantially similar to this bill. AB 1055 died pending a hearing in this committee.

AB 666 (Quirk-Silva), Chapter 7, Statutes of 2022, required the DHCS, on or before July 1, 2023, to develop a statewide SUD workforce needs assessment report that evaluates the current state of the SUD workforce, determines barriers to entry, and assesses the state's systems for regulating and supporting the SUD workforce.

AB 2473 (Nazarian), Chapter 594, Statutes of 2022, required the DHCS to determine the required core competencies for registered and certified counselors working within an alcoholism or drug abuse recovery and treatment program.

AB 2818 (Waldron) of 2022 would have stated legislative intent to establish one- and five-year plans aimed at expanding the SUD treatment workforce in California to aid in the treatment of

alcohol and drug abuse. AB 2818 was held on the Assembly Appropriations Committee suspense file.

SB 992 (Melendez) of 2022 would have established a licensing program similar to the program proposed under this bill, creating the Allied Behavioral Health Board within the DCA to administer and enforce the program and transferring the responsibility to oversee SUD certifying organizations from the DHCS to the board. SB 992 died pending hearing in the Senate Committee on Business, Professions and Economic Development.

SB 803 (Beall), Chapter 150, Statutes of 2020, required the DHCS to establish statewide requirements for counties or their representatives to use in developing certification programs for peer support specialists.

AB 2214 (Rodriguez) of 2018 would have established a voluntary certification process for recovery residences and would have required specified entities or persons who direct individuals into substance use treatment, or a judge or parole board, to first refer a person to a residence listed as a certified recovery residence. AB 2214 was held on the Assembly Appropriations Committee suspense file.

AB 2804 (Waldron) of 2018 was substantially similar to AB 2473 (Nazarian). AB 2804 was held on the Assembly Appropriations Committee suspense file.

AB 700 (Jones-Sawyer), Chapter 337, Statutes of 2017, before being amended to address a different subject matter, would have established classifications for SUD counselor certification, registrants, and interns using federal Substance Abuse and Mental Health Services Administration (SAMHSA) recommendations to be implemented by DHCS-approved certifying entities (COs).

SB 1101 (Wieckowski) of 2016 would have established a licensing program for alcohol and drug counselors and created the Alcohol and Drug Counseling Professional Bureau within DCA administer and enforce the program. SB 1101 was held on the Senate Appropriations Committee suspense file.

SB 570 (DeSaulnier) of 2014 would have established the Advanced Alcohol and Drug Counselor Licensing Act, establishing a licensing program for alcohol and drug counselors and creating the Advanced Alcohol and Drug Counselor Licensing Board within the DCA to administer and enforce the act. SB 570 was held on the Assembly Appropriations Committee suspense file.

AB 2007 (Williams) of 2012 would have established a licensing program for alcohol and drug counselors and required the Department of Public Health to administer and enforce the program. AB 2007 died pending a hearing in the Assembly Health Committee.

SB 1203 (DeSaulnier) of 2010 would have instituted a licensing and certification structure for alcohol and drug counselors by Department of Alcohol and Drug Programs. SB 1203 died pending a referral in the Assembly Rules Committee.

AB 239 (DeSaulnier) 2008 would have enacted the Alcoholism and Drug Abuse Counselors Licensing Law and provide for the licensure and regulation of alcoholism and drug abuse counselors by the Board of Behavioral Sciences. AB 239 was vetoed by Governor Schwarzenegger who stated, “It is unacceptable to create a two-tier classification for drug and

alcohol counselors in this state. Individuals seeking treatment for an addiction problem should not be subject to different standards based on their ability to pay. I am directing my Department of Alcohol and Drug Programs and Department of Consumer Affairs to work with stakeholders to craft a uniform standard for all alcohol and drug counselors so individuals seeking treatment are offered the same quality care across all sectors, whether in a public or private facility."

AB 1367 (DeSaulnier) 2007 would have enacted the Alcoholism and Drug Abuse Counselors Licensing Law and provide for the licensing or registration and regulation of alcoholism and drug abuse counselors and interns by the Board of Behavioral Sciences. AB 1367 was held on the Assembly Appropriations Committee suspense file.

AB 2571 (Longville) 2004 would have created the Board of Alcohol and Other Drugs of Abuse Professionals within the DCA and required licensing and certification of alcohol and other drugs of abuse professionals. AB 2571 failed passage in the Assembly Health Committee.

AB 1100 (Longville) of 2003 would have required licensing of alcohol and drug abuse counselors under the Alcohol and Drug Abuse Counselors Licensing Law and the Board of Behavioral Sciences. AB 1100 died pending a hearing in this committee.

SB 1716 (Vasconcellos) of 2002 would have enacted the Alcohol and Drug Abuse Counselors Licensing Law, requiring the Board of Behavioral Sciences to regulate and license alcohol and drug abuse counselors. SB 1716 was died pending a hearing in this committee.

SB 537 (Vasconcellos) of 2001 would have required the DCA in conjunction with relevant entities to review the need for licensing substance abuse counselors and to notify the Governor and the Legislature of any determination that licensing is not needed. SB 537 was vetoed by Governor Davis who stated, "Given the rapid decline of our economy and a budget shortfall of $1.1 billion through the first three months of this fiscal year alone, I have no choice but to oppose additional General Fund spending. In addition, many of the best counselors may not be eligible for licensure but are certified to provide services in drug and alcohol treatment programs. For this reason, I am directing the Department of Alcohol and Drug Programs to promulgate regulations to require that counselors in drug and alcohol treatment facilities be certified for quality assurance purposes.

ARGUMENTS IN SUPPORT:

The *California Consortium of Addiction Programs and Professionals (CCAPP)* (co-sponsor) writes in support:

> As California's largest certifying entity for AOD professionals, CCAPP is a longtime advocate and facilitator of quality standards in the SUD space. While we continue to do our best to ensure consumer protection within our means as a certifying entity, we also recognize the need to establish a board that will regulate, standardize, and license this profession. California is one of only a handful of populous states that does not have a license for alcohol drug counselors. The lack of licensure creates a significant gap in care for substance use disorder (SUD) patients who find little to no resources to treat their disease at its earliest onset – in a private practice setting. California must end its "inverted pyramid" of treatment where people with the disease of addiction must become sick enough to

> warrant expensive inpatient or intensive outpatient care before they receive treatment.
>
> [This bill] will establish the Licensed Alcohol Drug Counselor Board at the Department of Consumer Affairs (DCA) to house the new AOD counselor license. This license will protect consumers and establish counselor competency by requiring among many things; a master's degree, specified study in core subject matter, supervised work experience, and a passing score on a national licensing exam to use the title, "Licensed Alcohol Drug Counselor." While California is on the verge of obtaining $4 billion in workforce support from the BH-CONNECT federal waiver, now is the opportune time to stand the board up without impacting the General Fund.
>
> It is urgent that California establish licensure for this critical workforce when we are experiencing record highs in demand. We must ensure consumers can be confident in their provider choices and get the care they need.

The *California Society of Addiction Medicine* (co-sponsor) writes in support, "This measure is extremely important for proper, quality patient care."

The *Steinberg Institute* writes in support:

> California's treatment system resembles an inverted pyramid where people experiencing early onset symptoms of addiction are unable to obtain care from a private practitioner specializing in addiction and must wait till their disease progresses to the point of needing expensive outpatient or inpatient care. With the advent of fentanyl in almost all street drugs, people who may be experiencing problems with prescription drugs must have access to a counselor in their neighborhood who can treat their disease-specific symptoms before they seek illicit drugs.
>
> In addition to clear consumer harm, the lack of licensure in this behavioral health category hinders the workforce when we are experiencing demand like never before. It is also preventing Californians from accessing independent practitioner services for the treatment of substance use disorder (SUD), which is becoming more common in state Medicaid services across the country.
>
> Recent policy advancements, including CARE courts, crisis stabilization units, collocated behavioral health services at schools, and most recently, the expansion of SUD services under Proposition 1, must be supported by an expansion in the workforce. That can only occur with a comprehensive and recognized career ladder for SUD professionals. Given the increasing demand for addiction treatment services, especially in the wake of the opioid epidemic, California must prioritize the establishment of a regulated, professional workforce of alcohol and drug counselors. [This bill] offers a sensible, structured approach to achieving this goal, providing much-needed clarity and standards to the field.

ARGUMENTS IN OPPOSITION:

The *California Association of Alcohol and Drug Program Executives* are opposed to this bill unless it is amended:

> First, and most importantly, [this bill] establishes a separate board in the Department of Consumer Affairs (DCA) for licensing SUD counselors that fall outside of the process whereby other behavioral health professionals are licensed. We appreciate that the SUD licensing program is placed in DCA where it belongs, but why go through the expense and bureaucratic work of creating a separate board rather than requiring the Board of Behavioral Science (BBS) to establish and administer this licensing program? The BBS is already set up to perform the functions described by the bill for this program. To exclude SUD counselors from the BBS licensing process, we believe, is tantamount to saying that SUD counselors are not on par with other behavioral health professionals.
>
> Second, the way in which the bill proposes to fund the Licensed Alcohol Drug Counselor Board and the SUD licensing program is problematic. Diverting money from current SUD workforce expansion funds, opioid settlement funds, opioid response grants, and Proposition 64 grants reduces the resources that could otherwise be available to expand and strengthen underfunded community-based SUD prevention and treatment programs. We believe there are much better uses for these funds than to create an unnecessary new state bureaucracy.
>
> Regarding the membership of the Licensed Alcohol Drug Counselor Board, [this bill] requires that three of the members appointed by the Governor shall represent each approved certifying organization. However, there is no provision for a member representing a community-based treatment provider. Given that providers are important stakeholders in the SUD treatment field, they should be represented on any board that licenses SUD counselors.

SUNRISE REVIEW:

When there are proposals for new or expanded regulation of an occupation, legislators and administrative officials are expected to weigh arguments regarding the necessity of the proposed regulation, determine the appropriate level of regulation (e.g., registration, certification, or licensure), and select a set of standards (education, experience, examinations). As a result, the Legislature uses a process known as “sunrise” to review and assess the proposals.

