Date of Hearing: August 27, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
SB 1451 (Ashby) – As Amended August 26, 2024

NOTE: This bill is being heard pursuant to Assembly Rule 77.2.

SENATE VOTE: 36-0

SUBJECT: Professions and vocations

SUMMARY: Authorizes registered dental hygienists in alternative practice (RHDAPs) to continue to provide services in an area that has been decertified as a dental health professional shortage area; updates existing restrictions on the use of the words "doctor" or "physician" or similar terms by individuals not licensed as physicians and surgeons; makes changes to the requirements for nurse practitioners (NPs) practicing independent of standardized procedures; expressly authorizes licensed vocational nurses (LVNs) who have completed additional training to perform certain respiratory care services in specified settings; reschedules the Legislature's sunset review of the California Massage Therapy Council (CAMTC) and clarifies the term lengths and removal process for its board of directors; extends the sunset date on the authority for pharmacists to directly furnish COVID-19 oral therapeutics; requires pharmacists who dispense or furnish a dangerous drug pursuant to a veterinary prescription to offer specified drug documentation as part of their consultation; and makes various other changes to practice acts administered by boards and bureaus under the Department of Consumer Affairs (DCA).

EXISTING LAW:

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

2) Enumerates various regulatory boards, bureaus, committees, and commissions under the DCA's jurisdiction. (BPC § 101)

3) Establishes the Dental Hygiene Board of California (DHBC) within the DCA to regulate dental hygienists under the Dental Hygiene Practice Act. (BPC §§ 1902 *et seq.*)

4) Establishes the Department of Health Care Access and Information (HCAI), vested with responsibilities related to health planning and research development relating to the health professional workforce. (Health and Safety Code (HSC) §§ 127000 *et seq.*)

5) Provides that the DHBC shall issue a license as an RDHAP to a registered dental hygienist who meets additional specified education and training requirements or to a person who has received a letter of acceptance into the employment utilization phase of the Health Workforce Pilot Project No. 155 established by HCAI. (BPC § 1922)

6) Authorizes RDHAPs to practice as an employee of a dentist or of another RDHAP, as an independent contractor, as a sole proprietor of an alternative dental hygiene practice, or in specified clinic settings. (BPC § 1925)

7) Additionally authorizes an RDHAP to perform specified duties in the following settings:

   a) Residences of the homebound.

   b) Schools.

   c) Residential facilities and other institutions and medical settings that a residential facility patient has been transferred to for outpatient services.

   d) Dental health professional shortage areas, as certified by HCAI in accordance with existing office guidelines.

   e) Dental offices.

   (BPC § 1926)

8) Requires the Dental Board of California (DBC) to approve, modify, or reject recommendations by the DHBC regarding scope of practice issues within 90 days of submission of the recommendation. (BPC § 1905.2)

9) Establishes the Medical Board of California (MBC) within the DCA to regulate physicians and surgeons under the Medical Practice Act. (BPC §§ 2000 *et seq.*)

10) Establishes the Osteopathic Medical Board of California (OMBC) within the DCA to regulate osteopathic physicians and surgeons under the Osteopathic Act who possess the same privileges as licensees regulated by the MBC. (BPC §§ 2450 *et seq.*)

11) Declares that protection of the public shall be the highest priority for both the MBC and the OMBC in exercising their respective licensing, regulatory, and disciplinary functions, and that whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. (BPC § 2001.1; § 2450.1)

12) Provides that any person who practices or attempts to practice, or who advertises or holds themselves out as practicing, any system or mode of treating the sick or afflicted in California, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as a physician and surgeon or without being otherwise authorized to perform the act is guilty of a crime. (BPC § 2052)

13) Requires a person who provides certain alternative or complementary to healing arts services and who is not a licensed physician and surgeon to make a written disclosure to the client that they are not a licensed physician and that the services to be provided are not licensed by the state, among other disclosures. (BPC § 2053.6)

14) Prohibits any person who does not have a valid, unrevoked, and unsuspended certificate as a physician and surgeon from the MBC from using the words “doctor” or “physician,” the letters or prefix “Dr.,” the initials “M.D.,” or any other terms or letters indicating or implying that they are a physician and surgeon, with certain exceptions. (BPC § 2054)

15) Allows a person who has been issued a physician's and surgeon's certificate by the MBC to use the initials "M.D." (BPC § 2055)

16) Provides that nothing in the Medical Practice Act shall be construed as limiting the practice of other persons licensed, certified, or registered under any other provision of healing arts law when that person is engaged in their authorized and licensed practice. (BPC § 2061)

17) Makes it unlawful for any healing arts licensee to publically communicate a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services in connection with the professional practice or business for which they are licensed. (BPC § 651)