The process includes a questionnaire and a set of evaluative scales to be completed by the group supporting regulation. The questionnaire is an objective tool for collecting and analyzing information needed to arrive at accurate, informed, and publicly supportable decisions regarding the merits of regulatory proposals.

The Need for Sunrise. New regulatory and licensing proposals are generally intended to assure the competence of specified practitioners in different occupations. However, these proposals have resulted in a proliferation of licensure and certification programs, which are often met with mixed support. Proponents argue that regulation benefits the public by assuring competence and an avenue for consumer redress. Critics argue that regulation benefits a profession more than it benefits the public.

Sunrise helps distill those arguments by: (1) placing the burden of showing the necessity for new regulations on the requesting groups; (2) allowing the systematic collection of opinions both pro and con; and (3) documenting the criteria used to decide upon new regulatory proposals.

Sunrise has been in law since 1990, but recent studies continue to support the need for the process. Specifically, those studies show that, while licensing and other forms of regulation may increase employment opportunities and raise wages, they can also have negative or unintended economic impacts, such as shortages of practitioners or increased costs for services.[1]

In response to concerns over the growing number of professions requiring a license, the White House issued a report in 2015, *Occupational Licensing: A Framework for Policymakers*. The report agreed that, while licensing offers important protections to consumers and can benefit workers, there are also substantial costs, and licensing requirements may not always align with the skills necessary for the profession being licensed. Specifically, the report found:

> There is evidence that licensing requirements raise the price of goods and services, restrict employment opportunities, and make it more difficult for workers to take their skills across State lines. Too often, policymakers do not carefully weigh these costs and benefits when making decisions about whether or how to regulate a profession through licensing. In some cases, alternative forms of occupational regulation, such as State certification, may offer a better balance between consumer protections and flexibility for workers.

Levels of Regulation. If a review of the proponents' case indicates that regulation is necessary to protect public health, safety, and welfare, then a determination must be made regarding the appropriate level of regulation. As noted above, the public is often best served by minimal government intervention. The definitions and guidelines below are intended to facilitate the selection of the least restrictive level of regulation that will adequately protect the public interest.

Level I: Strengthen existing laws and controls. The choice may include providing stricter civil actions or criminal prosecutions. It is most appropriate where the public can effectively implement control.

Level II: Impose inspections and enforcement requirements. This choice may allow inspection and enforcement by a state agency. These should be considered where a service is provided that involves a hazard to the public health, safety, or welfare. Enforcement may include recourse to court injunctions and should apply to the business or organization providing the service, rather than the individual employees.

Level III: Impose registration requirements. Under registration, the state maintains an official roster of the practitioners of an occupation, recording also the location and other particulars of

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[1] See generally, Morris M. Kleiner, *Reforming Occupational Licensing Policies*, Discussion Paper 2015-01 (The Hamilton Project, Brookings Institution, March 2015); Michelle Natividad Rodriguez and Beth Avery, *Unlicensed & Untapped: Removing Barriers to State Occupational Licenses for People with Records* (National Employment Law Project, April 2016); *Jobs for Californians: Strategies to Ease Occupational Licensing Barriers,* Report #234 (Little Hoover Commission, 2016); Dick M. Carpenter II, Lisa Knepper, Kyle Sweetland, and Jennifer McDonald, *License to Work: A National Study of Burdens from Occupational Licensing*, 2nd Edition (Institute for Justice, November 2017); Adam Thierer and Trace Mitchell, *Occupational Licensing Reform and the Right to Earn a Living: A Blueprint for Action* (Mercatus Center/George Mason University April 2020).

the practice, including a description of the services provided. This level of regulation is appropriate where any threat to the public is small.

Level IV: Provide an opportunity for certification. Certification is voluntary; it grants recognition to persons who have met certain prerequisites. Certification protects a title: non-certified persons may perform the same tasks but may not use "certified" in their titles. Usually, an occupational association is the certifying agency, but the state can be one as well. Either can provide consumers a list of certified practitioners who have agreed to provide services of a specified quality for a stated fee. This level of regulation is appropriate when the potential for harm exists and when consumers have a substantial need to rely on the services of practitioners.

Level V: Impose licensure requirements. Under licensure, the state allows persons who meet predetermined standards to work at an occupation that would be unlawful for an unlicensed person to practice. Licensure protects the scope of practice and the title. It also provides for a disciplinary process administered by a state control agency. This level of regulation is appropriate only in those cases where a clear potential for harm exists and no lesser level of regulation can be shown to adequately protect the public.

Sunrise Criteria and Questions. Central to the sunrise process are nine sunrise criteria, which were developed in coordination with the Department of Consumer Affairs to provide a framework for evaluating the need for regulation. These criteria are:

1) Unregulated practice of the occupation in question will harm or endanger the public health, safety or welfare.
2) Existing protections available to the consumer are insufficient.
3) No alternatives to regulation will adequately protect the public.
4) Regulation will alleviate existing problems.
5) Practitioners operate independently, making decisions of consequence.
6) The functions and tasks of the occupation are clearly defined.
7) The occupation is clearly distinguishable from other occupations that are already regulated.
8) The occupation requires knowledge, skills, and abilities that are both teachable and testable.
9) The economic impact of regulation is justified.

The criteria were used to develop the sunrise questionnaire noted above and help legislators and administrators answer three policy questions:

1) Does the proposed regulation benefit the public health, safety, or welfare?
2) Will the proposed regulation be the most effective way to correct existing problems?
3) Is the level of the proposed regulation appropriate?

Sunrise Analysis. The following analysis is based on the above criteria and corresponding questions and answers provided by the author, sponsors of the bill, and applicant group in the sunrise questionnaire. The applicant group is the *California Consortium of Addiction Programs and Professionals* (co-sponsor), which states that it is seeking regulation on behalf of California consumers and practitioners of substance use disorder treatment.

Criteria 1. Unregulated practice of substance use counseling will harm or endanger the public health, safety, or welfare.

The applicant group argues, "Unregulated and incompetent practice leaves consumers in the treatment space inherently vulnerable to all types of physical, social, and financial harm as they are vulnerable - reliant on what is essentially an unsubstantiated trust in the practitioner. Without regulation to enforce a minimal level of competency in the most vulnerable of settings (private practice), there is no recourse for consumers, other than private legal action. Practitioners operating outside the purview of certification entities face little to no consequences for abusive treatment of clients in private practice. Revoked alcohol drug counselors, as well as those suspended or revoked by licensing boards, are able to continue to abuse clients as they please."

However, the practice of addiction medicine and substance use counseling is already regulated for purposes of this sunrise analysis. First, the licensing laws around medicine, psychology, nursing, behavioral science, and other related practices generally prohibit the professional practice of the clinical aspects of any form of counseling, including substance use counseling, without a license, exemption, or other authority to practice. To that end, all counseling services are subject to the licensing laws of the relevant practice act or, if provided by an unlicensed practitioner, subject to the administrative, civil, and misdemeanor penalties associated with those laws.

Second, unlicensed substance use counselors are specifically regulated by the DHCS under the state certification laws for alcohol or other drug programs. Any unlicensed person who provides substance use counseling in a program must be registered or certified by one of the DHCS-approved certifying organizations and meet specific education, training, and ethics requirements. While the certification requirements do not apply outside of certified alcohol or other drug programs, the existing licensing laws would apply to anyone providing services that fall under the respective scopes of practice of the laws.

Instead, the primary problem put forward by the applicant is, "Employers, employees, consumers, and regulators alike have long sought regulation that will create a uniform standard of qualifications and remedy the workforce shortage issues that are the result of largely inconsistent practice standards."

Specifically, the applicant seeks to address the following issues:

1) *Lack of Mild, Moderate, and After Care*. The applicant believes that authorizing substance use counselors to provide counseling services via a license will address the needs of individuals whose condition is not severe enough to necessitate entry into a program, do not want to enter a program, or have completed a program and are at risk of relapse.

2) *Fully Utilizing Training*. The applicant believes qualified substance use counselors should be able to perform functions they are trained to perform without unnecessary supervision, such as making medical necessity determinations under ODS. According to the applicant, "SUD peers, which represent a large percentage of peer specialists, must be supervised under a separate license, i.e. Licensed Social Worker or Marriage and Family Therapist. This inefficiency creates an unnecessary redundancy of mental health professionals taking these professionals away from an already constrained workforce. This redundancy and inefficiency also exist in the SUD space at large as a result of the lack of licensure precluding the billing

for SUD counselors without putting their services under the umbrella of an otherwise licensed professional."

3) *Private Practice*. As discussed above, existing licensing laws prohibit the clinical aspects of professional substance use counseling without a license outside of certified alcohol or drug other programs. The applicant wants to create an additional license type specific to substance use allowing for practice outside of the DHCS regulatory structure.

4) *Billing*. The applicant would like substance use counselors to be able to bill. According to the applicant, "Licensure also clears many of the technical obstacles impacting access to SUD care within current expansions in behavioral health services. Some of the expansions experiencing conflict as a result of the lack of licensure include the 9-8-8 crisis teams and peer services where certified counselors are not recognized for billing and supervision for addiction service provision."

   It is true that payers typically require reimbursable services to be provided by licensed practitioners, although some will pay for service provided under supervision. The applicants argue that the inability to bill will deter patients from seeking private practice services.

5) *Attractiveness of the Profession*. According to the applicants, "Establishing licensure also increases the attractiveness of the profession and the retention of professionals in the field as there will be perceived value."

Criteria 2. Existing protections available to the consumer are insufficient.

Most of the problems the applicant is trying to solve with this bill are not related to protecting consumers from incompetent practice by individual substance use counselors. The applicant has only put forward one potential problem relevant to this criteria, the unlicensed practice of substance use counseling in private settings. However, the applicant notes, "It is hard to ascertain how likely harm will occur for many reasons. In private practice, there is no place for consumers to complain about abuses.… Unlike treatment for other physical injuries, persons who are poorly treated for substance use disorder will not readily complain. A person who receives improper treatment for a broken limb can recognize that improper care was given and would not normally be questioned about his or her contribution to the treatment process. This person is viewed as a 'victim' and will receive corrective treatment. A person with addiction who is given inadequate care is unable to recognize that substandard care was given or is so desperate to get well that they feel that bad care is their only option, 'their one shot.' In addition, the person with addiction is not likely to express dissatisfaction due to low self-esteem and feelings of failure concerning their own attempt at recovery. For these reasons, the identification and compilation of statistics concerning inadequate treatment are difficult to achieve and are likely to be higher than reported. Despite difficulties in ascertaining the likelihood of harm, it is clear that harm occurs."