18) Makes it unlawful for any person to make or disseminate any statement in the advertising of services, professional or otherwise, which is untrue or misleading. (BPC § 17500)

19) Establishes the Board of Registered Nursing (BRN) within the DCA to regulate licensed registered nurses under the Nursing Practice Act. (BPC §§ 2700 *et seq.*)

20) Defines "the practice of nursing" 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)

21) Includes within the scope of nursing practice the following:

    a) 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))

    b) 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))

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

    d) 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))

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

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

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

23) Establishes standardized procedure guidelines jointly promulgated by the Medical Board of California and the BRN. (California Code of Regulations (CCR), Title 16, § 1474)

24) Requires standardized procedures to include a written description of the method used during development and approval. (CCR, tit. 16, § 1474(a))

25) Specifies the required form and content of standardized procedures, including that they are in writing and signed, specify the authorized functions, establish procedure protocols, detail education and training requirements, provide for evaluation and of authorized nurses, provide for the maintenance of records of authorized nurses, establish the scope of physician supervision, set forth circumstances requiring physician consultation, state limitations on settings, specify patient record keeping requirements, and provide for periodic review of the standardized procedures. (CCR, tit. 16, § 1474(b))

26) Establishes a category of advanced practice registered nurses known as NPs, and specifies the requirements for certification. (BPC §§ 2834-2837.105)

27) Establishes the following categories of NP:

a) Family/individual across the lifespan. (CCR, tit. 16, § 1481(a)(1))

b) Adult-gerontology, primary care or acute care. (CCR, tit. 16, § 1481(a)(2))

c) Neonatal. (CCR, tit. 16, § 1481(a)(3))

d) Pediatrics, primary care or acute care. (CCR, tit. 16, § 1481(a)(4))

e) Women's health/gender-related. (CCR, tit. 16, § 1481(a)(5))

f) Psychiatric-Mental Health across the lifespan. (CCR, tit. 16, § 1481(a)(6))

28) Authorizes an NP who meets specified requirements, commencing January 1, 2023, to perform the following procedures independent of standardized procedures and physician oversight:

a) Conduct an advanced assessment. (BPC § 2837.103(c)(1))

b) Order, perform, and interpret diagnostic procedures. (BPC § 2837.103(c)(2)(A))

c) For radiologic procedures, a nurse practitioner can order diagnostic procedures and utilize the findings or results in treating the patient. A nurse practitioner may perform or interpret clinical laboratory procedures that they are permitted to perform under Section 1206 and under the federal Clinical Laboratory Improvement Act (CLIA). (BPC § 2837.103(c)(2)(B))

d) Establish primary and differential diagnoses. (BPC § 2837.103(c)(3))

e) Prescribe, order, administer, dispense, procure, and furnish therapeutic measures, including, but not limited to, the following:

i) Diagnose, prescribe, and institute therapy or referral of patients to health care agencies, health care providers, and community resources. (BPC § 2837.103(c)(4)(A))

ii) Prescribe, administer, dispense, and furnish pharmacological agents, including over-the-counter, legend, and controlled substances. (BPC § 2837.103(c)(4)(B))

iii) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including, but not limited to, durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services, including, but not limited to, home health care, hospice, and physical and occupational therapy. (BPC § 2837.103(c)(4)(C))

f) After performing a physical examination, certify disability. (BPC § 2837.103(c)(5))

g) Delegate specified tasks to a medical assistant. (BPC § 2837.103(c)(6))

29) Requires an NP who seeks to practice independent of standardized procedures to obtain certification from the BRN and complete a "transition to practice" in California of a minimum of three full-time equivalent years of practice or 4,600 hours. (BPC § 2837.103(a)(1)(D); CCR, tit. 16, §§ 1482.3, 1482.4).

30) Defines "transition to practice" as additional clinical experience and mentorship provided to prepare a nurse practitioner to practice independently, including managing a panel of patients, working in a complex health care setting, interpersonal communication, interpersonal collaboration and team-based care, professionalism, and business management of a practice. (BPC § 2837.101(c))

31) Requires the BRN to, by regulation, define minimum standards for transition to practice and specifies that clinical experience may include experience obtained before January 1, 2021, if the experience meets the requirements established by the BRN. (BPC § 2837.101(c))

32) Requires an NP who seeks to practice independent of standardized procedures to prove completion of a transition to practice by submitting to the BRN one or more attestations of a physician or surgeon or another NP already authorized to practice independent of standardized procedures; requires an attesting physician or surgeon or NP practicing to specialize in the same specialty area or category in which the applicant seeks certification as an NP; and prohibits the attester from having a familial or financial relationship with the applicant. (CCR, tit. 16, §§ 1482.3(a)(13), 1482.4(a)(13))

33) Requires the transition to practice to be completed within five years prior to the date the applicant applies for certification as an NP practicing independent of standardized procedures. (CCR, tit. 16, §§ 1482.3(a)(13)(A)(ii), 1482.4(a)(13)(A)(ii))

34) Requires the transition to practice to be completed in direct patient care and in the same category of NP practice in which the applicant seeks certification. (CCR, tit. 16, § 1482.3(a)(13)(A)(iv), 1482.4(a)(13)(A)(iv))

35) Authorizes an NP who meets all of the requirements for practice independent of standardized procedures to practice in one of the following settings or organizations in which one or more physician and surgeons practice with the NP:

    a) A clinic. (BPC § 2837.103(a)(2)(A))

    b) A health facility, except for correctional treatment centers and state hospitals. (BPC § 2837.103(a)(2)(B))

    c) A county medical facility. (BPC § 2837.103(a)(2)(C))

    d) Any lawfully organized group of physicians and surgeons that provides health care services. (BPC § 2837.103(a)(2)(D))

    e) A home health agency. (BPC § 2837.103(a)(2)(E))

    f) A licensed hospice facility. (BPC § 2837.103(a)(2)(F))

36) Authorizes an NP who has practiced in good standing for three years independent of standardized procedures to seek a certificate from the BRN to practice outside of the settings in which one or physician and surgeons practice. (BPC § 2837.104(b); (CCR, tit. 16, § 1482.4(a)(14))

37) Requires an NP to verbally inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon, for purposes of Spanish language speakers, use standardized phrase "enfermera especializada." (BPC §§ 2837.103(d), 2837.104(d); CCR, tit. 16, § 1487(b))

38) Requires an NP, except when working in facilities under the Department of Corrections and Rehabilitation, to advise patients that they have the right to see a physician and surgeon on request and the circumstances under which they must be referred to see a physician and surgeon. (CCR, tit. 16, § 1487(c))

39) Establishes the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) within the DCA to regulate licensed vocational nurses (LVNs) and psychiatric technicians under the Vocational Nursing Practice Act and the Psychiatric Technicians Law. (BPC §§ 2840–2895.5; 4500–4548)

40) Establishes the Respiratory Care Board of California (RCB) within the DCA to regulate respiratory care practitioners under the Respiratory Care Practice Act. (BPC §§ 3700 *et seq.*)

41) Defines respiratory care practice as a health care profession employed under the supervision of a medical director in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and

associated aspects of cardiopulmonary and other systems functions, as specified. (BPC §§ 3702; 3702.7)

42) Provides that the practice of respiratory care shall be performed under the supervision of a medical director in accordance with a prescription of a physician and surgeon or pursuant to respiratory care protocols. (BPC § 3703)

43) Specifies activities that are not prohibited by the Respiratory Care Act, including:

a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.

b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold themselves out to be a respiratory care practitioner licensed under the provisions of the Act.

c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.

d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their specialty.

e) Respiratory care services in case of an emergency, which includes an epidemic or public disaster.

f) Persons from engaging in cardiopulmonary research.

g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication.

h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the Department of Public Health (CDPH) of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the board.

i) The performance of certain respiratory care practices by an LVN licensed by the BVNPT who is employed by a home health agency licensed by the CDPH, subject to certain conditions.

(BPC § 3765)

44) Requires that, before January 1, 2025, LVNs performing respiratory care practices complete patient-specific training satisfactory to their employer. (BPC § 3765(i)(1))

45) Requires that, on or after January 1, 2025, patient-specific training offered by employers are in accordance with guidelines that shall be promulgated by the RCB no later than that same date, in collaboration with the BVNPT. (BPC § 3765(i)(2))

46) Establishes the Massage Therapy Act to provide for the voluntary certification of massage therapists by CAMTC, a private nonprofit organization. (BPC §§ 4600 *et seq.*)

47) Provides CAMTC with authority to take any reasonable actions necessary to carry out the responsibilities and duties set forth in the Massage Therapy Act, including, but not limited to, hiring staff, entering into contracts, and developing policies, procedures, rules, and bylaws to implement this chapter. (BPC § 4602(b))

48) Provides that CAMTC shall be governed by a board of directors comprised of 13 members, each appointed by an agency or organization representing local government, anti-trafficking advocates, higher education, and the massage industry. (BPC § 4602(f))

49) States that protection of the public shall be the highest priority for CAMTC in exercising its certification and disciplinary authority, and any other 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 § 4603)

50) Provides that it is an unfair business practice for any person to use the title of "certified massage therapist" or "certified massage practitioner," or any other term, such as "licensed," "certified," "CMT," or "CMP," in any manner whatsoever that implies or suggests that the person is certified as a massage therapist or massage practitioner, unless that person currently holds an active and valid certificate issued by CAMTC. (BPC § 4611)