Despite the applicant's assertion that harm clearly occurs, it is impossible to verify without data. The anecdotal instances of harm in private setting provided by the applicant in the sunrise questionnaire and appendices relate to behavior by licensed providers (including physicians), occurred in other states, or would not be resolved through licensure of individual counselors. As a result, any analysis of the sufficiency of existing administrative, civil, or criminal penalties will be incomplete.

The following are the conceptual harmful practice relating to substance use treatment that might be occurring in unregulated private practice of substance use counseling:

1) *Fraud and Abuse*. According to the ASAM:

> While instances of fraudulent and abusive practices are not unique to the field of addiction medicine, seeking addiction treatment is often under emergency circumstances, making individuals with addiction particularly vulnerable to fraudulent and abusive business practices. These practices include call center employees obtaining personal information patients submit online and brokering it to the highest bidding treatment provider. Internet search engines have taken steps to block related online tactics, including partnering with a monitoring and certification firm. Patients also may be enticed to enter, stay, or switch addiction treatment programs with payments or gifts. Perhaps most egregiously, addiction services may be provided in exchange for sex or labor, which is commonly known as human trafficking. In response, governments have passed laws banning such practices and implemented voluntary sober home licensure and certification programs to help eliminate patient brokering and human trafficking in connection with addiction treatment.
>
> Some addiction treatment programs may file false or fraudulent insurance claims for services not rendered, and these practices have increased in conjunction with the expansion of health insurance coverage of addiction treatment benefits. The U.S. Department of Justice Criminal Division launched the Sober Homes Initiative that has targeted almost $1 billion in allegedly false and fraudulent claims in connection with addiction treatment facilities or sober homes in its first two years.

   These unscrupulous business practice abuses are not likely to be resolved by additional regulation of individual substance use counselors. Call centers and referral companies would not require a professional substance use counselor license and would need to be regulated in another way. The enticement of entry into a treatment program is already regulated under the program and facility certification and licensing laws. Human trafficking is criminal behavior that a license is unlikely to prevent.

2) *Coercion*. According to the ASAM, "Addiction affects behaviors and decision-making, but does not make individuals with addiction wholly incapable of making decisions about their treatment. Nevertheless, coercive strategies that consist of legal, formal, and informal 'social controls' aimed at causing a person to take a prescribed action through the use of force or threats, rely on an assumption that addiction undermines individuals' autonomy and capability to make well-reasoned decisions. These types of coercive strategies often accompany addiction treatment or make participation in it contingent on compliance." It is unclear to what extent unlicensed substance use counselors are using coercion in their unlicensed practices without consequence in California.

3) *Incompetent Practice*. If a person claims to be a substance use counselor without the proper training and provides incompetent services, as with most health care, the person can cause significant harm or death. According to the applicant, "Addiction is a life-threatening disease where practitioner incompetence can and has led to death. Given the advent of fentanyl and other deadly compounds entering the illicit drug market, mistakes in addiction treatment

could not be more consequential. Treating addiction requires a high degree of specialized knowledge on many topics, including detoxification, medication-assisted treatment, cognitive and behavioral processes, suicidal ideation, proper referral techniques, screening for physical/mental needs and emergencies, co-dependence and family interrelationships impacted by addiction, legal and criminal justice interactions, complex "whole person" approaches to care, appropriate client documentation/record keeping, and ethical treatment standards. There is a substantial body of curricula specific to this field for which counselors must obtain competency in."

However, it is unclear to what extent unlicensed and incompetent practice is happening.

4) *Practice after License or Certification Revocation*. The applicant argues that a counselor who has their license revoked in another state or their certificate or registration revoked by a certifying entity can simply start a private business providing unlicensed counseling services in California without consequence. While it is unclear how often this occurs, there are also existing restrictions on unlicensed practice that should deter this behavior. If not, then a new licensing law, which relies on the same penalties against unlicensed practice, would also not be effective.

Criteria 3. No alternatives to regulation will adequately protect the public.

The primary purpose of the licensing program under this bill is to address workforce and access to care, and there are numerous ways to address the workforce issues without creating a new licensing program, such as developing apprenticeship programs, funding or incentivizing substance use educational programs to obtain accreditation, directly authorizing billing or other funding mechanisms for the provision of substance use counseling, or otherwise identifying and addressing unnecessary barriers to the effective utilization of qualified counselors. If the barrier to practice is the result of a law or regulation, the law can be amended.

In terms of the harm to consumers, because the nature of and frequency of the harm caused by unlicensed counselors, any of four of the levels of regulation below licensing suggested as part of this sunrise process could be adequate (level I: strengthen existing laws and controls; level II: impose inspections and enforcement requirements; level III: impose registration requirements; level IV: establish requirements for the use of a particular title).

The applicant argues, "Market controls are unable to reduce the influx of unqualified practitioners in the market. In fact, they seem to encourage the entrance of unqualified individuals. With the advent of the Affordable Care Act, new proposals to provide addiction treatment in communities, and an expansion of recovery residences (sober living), the state faces the prospect of market forces driving low-quality counselors into the market in response to increased demand. And while there are many good actors, the lack of standards and accountability for abuse and incompetence, allows for too many bad or unqualified actors to continue to exploit consumer trust in old and new ways."

The applicant further argues that "Private administrative means have been employed by the three certifying organizations in California in an effort to improve consumer health and safety. But these mechanisms can only be applied within the certifying organization and still fall short as they rely on practitioners to uphold them."

The applicant also argues the following non-governmental avenues are insufficient:

1) Code of ethics: "There is no state-adopted code of ethics that is enforceable in private practice. Even in facilities where there is statutory authority for DHCS to address, regulation does not coincide with the codes of ethics of the major certifying organizations. There are some behaviors prohibited by regulation, others are enforced by [certifying organizations]. Neither is effective in addressing private practitioners."

2) Codes of practice enforced by professional associations: "Private certifying groups require a code of ethics and program certification/licensure also requires a code of ethics"

3) Dispute-resolution mechanisms such as mediation or arbitration: "Does not exist at this time."

4) Recourse to currently applicable law: "Other than sexual exploitation, which is rarely prosecuted, there is no statute pertaining to addiction counselor ethics."

5) Regulation of those who employ or supervise practitioners: "There are requirements that counselors be certified or registered in facilities licensed by the state. There is no regulation outside of those facilities. The state does not keep a centralized database of practitioners; typically a counselor is terminated by a program before regulators can respond. The counselor then moves to another facility or to private practice."

6) Other measures attempted: "The applicants have worked with the DHCS on a Uniform Code of Conduct. This regulatory approach applies only to those working in facilities. Resources provided by the Department are inadequate and not supported by fee collection from certified counselors."

Criteria 4. Regulation will mitigate existing problems.

As discussed above, the problem of consumer harm is unsupported by data. However, even if harm is occurring, the data needed for to determine whether additional regulation will mitigate the harm may not exist in a useful format.

In terms of the other problems put forward by the applicant:

1) *Lack of Mild, Moderate, and After Care*. To the extent regulation would authorize substance use counselors to provide counseling services in the private practice setting, it may address the needs of individuals whose condition is not severe enough to necessitate entry into a program, do not want to enter a program, or have completed a program and are at risk of relapse. However, it is unclear if licensing, the highest level of regulation for purposes of this analysis, is necessary to accomplish that goal.

2) *Fully Utilizing Training*. To the extent additional regulation would authorize substance use counselors to provide counseling services with the appropriate level of independence and

supervision, it would mitigate this problem. However, a lower level of regulation or reducing regulation altogether would also mitigate this problem.

3) *Private Practice*. As noted above, additional regulation may address workforce needs related to care by authorizing private practice, but licensing is not the only way to authorize private practice.

4) *Billing*. Additional regulation, by virtue of creating a license that can be used to bill payers who require reimbursable services to be provided by licensed practitioners, would solve the problem of being unable to bill.

5) *Attractiveness of the Profession*. Any additional regulation that improves practice, pay, or benefits of substance use counselors will increase the attractiveness of the profession.

Criteria 5. Practitioners operate independently, making decisions of consequence.

According to the applicants:

> There are many professional judgments made by practitioners. SUD counselors are considered the experts for addiction treatment. Thus they are generally assigned the highest level of independent decision-making for clients, including intake assessments, treatment planning, progress notes, changes to treatment plans, referrals to other professionals, and discharge plans/summaries. All require high levels of competence and independent decision-making. Decisions are made independently and sometimes as members of a treatment team (which may include physicians, clinical supervisors, management, psychologists, or other professionals). Alcohol drug counselors are required to engage in complex and unpredictable tasks on the client's behalf, and in doing so must exercise their discretion, making judgments - deciding what is "best" in the particular situation.
>
> An example of the highest consequence decision-making would be as follows: SUD treatment practitioners are bound by confidentiality. However, if a client is professionally assessed to be of harm to self or others, the practitioner would then elicit assistance from emergency medical or mental health team(s) to ensure the safety of the client or others. The consequence is measurable in that consumer protection is first and foremost, as opposed to confidentiality. The potential unintended consequence, in this case, could range from the client not returning to the treatment program in which he/she was originally admitted, or at worst, death or violence toward others.

Criteria 6. Functions and tasks of the occupation are clearly defined.

The functions and tasks of substance use counselors have been defined by the certifying organizations and other states that license substance use counselors. According to the applicants:

> SUD counseling is a process involving a psychotherapeutic relationship between a client experiencing addiction, dependence, abuse of alcohol or other drugs, or additional symptoms relating to substance use, and a counselor or therapist trained to provide that help in addressing that addiction, dependence, or abuse.

Addiction counseling includes the professional and ethical application of basic tasks and responsibilities, including all of the following:

A. Screening is the process by which a client is determined to be eligible for admission to a particular alcohol and drug treatment program.

B. Initial intake is the administrative and initial assessment procedures for admission to an alcohol and drug treatment program. Assessment does not include psychological testing intended to measure or diagnose mental illness.

C. Orientation is the act of describing to the client the general nature and goals of the alcohol and drug treatment program, including rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program.

D. Alcohol and drug abuse counseling, including individual, group, and significant others. The utilization of special skills to assist individuals, families, or groups in achieving objectives through exploration of a problem and its ramifications, examination of attitudes and feelings, considerations of alternative solutions, and decision-making as each relates to substance use. Counseling shall be limited to assisting a client in learning more about him or herself for the purposes of understanding how to effectuate a clearly perceived and realistically defined goals as related to abstinence. Counseling is limited to assisting the client to learn or acquire new skills that will enable the client to cope and adjust to life situations without the use of substances.

E. Case management is the activities that bring services, agencies, resources, or individuals together within a planned framework of action toward achievement of established goals. Case management may involve liaison activities and collateral contacts.

F. Crisis intervention is providing services that respond to an alcohol or drug user's needs during acute emotional or physical distress, including, but not limited to, referrals for assessment of the client's need for additional psychological or medical treatment for client behaviors that signal risk or prolonged distress.

G. Assessment is the use of procedures by which a counselor or program identifies and evaluates an individual's strengths, weaknesses, problems, and needs for the development of the alcohol and drug treatment plan.

H. Treatment planning is the process by which the counselor and the client identify and rank problems needing resolution, establish agreed-upon immediate and long-term goals, and decide on a treatment process and the resources to be utilized.

I. Client education is providing information to individuals and groups concerning alcohol and drug use and the services and resources available.

J. Referral is identifying the needs of the client that cannot be met by the counselor or agency, as well as assisting the client in utilizing the support systems and community resources available.

K. Reports and recordkeeping are the documentation of the client's progress in achieving his or her goals.

L. Consultation with other professionals with regard to client treatment or services and communicating

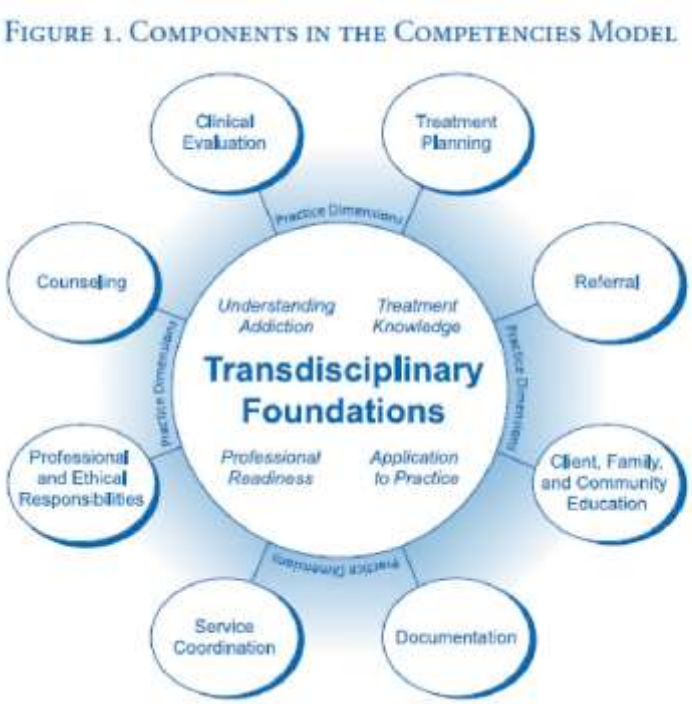
Criteria 7. The occupation is clearly distinguishable from other occupations that are already regulated.

There are regulated professions that are authorized to perform addiction medicine, treatment, and counseling. Substance use counselors would practice a specialized subset of the authorized scope of practice of the other professions. According to the applicant:

> And as a result of high comorbidity amongst SUD and mental health populations, other professions that provide services for SUD treatment include Licensed Marriage and Family Therapists, Licensed Psychologists and Licensed Professional Counselors. However, it is important not to conflate comorbidity and distinguishability in these professions. The education requirements for all of the above-mentioned mental health professions require a mere 15 total hours of education specific to alcohol/drug treatment. The high rates of comorbidity between SUD and mental health patients makes it important for professionals in both sectors to have knowledge of the other specialty as it affords both the ability to cooperate in care coordination, an integral part of treating comorbid patients. In this sense, the 15 hours of SUD-specific knowledge is sufficient for mental health professionals, but 15 hours is not enough to treat a primary SUD diagnosis alone. Evidence supports integrated care where treatment of both SUD and mental health disorders are simultaneously addressed for the best health outcomes.... This is to say high quality treatment requires the two occupations to coexist in separate but interacting spheres of practice.
>
> The proposed measure requires substantially more education, experience, and a practicum that is specific to the treatment of SUD abuse and addiction.

Criteria 8. The occupation requires possession of knowledge, skills, and abilities that are both teachable and testable.

Substance use counseling has an established set of knowledge, skills, and abilities (KSA) that is required for certification by the applicant and other certifying organizations. The KSA are used across the nation. According to the applicant, "Yes, the national standards clearly define the accepted set of core knowledge, skills, and abilities needed for alcohol and drug counselors. Standards are defined in Appendix JJ: SAMHSA, TAP 21. The model specifically addresses the professional practice needs, or practice dimensions, of addiction counselors. Each practice dimension includes a set of competencies, and, within each competency, the KSAs necessary for effective addiction counseling are outlined. The National Curriculum Committee's goal for the future is to help ensure that every addiction counselor possesses, to an appropriate degree, each competency listed, regardless of setting or treatment model. (See Diagram below, taken directly from SAMHSA, TAP 21.)"



[Alternative Text: A diagram of "Transdisciplinary Foundations," the four of which are "understanding addiction," "treatment knowledge," "professional readiness," and "application to practice." It also specifies "practice dimensions," the eight of which are "clinical evaluation," "treatment planning," "referral," "client, family, and community education," "documentation," "service coordination," and "professional and ethical responsibility."]

Criteria 9. The economic impact of regulation is justified.

Given the ongoing crises surrounding problematic substance use, there is a need for more substance use treatment options. The state continues to invest funds in the treatment of substance use. The applicant writes, "According to the National Drug Control Budget: FY 2022 Funding Highlights, Executive Office of the President, Office of National Drug Control Policy, May 2021 (Appendix LL: National Drug Control budget: FY 2022 Funding Highlights, Executive Office of the President, Office of National Drug Control Policy, March 2021), $20.5 billion will be spent on alcohol and drug treatment in FY 2022. Because a large percentage of addiction treatment is not provided until an individual must seek services from publicly funded programs, the establishment of a license to treat addiction in private practice settings can help reduce the outlay of public funding dedicated to it."

The operation of this bill is conditioned upon appropriation by the Legislature from specified earmarked funds. In terms of the cost to the practitioners, the bill limits the cost of the license to $200 for up to ten years or until the board is no longer publicly funded. After either of those conditions are met, the cost of the license will likely increase significantly. Based on the number of certified counselors with a master's degree or higher, there would be approximately 890 applicants. However, the bill allows for counselors who met "the requirements of the International Certification & Reciprocity Consortium to sit for the Advanced Alcohol & Other Drug Counselor written examination at the time of the examination," which could be less than a master's degree. According to the applicant, "More than 1,000 certified SUD counselors could apply in the first year."

The two comparable boards are the Naturopathic Medicine Committee and the Podiatric Medical Board. At the end of FY 2021-22, the Naturopathic Medicine Committee reported 1,124 licensees. Currently, the application fee is $400, the initial license fee is $1,000, and the biennial renewal fee is $1,000.

At the end of FY 2021-22, the Podiatric Medical Board reported 2,675 licensees. Currently, the application fee is $100, the initial license fee is $800, and the biennial renewal fee is $1,318.

POLICY ISSUES FOR CONSIDERATION:

1) *Sunrise Review*. As noted above, the criteria and the sunrise questionnaire are intended to assist policy makers in answering the following questions:

   a) *Does the proposed regulation benefit the public health, safety, or welfare?* As discussed above, the primary benefits sought by the sponsors are not related to the need to address incompetent practice, harm, or abuse. Rather they are seeking to address issues related to workforce and access to care. Still, the purported problems being solved are:

      i) *Incompetent Practice*. The unlicensed practice of substance use counseling is currently prohibited outside of DHCS-certified substance use programs. To the extent unlicensed practice occurs outside of those settings, the new license and board under this bill may increase consumer awareness and add a dedicated board to enforce against unlicensed practice. However, the new board would have the same authority as any other board to investigate and prosecute unlicensed practice, cease and desist letters and administrative fines. The administrative fines levied by licensing boards are generally collected if the offender applies for or renews a license. If the offender does not seek a license, the fines often go unpaid.

      ii) *Fraud and Other Abusive Practices*. The instances of fraud and other abusive practices presented by the applicant are not likely to be resolved by additional regulation of individual substance use counselors. Predatory call centers and referral companies would not require a professional substance use counselor license under this bill. Treatment programs that use gifts or other incentives to attract or maintain consumers are already regulated under the DHCS program and facility certification and licensing laws. The other anecdotal incidents involved practitioners who are already licensed and would not be resolved with an additional license.

      iii) *Workforce*. While speculative, there may be an increase in the profession due to the desirability of having a professional license, the ability to bill health plans and insurance, and the ability to practice to the extent of their training.

      iv) *Increased Access to Counselors*. The new license would (1) authorize substance use counselors to practice outside of DHCS-certified substance use programs and (2) authorize them to diagnose and perform medical-necessity determinations for purposes of public and private payer reimbursement. This may increase access because a new type of provider would be available for substance use treatment that does not necessitate entry into a certified program. In addition, if payers are willing to cover and reimburse services because they are provided by counselors pursuant to the new license, then patients and clients may be more willing to seek out the services.

b) *Will the proposed regulation be the most effective way to correct existing problems?* There may be other more effective ways to correct the existing problems:

i) *Incompetent Practice*. The sponsors did not provide significant evidence of incompetent unlicensed practice, so any level of regulation below licensure, such as title protection, would could provide benefits without the cost of establishing a new board and imposing license fees on substance use counselors.

ii) *Fraud and Other Abusive Practices*. Because licensure would not likely solve the instances of fraud and other abusive practices described in the sunrise questionnaire and appendices, there may be more effective ways to correct this problem.

iii) *Workforce*. This bill may help incentivize people to join the substance use counseling profession, but it is unclear that it is the most effective approach. Other approaches could include developing apprenticeship programs, funding or incentivizing substance use educational programs to obtain accreditation, directly authorizing billing or other funding mechanisms for the provision of substance use counseling, or otherwise identifying and addressing unnecessary barriers to the effective utilization of qualified counselors.

iv) *Increased Access to Counselors*. This bill may increase access to counselors, but it is unclear that it is the most effective approach. Substance use care is complex, and licensing is a tool for consumer protection and safety, not increasing access to care. If there are regulatory barriers that prevent access to qualified counselors, it may be more effective to address those barriers directly, rather than bypassing them by creating a new license category.

c) *Is the level of the proposed regulation appropriate?* This bill proposes the highest level of regulation for purposes of a sunrise analysis. However, there may be more appropriate levels of regulation that still accomplish the goals of this bill:

i) *Level I: Strengthen existing laws and controls*. The conceptual harms relating to unlicensed practice may be addressed by increasing civil penalties. For instance, the Unfair Practices Act creates a private right of action for anyone to enjoin deceptive practices and authorizes treble (triple) damages for those actually harmed.

ii) *Level IV: Provide an opportunity for certification*. While substance use counselors must be certified when providing services in certified programs and licensed facilities, the requirement could be expanded to anyone purporting to provide substance use counseling. By virtue of the certification by a certifying organization, all substance use counselors would have to meet the same educational requirements before using the title or practicing. They would also have "state recognition," which could be used for purposes of reciprocity in other states or potentially payer reimbursement.

The requirement could be further tailored to provide a scope of practice and practice requirements (such as displaying a certificate publicly). If a certifying organization suspends or revokes the counselors, certificate, then the state authorization would be revoked as well.

2) *Lack of a Sunset Date*. This bill creates a new licensing board but does not include a sunset date. A sunset date provides an opportunity to review the performance of the board and necessity of regulation.

3) *Private Entity Board Members*. This bill authorizes representatives of the certifying organizations, which are private entities, to sit on the board. This is not typical of DCA boards. Because the intent is for the certifying entities to advise on the practice standards of substance use counselors, it may be more appropriate for the members to serve on an advisory committee.

4) *Regional vs. Programmatic accreditation*. This bill requires education to be obtained from a school, college, or university approved by the Bureau for Private Postsecondary Education (BPPE) or accredited by the National Addiction Studies Accreditation Commission, the California Consortium of Addiction Programs and Professionals, or a regional or national institutional accrediting agency that is recognized by the United States Department of Education. As a result this bill allows a school or program to be approved at either the institutional level or the programmatic level, but not both. Institutional accreditation and BPPE approval relates to the quality and sustainability of an institution overall. Programmatic accreditation relates to the quality of a specific subject and in this case would be addiction studies.

5) *Alternate Criminal History Process*. This bill establishes a process for assessing criminal history that is unique among DCA boards. The goal of the process is to allow for counselors who may have dealt with problems related to prior use. However, there are uniform standards and laws for the way boards determine whether criminal history is substantially related to the practice regulated by the board. In this case, there would be counselors on the board who are able to utilize their experience when developing the substantial relation criteria.

6) *CE Attestations Under Perjury*. This bill specifically makes attestations relating to continuing education not subject to the penalty of perjury. This would be unique among DCA boards. Other licensees, such as LPCCs, are specifically required to attest under penalty of perjury: "The board shall not renew any registration pursuant to this chapter unless the registrant certifies under penalty of perjury to the board, and on a form prescribed by the board, that they have completed not less than three hours of continuing education in the subject of California law and ethics during the preceding year" (BPC § 4999.76(a)(2)).

7) *Referring Complaints*. This bill requires the board to refer complaints about licensed and certified behavioral health workers to private organizations, which is unique among DCA boards. Because the board has the authority to investigate complaints, the referral of a complaint to a private organization may be viewed as verification of the complaint, which presents due process concerns.

8) *Alignment of Licensure Requirements.* This bill requires the board to align licensure requirements to the Substance Abuse and Mental Health Services Administration's career ladder for substance use disorder counselors, but the licensure requirements are already established in the bill. It is unclear whether this would allow the board to deviate from the statutory requirements for licensure.

9) *Procedures for Approving Reciprocity*. This bill requires the board to establish procedures for approving reciprocity with other states or nations, but does not specify any criteria, such as

whether the requirements must be substantially similar to California law or whether endorsement applicants must complete a California-specific law and ethics examination.

10) *Lack of Title Protection*. This bill prohibits the use of the specific title of "Licensed Alcohol Drug Counselor," but allows the use of any other similar title, such as "alcohol drug counselor" or "substance use counselor."

11) *Exemption for Employees and Volunteers of Treatment Programs and Facilities*. This bill exempts from the licensing requirements employees and volunteers of certified programs and licensed facilities. However, if licensure is necessary to prevent consumer harm and there are concerns over inconsistent practice standards, then an exemption may not further the policy goals of this bill.

IMPLEMENTATION ISSUES:

1) *Erroneous References and Definitions*. This bill:

   a) Contains multiple references to the unused terms registrant, registration, intern, and trainee.

   b) Makes erroneous cross references to the bills licensing requirements (§ 4458) when referring to education (§ 4459) and continuing education (§ 4460).

   c) Makes an erroneous cross reference to Chapter 7 of Part 2 of Division 10.5 of the HSC when referring to certifying organizations, when certifying organizations are addressed under Chapter 7.2.

   d) Makes a cross reference to the scope of practice provisions (§ 4457) in the enforcement requirements on issuing a license (§ 4465), but § 4458 is the license issuance provision.

2) *Timing of the Issuance of Licenses*. This bill requires the board to adopt rules and regulations to implement this chapter on or before December 31, 2027, but does not specify when it must begin issuing licenses.

3) *Duplicative or Conflicting Mandates*. This bill establishes a list of mandates (§ 4456) that are either duplicative or conflicting with other requirements under the bill:

   a) Issue licenses and register interns and trainees—this requirement is both in conflict and duplicative of other parts of the bill. The board is already required to issue licenses and is not required to register interns and trainees.

   b) Establish procedures for the receipt, investigation, and resolution of complaints against licensees, interns, and trainees—this requirement is both in conflict and duplicative of other parts of the bill. The board is required to take enforcement action but is not required to register interns and trainees.

   c) Take disciplinary action against a licensee, intern, or trainee where appropriate, including, but not limited to, censure or reprimand, probation, suspension, or revocation of the license or registration, or imposition of fines or fees—this requirement is both in conflict and duplicative of other parts of the bill. The board is required to take enforcement action but is not required to register interns and trainees.

d) Establish parameters of unprofessional conduct for licensees that are consistent with generally accepted ethics codes for the profession—this requirement is duplicative of the unprofessional conduct provisions under the bill.

e) Establish reinstatement procedures for an expired or revoked license—this requirement is duplicative of the reinstatement procedures under the bill.

f) Establish a process for approving supervised work experience hours earned by applicants that were obtained while certified by an approved certification organization, prior to completion of a master's degree—this requirement is in conflict with the work requirements under the bill. Five years after the issuance of licenses, applicants must document either certification by a certification by a certifying organization or completion of 2,000 hours of postgraduate supervised work experience without a certificate.

4) *Incomplete Exemptions*. This bill exempts a physician and surgeon, a registered nurse, a psychologist, an LMFT or LCSW from performing any of the LDAC scope of practice, provided that the individual does not use the title "Licensed Alcohol Drug Counselor," but does not exempt LPCCs or LEPs.

5) *Funding*. This bill is contingent on funding from five types of funds or any other funding for addiction and overdose. It also locks the license fee at $200 for ten years or until "self-funded" but does not specify if the board can increase fees if still receiving an insufficient amount of outside funds.

REGISTERED SUPPORT:

California Consortium of Addiction Programs and Professionals (co-sponsor)
California Council of Community Behavioral Health Agencies (co-sponsor)
California Society of Addiction Medicine (co-sponsor)
American River Wellness
Anaheim Lighthouse
Aspire Counseling San Luis Obispo
Aton Center
Bold Recovery
California Access Coalition
California Alliance for State Advocacy
California Recovery Center
Capo by the Sea
Capo Canyon Recovery
Chabad Treatment Center
Community Social Model Advocates
First Responder Health
First Responder Wellness
Fred Brown's Recovery Services
Hemet Valley Recovery Center
National Alliance for Recovery Residences
New Directions for Women
New Found Life Treatment Center
Opus Health
Orange County Recovery Collaboration

River City Recovery Center
Salinas Valley Health Medical Center
Steinberg Institute
Sun Street Centers
Sun Street Centers King City
The Counseling Team International
The Purpose of Recovery
The Recovery Advocacy Project
The Villa Center
Young People in Recovery

REGISTERED OPPOSITION:

California Association of Alcohol and Drug Program Executives (unless amended)

Analysis Prepared by: Vincent Chee / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2862 (Gipson) – As Introduced February 15, 2024

NOTE: This bill is double referred and if passed by this Committee will be re-referred to the Assembly Committee on Judiciary.

SUBJECT: Licenses: African American applicants.

SUMMARY: Requires state licensing boards to prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States.

EXISTING LAW:

1) Provides that the term "board" includes "bureau," "commission," "committee," "department," "division," "examining committee," "program," and "agency." (Business and Professions Code (BCP) § 22)

2) States that unless otherwise expressly provided, the term "license" means license, certificate, registration, or other means to engage in a business or profession regulated by the Business and Professions Code. (BPC § 23.7)

3) Establishes the Department of Consumer Affairs (DCA) within the Business, Consumer Services, and Housing Agency. (BPC § 100)

4) Enumerates various regulatory boards, bureaus, committees, and commissions under the DCA's jurisdiction. (BPC § 101)

5) States that boards, bureaus, and commissions within the DCA must establish minimum qualifications and levels of competency and license persons desiring to engage in the occupations they regulate, upon determining that such persons possess the requisite skills and qualifications necessary to provide safe and effective services to the public. (BPC § 101.6)

6) Requires boards within the DCA to expedite, and authorizes boards to assist, the initial licensure process for an applicant who has served as an active duty member of the Armed Forces of the United States and was honorably discharged or who, beginning July 1, 2024, is enrolled in the United States Department of Defense SkillBridge program. (BPC § 115.4)

7) Requires boards within the DCA to expedite the licensure process and waive any associated fees for applicants who hold a current license in another state and who are married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders. (BPC § 115.5)

8) Requires boards within the DCA to expedite, and authorizes boards to assist, the initial licensure process for applicants who have been admitted to the United States as a refugee, have been granted asylum by the Secretary of Homeland Security or the Attorney General of the United States, or have a special immigrant visa. (BPC § 135.4)

9) Requires the Medical Board of California (MBC), the Osteopathic Medical Board of California (OMBC), the Board of Registered Nursing (BRN), and the Physician Assistant Board (PAB) to expedite the licensure process for applicants who demonstrate that they intend to provide abortions within the scope of practice of their license. (BPC § 870)

10) Requires the MBC to give priority review status to the application of an applicant for a physician's and surgeon's certificate who can demonstrate that they intend to practice in a medically underserved area or serve a medically underserved population. (BPC § 2092)\

11) Requests that the Regents of the University of California assemble a colloquium of scholars to draft a research proposal to analyze the economic benefits of slavery that accrued to owners and the businesses, including insurance companies and their subsidiaries, that received those benefits. (Education Code § 92615)

12) Requires the Insurance Commissioner to obtain the names of any slaveholders or slaves described in specified insurance records, and to make the information available to the public and the Legislature. (Insurance Code § 13811)

13) Declares that descendants of slaves, whose ancestors were defined as private property, dehumanized, divided from their families, forced to perform labor without appropriate compensation or benefits, and whose ancestors' owners were compensated for damages by insurers, are entitled to full disclosure. (Insurance Code § 13813)

14) Requires the State Controller's Office and the Department of Human Resources, when collecting demographic data as to the ancestry or ethnic origin of persons hired into state employment, to include collection categories and tabulations for Black or African American groups, including, but not limited to, African Americans who are descendants of persons who were enslaved in the United States. (Government Code § 8310.6)

THIS BILL:

1) Requires boards to prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States.

2) Clarifies that "board" includes "bureau," "commission," "committee," "department," "division," "examining committee," "program," and "agency"; and "license" includes certificate, registration, or other means to engage in a regulated business or profession.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the author as part of a package of bills introduced by members of the California Legislative Black Caucus. According to the author:

> "AB 2465 would provide an imperative initiative of the prioritization of African Americans when seeking occupational licenses, especially those who are descendants of slaves. There has been historical long-standing deficiencies and internal barriers to African Americans seeking professional work, and by prioritizing their applications, we are bridging the gap of professional inequities of under representation and under compensation."

Background.

Expedited Licensure. The DCA consists of 36 boards, bureaus, and other entities responsible for licensing, certifying, or otherwise regulating professionals in California. As of March 2023, there are over 3.4 million licensees overseen by programs under the DCA, including health professionals regulated by healing arts boards under Division 2 of the Business and Professions Code. Each licensing program has its own unique requirements, with the governing acts for each profession providing for various prerequisites including prelicensure education, training, and examination. Most boards additionally require the payment of a fee and some form of background check for each applicant.

The average length of time between the submission of an initial license application and approval by an entity under the DCA can vary based on a number of circumstances, including increased workload, delays in obtaining an applicant's criminal history, and deficiencies in an application. Boards typically set internal targets for application processing timelines and seek adequate staffing in an effort to meet those targets consistently. License processing timelines are then regularly evaluated through the Legislature's sunset review oversight process.

The first expedited licensure laws specifically related to the unique needs of military families. The Syracuse University Institute for Veterans and Military Families found that up to 35 percent of military spouses are employed in fields requiring licensure. Because each state possesses its own licensing regime for professional occupations, military family members are required to obtain a new license each time they move states, with one-third of military spouses reportedly moving four or more times while their partner is on active duty. Because of the barriers encountered by military family members who seek to relocate their licensed work to a new state, it is understood that continuing to work in their field is often challenging if not impossible.

In an effort to address these concerns, Assembly Bill 1904 (Block) was enacted in 2012 to require boards and bureaus under the DCA to expedite the licensure process for military spouses and domestic partners of a military member who is on active duty in California. Two years later, Senate Bill 1226 (Correa) was enacted to similarly require boards and bureaus under the DCA to expedite applications from honorably discharged veterans, with the goal of enabling these individuals to quickly transition into civilian employment upon retiring from service.

Statute requires entities under the DCA to annually report the number of applications for expedited licensure that were submitted by veterans and active-duty spouses and partners. For example, in Fiscal Year 2022-23, the MBC received 14 applications from military spouses or partners and 101 applications from honorably discharged veterans subject to expedited processing. In 2023, the federal Servicemembers Civil Relief Act (SCRA) imposed new requirements on states to recognize qualifying out-of-state licenses for service members and their spouses. This new form of enhanced license portability potentially displaces the need for expedited licensure for these applicants.

A decade after the first expedited licensure laws were enacted for military families, the Legislature enacted Assembly Bill 2113 (Low) in 2020 to require licensing entities under the DCA to expedite licensure applications for refugees, asylees, and Special Immigrant Visa holders. The intent of this bill was to address the urgency of allowing those forced to flee their homes to restart their lives upon acceptance into California with refugee status. It is understood that the population of license applicants who have utilized this new expedited licensure program across all DCA entities is, to date, relatively small.

Subsequently in 2022, the Legislature enacted Assembly Bill 657 (Cooper) to add another category of applicants eligible for expedited licensure. This bill required the MBC, OMBC, the BRN, and the PAB to expedite the license application for an applicant who demonstrates that they intend to provide abortions. This bill was passed in the wake of the Supreme Court's decision to overturn *Roe v. Wade*, which led to concerns that with approximately half of all states likely to seek to ban abortion, patients in those states would come to California to receive abortion services, creating a swell in demand for abortion providers. Assembly Bill 657 was passed to ensure that there is an adequate health care provider workforce to provide urgent reproductive care services.

State Efforts to Provide Reparations to Descendants of Slavery. In 2020, the Legislature enacted Assembly Bill 3121 (Weber), which established the Task Force to Study and Develop Reparation Proposals for African Americans, with a Special Consideration for African Americans Who are Descendants of Persons Enslaved in the United States. The bill's findings and declarations acknowledged that "more than 4,000,000 Africans and their descendants were enslaved in the United States and the colonies that became the United States from 1619 to 1865." The bill further found that as "a result of the historic and continued discrimination, African Americans continue to suffer debilitating economic, educational, and health hardships," including, among other hardships, "an unemployment rate more than twice the current white unemployment rate."

The Task Force created by AB 3121 was given responsibility for studying and developing reparation proposals for African Americans as a result of slavery and numerous subsequent forms of discrimination based on race. The Task Force was then required to recommend appropriate remedies in consideration of its findings, which were submitted as a report to the Legislature on June 29, 2023. The *California Reparations Report*, drafted with staff assistance from the California Department of Justice, totals over a thousand pages and provides a comprehensive history of the numerous past injustices and persistent inequalities and discriminatory practices. The report also includes a number of recommendations for how the state should formally apologize for slavery, provide compensation and restitution, and address the pervasive effects of enslavement and other historical atrocities.

Chapter 10 of the Task Force's report, titled "Stolen Labor and Hindered Opportunity," addresses how African Americans have historically been excluded from occupational licenses. As discussed in the report, "state licensure systems worked in parallel to exclusion by unions and professional societies in a way that has been described by scholars as "particularly effective" in excluding Black workers from skilled, higher paid jobs. White craft unions implemented unfair tests, conducted exclusively by white examiners to exclude qualified Black workers."

The report additionally describes how as the use of licensure to regulate jobs increased beginning in the 1950s, African American workers continued to be excluded from economic opportunity, in large part due to laws disqualifying licenses for applicants with criminal records, which disproportionately impacted African Americans. This specific issue was previously addressed in California through the Legislature's enactment of Assembly Bill 2138 (Chiu/Low) in 2018, which reduced barriers to licensure for individuals with prior criminal histories by limiting the discretion of most regulatory boards to deny a new license application to cases where the applicant was formally convicted of a substantially related crime or subjected to formal discipline by a licensing board, with nonviolent offenses older than seven years no longer eligible for license denial.

In its discussion of issues relating to professional licensure, the Task Force concludes by stating that "while AB 2138 represents progress, other schemes remain in California which continue to have a racially discriminatory impact." The Task Force then provides several recommendations on how the Legislature could "expand on AB 2138." This includes a recommendation in favor of "prioritizing African American applicants seeking occupational licenses, especially those who are descendants [of slavery]."

On January 31, 2024, the California Legislative Black Caucus announced the introduction of the 2024 Reparations Priority Bill Package, consisting of a series of bills introduced by members of the caucus to implement the recommendations in the Task Force's report. As part of that package, this bill seeks to implement the Task Force's recommendation by requiring boards to prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States. This requirement would be similar to existing expedited licensure processes for military families, refugee applicants, and abortion providers. While this bill would only represent a single step in what could be considered a long journey toward addressing the malignant consequences of slavery and systemic discrimination, the author believes it would meaningfully address the specific impact those transgressions have had on African Americans seeking licensure in California.

Current Related Legislation.

ACR 135 (Weber) would formally acknowledge the harms and atrocities committed by representatives of the State of California who promoted, facilitated, enforced, and permitted the institution of chattel slavery and the legacy of ongoing badges and incidents of slavery that form the systemic structures of discrimination. *This bill is pending in the Senate Committee on Judiciary.*

AB 3089 (Jones-Sawyer) would provide that the State of California apologizes for perpetuating the harms African Americans faced by having imbued racial prejudice through segregation, public and private discrimination, and unequal disbursal of state and federal funding and declares that such actions shall not be repeated. *This bill is pending in the Assembly Committee on Judiciary.*

AB 2166 (Weber) would update existing prelicensure education and examination requirements for license applicants under the State Board of Barbering and Cosmetology to include instruction and testing on the provision of services to individuals with all hair types and textures. *This bill is pending in this committee.*

AB 2442 (Zbur) requires specified healing arts boards under the DCA to expedite the licensure process for applicants who demonstrate that they intend to provide gender-affirming health care or gender-affirming mental health care services. *This bill is pending in this committee.*

SB 1067 (Smallwood-Cuevas) would require healing arts boards to expedite the licensure process for applicants who intend to practice in a medically underserved area. *This bill is pending in the Senate Committee on Business, Professions, and Economic Development.*

Prior Related Legislation.

AB 657 (Cooper, Chapter 560, Statutes of 2022) requires specified boards under the DCA to expedite applications from applicants who demonstrate that they intend to provide abortions.

AB 3121 (Weber, Chapter 319, Statutes of 2020) established the Task Force to Study and Develop Reparation Proposals for African Americans, with a Special Consideration for African Americans Who are Descendants of Persons Enslaved in the United States.

AB 2113 (Low, Chapter 186, Statutes of 2020) requires entities under the DCA to expedite applications from refugees, asylees, and special immigrant visa holders.

AB 2138 (Chiu, Chapter 995, Statutes of 2018) reduced barriers to licensure for individuals with prior criminal convictions.

SB 1226 (Correa, Chapter 657, Statutes of 2014) requires entities under the DCA to expedite applications from honorable discharged veterans.

AB 1904 (Block, Chapter 399, Statutes of 2012) requires entities under the DCA to expedite applications from military spouses and partners.

ARGUMENTS IN SUPPORT:

The **California African American Chamber of Commerce** supports this bill, writing: "By prioritizing African American applicants, especially those with ancestral ties to slavery, AB 2862 seeks to promote equity and provide opportunities for economic advancement within our community. This legislation is crucial in fostering diversity and inclusivity in various industries, paving the way for greater representation and participation of African Americans in the workforce. Furthermore, AB 2862 aligns with the California African American Chamber of Commerce's mission to drive economic opportunity and wealth creation for African American businesses. By ensuring fair access to licensure, this bill contributes to our overarching goal of promoting economic empowerment and prosperity for African American entrepreneurs and professionals across the state."

ARGUMENTS IN OPPOSITION:

The **Pacific Legal Foundation** (PLF) writes in opposition to this bill: "Fewer barriers to entering the workforce, not more, will meaningfully advance opportunity in California. Barriers based on race are especially odious and detrimental. Licensing laws already hinder opportunity, and the government does not need to make things worse by injecting racial discrimination into the system." The PLF further argues that this bill violates the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

POLICY ISSUE(S) FOR CONSIDERATION:

Creation of Additional Expedited Licensure Processes. When expedited licensure was first established as a process in California, it was intended to address unique issues relating to military families who move frequently and can often not afford to wait to qualify for a new license each time they relocate to a new state. The addition of refugee and asylee applicants was intended to respond to a growing international refugee crisis by providing similar benefits to a small number of applicants whose relocation to California was presumably abrupt and who would need to rebuild their professions. In that same spirit, the extension of expedited licensure to abortion care providers was aimed at preparing for a potential influx of demand for those services in the wake of the Supreme Court's decision to overturn longstanding protections for reproductive rights.

Several pieces of legislation have been introduced this year that would establish new expedited licensure requirements for additional populations of applicants. Each of these proposals is certainly meritorious, as were each of the measures previously signed into law. However, there is potentially a cause for concern that as the state contemplates adding more categories of license applicants to the growing list of applications that must be expedited by entities within the DCA, the value of expediting each applicant type becomes diluted and non-expedited applications could become unduly delayed.

If the Legislature intends to extend expedited licensure requirements to new demographics of applicants—which the author of this bill has argued cogently in favor of doing—attention should be paid to the impact that all these proposals ultimately have in their totality. The Legislature should also subsequently revisit the need for expedited licensure requirements that were established in particular contexts and determine if they are still needed, which could be achieved by the addition of sunset clauses. It may ultimately prove to be appropriate to continue expediting the licenses applications for those proposed in this bill in the future.

Constitutionality. In June of 2023, the Supreme Court of the United States issued its ruling in *Students for Fair Admissions v. Harvard*, in which it decided that the Equal Protection Clause of the Fourteenth Amendment prohibits universities from positively considering race as a factor in admissions. This decision strongly suggests an antagonistic position within the current composition of the Supreme Court when reviewing policies that necessarily consider race as a means of improving equitable access to opportunity or providing redress to representatives of racial groups that have been subjected to discrimination and marginalization. The likelihood of this bill's provisions surviving a strict scrutiny examination by the Supreme Court will be more thoroughly discussed when this bill is re-referred to the Assembly Committee on Judiciary.

IMPLEMENTATION ISSUES:

As currently drafted, this bill would create a new division within the Business and Professions Code for purposes of establishing a single statute with two subdivisions—one of which contains provisions identical to those codified elsewhere that apply to the entire code. In addition to considerations of statutory organization and aesthetics, this placement potentially generates uncertainty relating to the bill's applicability. The author may wish to relocate the provisions of the bill to a section in the chapter that currently includes other expedited licensure requirements.

AMENDMENTS:

1) To allow the Legislature to revisit the expedited licensure requirements of this bill in the future to determine if those requirements are still needed, add a new subdivision providing that the bill's provisions will sunset in four years unless extended by the Legislature.

2) To relocate the bill's contents to an existing chapter of code, strike Section 1 of the bill and instead add the language contained in subdivision (b) to a newly created Section 115.7 in Chapter 1 of the Business and Professions Code.

REGISTERED SUPPORT:

California African American Chamber of Commerce
Greater Sacramento Urban League
One individual

REGISTERED OPPOSITION:

Pacific Legal Foundation

Analysis Prepared by: Robert Sumner / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2918 (Zbur) – As Amended March 18, 2024

SUBJECT: State Board of Barbering and Cosmetology: licensee information.

SUMMARY: Makes technical changes to existing law requiring the State Board of Barbering and Cosmetology (BBC) to update the addresses of its licensees on public records.

EXISTING LAW:

1) Establishes the BBC within the Department of Consumer Affairs (DCA) to license barbers, cosmetologists, hairstylists, electrologists, estheticians, and manicurists pursuant to the Barbering and Cosmetology Act. (Business and Professions Code (BPC) §§ 7301 *et seq.*)

2) Provides that protection of the public is the highest priority for the BBC. (BPC § 7303.1)

3) Requires the BBC to engage in specified activities, including the making of rules and regulations, the development and administration of examinations, and the issuance of licenses. (BPC § 7312)

4) Establishes various requirements for individuals to submit applications to the BBC for licensure or license renewal. (BPC §§ 7396 – 7402.5)

5) Requires licensees of the board, except for establishments to notify the BBC within 30 days of a change of address, and requires the BBC to make necessary changes in the register. (BPC § 7400)

6) Requires entities within the DCA to publish on the internet information regarding every license issued by that entity, including the licensee's address of record. (BPC § 27)

THIS BILL:

1) Provides that, after receiving a change of address notification from a licensee, the BBC shall make the necessary changes in any board records and, where applicable, in the licensee's public profile maintained on the BBC's internet website.

FISCAL EFFECT: Unknown; this bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the author. According to the author:

> "AB 2918 enhances transparency and accountability within the regulatory framework of the Board of Barbering and Cosmetology. It mandates the timely updating of licensee addresses on the board's website, bridging any discrepancies between internal board records and the public records on this website. This bill ensures consumers have reliable access to up-to-date information about licensed professionals, enabling them to make informed decisions regarding which provider to go to."

Background.

State Board of Barbering and Cosmetology. The BBC is responsible for licensing and regulating barbers, cosmetologists, hairstylists, estheticians, electrologists, manicurists, apprentices, and establishments. The BBC is one of the largest boards in the country, with over 615,000 licensees. As of the board's most recent sunset review, the BBC annually issues approximately 261,000 licenses (initial and renewal licenses) and administers approximately 28,000 written examinations (initial and retake examinees). Each profession has its own scope of practice, entry-level requirements, and professional settings, with some overlap in areas. In addition to licensing individuals, the BBC approves schools.

Address Disclosure Requirements. Provisions of law generally applicable to entities under the DCA require boards "provide on the internet information regarding the status of every license issued by that entity in accordance with the California Public Records Act … and the Information Practices Act." The statute specifically requires that the public information include "information on suspensions and revocations of licenses issued by the entity and other related enforcement action, including accusations filed pursuant to the Administrative Procedure Act … taken by the entity relative to persons, businesses, or facilities subject to licensure or regulation by the entity." Additional statutes provide for further requirements for individual boards within the DCA to post specified information about licensees on their websites.

This section of law specifically states that "each entity shall disclose a licensee's address of record." Statute specifically states that this address does not need to be a home address, but that "each entity shall allow a licensee to provide a post office box number or other alternate address, instead of the licensee's home address, as the address of record." Boards are allowed to require a physical business address or residence address for its internal administrative use; however, that information would not be disclosed if an alternate address of record has been provided.

The Barbering and Cosmetology Act requires every licensee, with the exception of establishments, to notify the BBC within 30 days after a change of address. The licensee must provide the BBC with their new address. At that time, the BBC is required to "make the necessary changes in the register."

The term "register" is not an accurate description of how the BBC publishes information about its licensees, including addresses of record. Instead, information about licensees is found on the BBC's website, which offers a license search feature through the BBC's utilization of the BrEZe information technology system. This bill would update the Barbering and Cosmetology Act to reflect that rather than requiring the BBC to make necessary changes in the register, the BBC shall update the licensee's address in the licensee's public profile maintained on the BBC's internet website. This technical update better reflects the BBC's compliance with laws governing public disclosure of licensee information through the use of its website.

Current Related Legislation.

AB 2444 (Lee) would require the BBC to disseminate informational materials on basic labor laws to its licensees. *This bill is pending in the Assembly Committee on Labor and Employment.*

SB 1084 (Nguyen) would abolish the hairstylist license and remove various services from the scopes of practice of barbering and cosmetology. *This bill is pending in the Senate Committee on Business, Professions, and Economic Development.*

Prior Related Legislation.

SB 372 (Menjivar, Chapter 225, Statutes of 2023) required boards under the DCA to replace references to a licensee's former name or gender on any website upon request when the licensee's name was changed due to a court-ordered change in gender or under circumstances that resulted in participation in state's address confidentiality program.

SB 803 (Roth, Chapter 648, Statutes of 2021) extended the operation of the BBC and, among other things, reduced the required number of hours for courses in barbering and cosmetology to 1,000 hours and established a hairstylist license.

REGISTERED SUPPORT:

None on file.

REGISTERED OPPOSITION:

None on file.

Analysis Prepared by: Robert Sumner / B. & P. / (916) 319-3301

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 3176 (Hoover) – As Introduced February 16, 2024

SUBJECT: Professional land surveyors: surveying practices: monuments and corner accessories.

SUMMARY: Requires licensed land surveyors to restore or rehabilitate any monument or corner accessory that is used as part of a survey to a permanent condition so that it may be referenced and used in the future.

EXISTING LAW:

1) Provides for the licensure and regulation of land surveyors by the Board of Professional Engineers, Land Surveyors and Geologists (BPELSG) within the Department of Consumer Affairs (DCA) under the Professional Land Surveyor's Act (Act). (Business and Professions Code (BPC) §§ 8700 *et seq.*)

2) Establishes various activities that, either in a public or private capacity, constitute the practice of land surveying, including but not limited to:

    a) Locating, relocating, establishing, reestablishing, or retracing the alignment or elevation for any of the fixed works embraced within the practice of civil engineering.

    b) Determining the configuration or contour of the earth's surface, or the position of fixed objects above, on, or below the surface of the earth by applying the principles of mathematics or photogrammetry.

    c) Locating, relocating, establishing, reestablishing, or retracing any property line or boundary of any parcel of land, right-of-way, easement, or alignment of those lines or boundaries.

    d) Making any survey for the subdivision or resubdivision of any tract of land.

    e) Determining the position for any monument or reference point that marks a property line, boundary, or corner, or setting, resetting, or replacing any monument or reference point.

    (BPC § 8726)

3) Authorizes a licensed land surveyor to perform land planning in connection with the land surveying activities authorized under the Act. (BPC § 8761.2)

4) Authorizes licensed land surveyors and registered civil engineers to administer and certify oaths when:

    a) It becomes necessary to take testimony for the identification or establishment of old, lost or obliterated corners;

b) A corner or monument is found in a perishable condition, and it appears desirable that evidence concerning it be perpetuated; or

c) The importance of the survey makes it desirable to administer an oath to his assistants for the faithful performance of their duty.

(BPC § 8760)

5) Authorizes land surveyors, after making a field survey in conformity with their practice, to file a record of survey with the county surveyor in the county in which the field survey was made, and specifies certain instances in which this report filing is mandatory. (BPC § 8762)

6) Mandates that the record of survey shall, among other applicable activities, demonstrate all monuments found, set, reset, replaced, or removed, describing their kind, size, and location, and giving other data relating thereto. (BPC § 8764(a)(1))

7) Mandates that monuments shall be sufficient in number and durability and efficiently placed so as not to be readily disturbed, to ensure, together with monuments already existing, the perpetuation or facile reestablishment of any point or line of the survey. (BPC § 8771(a))

8) Mandates that a permanent monument shall be reset in the surface of new construction or otherwise set to perpetuate the location if any monument could be destroyed, damaged, covered disturbed or otherwise obliterated, and that a corner record or record of survey shall be filed with the county surveyor prior to the recording of a certificate of completion for the project. (BPC § 8771(c))

9) Requires survey monuments to be permanently and visibly marked or tagged with the certificate number of the surveyor or civil engineer setting it, each number to be preceded by the letters "L.S." or "R.C.E.," respectively, or shall be marked with the name of the public agency that set it. (BPC § 8772)

10) Mandates that a person authorized to practice land surveying in California shall complete, sign, stamp, and file a "corner record" with the county surveyor in the county where the corners are situated, defined as a written record of corner establishment or restoration pursuant to the Survey of the Public Lands of the United States published by the federal Bureau of Land Management, as well as every accessory to such corner. (BPC § 8773(a))

11) Clarifies that any person authorized to practice land surveying may file a corner record for any property corners, property controlling corners, reference monuments, or accessories to a property corner. (BPC § 8773)

12) Mandates that, when conducting a corner record, the licensed land surveyor or registered civil engineer shall reconstruct or rehabilitate the monument of such corner, and accessories to such corner, so that the monument shall be left by them in as permanent a condition as reasonably possible for future use. (BPC § 8773.3)

THIS BILL:

1) Requires that, in every case where a survey monument or corner accessory is found in a physical condition that is less than permanent or durable, the licensed land surveyor or civil

engineer reconstruct or rehabilitate the monument to be in as permanent a state as reasonably possible for all future use.

FISCAL EFFECT: None.

COMMENTS:

Purpose. This bill is sponsored by the **California Land Surveyors Association.** According to the author:

> This bill is an opportunity to better serve our communities though the work land surveyors do to assess public and private property. Not only will it ensure that property lines are appropriately marked, but it has the potential to save our communities long term costs associated with reestablishing boundaries.

Background. Land surveyors are an important part of civil administration, land development and property law. Land surveyors establish and update property boundary lines, ensure property boundaries are accurate, aid in creating maps, and provide information regarding topography and geographic features that is critical to construction and civil engineering projects. Land surveyors work with, or sometimes directly for, state and local governments, and can also provide mapping and property information for private entities as well.

The Public Land Survey System. Developed by the Land Ordinance of 1785 under the direction of Thomas Jefferson, the Public Land Survey System (PLSS) was first developed to divide and map out land ceded to the United States following the Revolutionary War. Since then, the PLSS has been the primary method of subdividing, describing, and making available for sale land that is ceded or acquired by the United States. As such, not every state is included in the PLSS — such as the original thirteen colonies, Texas, and others — but California is. Land surveyed under the PLSS is divided by state, principle meridian, township, range, and section, with further subdivisions thereafter. Importantly, the corners of each township are marked upon surveillance; early surveyors would mark corners with makeshift physical markers or noted by natural characteristics (i.e. a nearby tree or body of water), while modern technology allows surveyors to set monuments in corners, as further described below. The US Bureau of Land Management continues to maintain and update the PLSS, and as such routinely resurveys and reestablishes corner records.

Survey monuments. As part of their duties of establishing and maintaining accurate property boundaries and corner records, land surveyors will mark or place "monuments" — also sometimes called "property markers" — to define the location of private or public property lines. Typical monuments are metal disks placed into the ground or otherwise permanently affixed to the land along the property boundary. Survey monuments must include the certificate number of the surveyor, engineer, or public agency that set it. Monuments are also often imprinted with relevant information, including the name of the surveyor or agency and the date the monument was placed, though this is not required by law.

Under current law, a land surveyor is required to restore or rehabilitate a degraded monument they come across on the field, but only in the instance that they are performing a survey for purposes of establishing or verifying a corner record in a county. According to the sponsors, this limits the ability for land surveyors to repair monuments they come across during other types of surveys, and can lead to difficulty and increased costs to accurately survey areas over time if

monuments that are in disrepair continue to degrade. As such, this measure would require that land surveyors restore any monument that is used as part of any survey, not just corner records, to ensure the monuments are in a "permanent" state as to be located for future use.

Current Related Legislation.

AB 3253 (Committee on Business and Professions) is the sunset bill for the Board for Professional Engineers, Land Surveyors, and Geologists.

Prior Related Legislation.

SB 1120 (Jones), Chapter 302, Statutes of 2022 required applicants, licensees, and certificate holders to provide the BPELSG with a valid email address, if available, and notify the BPELSG of any email address changes; clarified that unlicensed individuals cannot offer professional engineering and land surveying services; and updated certain land survey requirements.

AB 1522 (Low), Chapter 630, Statutes of 2019 extended the sunset date for the BPELSG and its authority to appoint an executive officer until January 1, 2024; authorized the BPELSG to take enforcement actions against a geologist-in-training certificate; continued disciplinary authority; and made other technical and clarifying changes.

SB 920 (Cannella), Chapter 150, Statutes of 2018 extended the authorization for licensed engineers, land surveyors, and architects to form limited liability partnerships until January 1, 2026.

ARGUMENTS IN SUPPORT:

This bill is sponsored by the **California Land Surveyors Association** (CLSA). According to CLSA: "In surveying, monuments are fundamental to defining boundaries as they define the location of private or public property lines. These monuments come in many forms but are often represented by a small tack in a metal plug in concrete. If a monument has been removed, damaged, or altered, the landowner my face excessive costs to pay for the reestablishment of the boundary by a professional land surveyor. Thus, preservation of monuments is critical to the future accuracy and costs of land surveying"

ARGUMENTS IN OPPOSITION:

In an "**Oppose unless amended"** letter submitted to the bill author and this committee, the **Board of Professional Engineers, Land Surveyors and Geologists** (BPELSG) writes: "While the Board generally agrees with this policy issue, the Board does have some concerns with the inclusion of corner accessories and with the use of the terms "permanent" and "durable.""

IMPLEMENTATION ISSUES:

In a letter addressed to the author and committee, the BPELSG notes that while they are supportive of the policy intent of this bill, they have technical concern regarding the use of "accessory" in the current language. Specifically, corner accessories are often adjacent physical characteristics to the corner, such as nearby boulders, trees, bodies of water, or other natural descriptor. As such, the requirement to restore accessory to a "permanent" and "durable" state is

impractical. The author should amend the bill to clarify that only monuments must be rehabilitated or restored.

AMENDMENTS:

In order to address technical concerns raised by the BPELSG, amend the bill as follows:

On page 2 after line 2:

In every case where a *monument* ~~*or* corner record is filed pursuant to Section 8773, *accessory*~~ *is found with a physical condition that is less than permanent and durable,* the licensed land surveyor or registered civil engineer *using that monument* ~~*or corner accessory*~~ *as control in any survey* shall reconstruct or rehabilitate the monument ~~of such corner, and accessories to such *or* corner~~, so that the same shall be left by ~~him~~ *them* in such physical condition that it remains as permanent a monument ~~*or corner accessory*~~ as is reasonably possible and so that the same may be reasonably expected to be located with facility at all times in the future.

REGISTERED SUPPORT:

California Land Surveyors Association *(Sponsor)*

REGISTERED OPPOSITION:

Board of Professional Engineers, Land Surveyors, and Geologists *(Unless Amended)*

Analysis Prepared by: Edward Franco / B. & P. / (916) 319-3301