51) Provides CAMTC with responsibility for approving massage schools. (BPC § 4615)

52) Provides that the Massage Therapy Act shall remain in effect only until January 1, 2027, and as of that date is repealed. (BPC § 4621)

53) Establishes the California State Board of Pharmacy (BOP) within the DCA to regulate the pharmacy profession under the Pharmacy Law. (BPC §§ 4000 *et seq.*)

54) Authorizes pharmacists to furnish COVID-19 oral therapeutics to patients who test positive for SARS-CoV-2, without a prior prescription, until January 1, 2025. (BPC § 4052.04)

55) Establishes the Veterinary Medical Board (VMB) within the DCA to regulate veterinarians and registered veterinary technicians (RVTs) under the Veterinary Medicine Practice Act. (BPC §§ 4800 *et seq.*)

56) Provides that a person practices veterinary medicine when they, among other things, administer a drug or medicine for the prevention, cure, or relief of a wound, fracture, bodily injury, or disease of animals. (BPC § 4826)

57) Prohibits a veterinarian from prescribing, dispensing, or administering a drug, medicine, or treatment unless a veterinarian-client-patient relationship exists, subject to certain exceptions. (BPC § 4826.6)

58) Requires that, each time a veterinarian initially prescribes, dispenses, or furnishes a dangerous drug to an animal patient in an outpatient setting, the veterinarian shall offer to provide, verbally, in writing, or by email to the client, a consultation including the following:

a) The name and description of the dangerous drug,

b) The route of administration, dosage form, dosage, duration of drug therapy, the duration of the effects of the drug, and the common severe adverse effects associated with the use of a short-acting or long-acting drug,

c) Any special directions for proper use and storage,

d) Actions to be taken in the event of a missed dose, and

e) If available, precautions and relevant warnings provided by the drug's manufacturer, including common severe adverse effects of the drug.

(BPC § 4829.5(a))

59) Requires a veterinarian to provide drug documentation to a client, if available. (BPC § 4829.5(b))

60) Authorizes a veterinarian to delegate the task of providing consultation and drug documentation to an RVT or veterinary assistant. (BPC § 4829.5(c))

61) Establishes the State Board of Barbering and Cosmetology (BBC) within the DCA to regulate barbers, cosmetologists, hairstylists, electrologists, estheticians, and manicurists under the Barbering and Cosmetology Act. (BPC §§ 7301 *et seq.*)

62) Defines the practice of hairstyling as all or any combination of the following:

a) Styling of all textures of hair by standard methods that are current at the time of the hairstyling.

b) Arranging, blow drying, cleansing, curling, cutting, dressing, extending, shampooing, waving, or nonchemically straightening the hair of any person using both electrical and nonelectrical devices.

(BPC § 7316)

63) Establishes fee amounts that may be charged to applicants and licensees by the BBC and specifically provides that the fee for a hairstylist application and examination shall be either $50 or a lower fee in an amount as determined by the BBC, not to exceed the reasonable cost of developing, purchasing, grading, and administering the examination. (BPC § 7323)

64) Establishes the Structural Pest Control Board (SPCB) within the DCA to regulate structural pest control operators under the Structural Pest Control Act. (BPC §§ 8500 *et seq.*)

65) Requires that, as a condition of license renewal, a licensee of the SPCB must submit proof of continuing education, or equivalent activity, informing themselves of developments in the field of pest control, and authorizes licensees to take an examination issued by the SPCB in lieu of continuing education. (BPC § 8593)

66) Provides that the SPCB shall require applicants for license renewal to submit proof that they have completed approved courses of continuing education in pesticide application and use, and provides that in lieu of submitting that proof, the licensee may successfully pass an applicator's examination for renewal of a license given by the SPCB. (BPC § 8593.1)

67) Establishes the Bureau of Automotive Repair (BAR) within the DCA to administer and enforce the Automotive Repair Act. (BPC § 9882)

68) Establishes the Bureau of Household Goods and Services (BHGS) within the DCA to regulate movers, home inspectors, and other household services under the Home Furnishings and Thermal Insulation Act and the Household Movers Act. (BPC § 9810; §§ 19000 *et seq*; §§ 19225 *et seq*.)

69) Requires that, in order to engage in business of transportation of used household goods and personal effects, a household mover shall obtain a permit issued by the BHGS. (BPC § 19237(a))

70) Requires that, in order to transport household goods and personal effects from this state to another state or from another state to this state, a household mover shall obtain valid operating authority issued by the Federal Motor Carrier Safety Administration. (BPC § 19237(a)(2))

71) Requires that, among other requirements, an applicant for a household movers permit may qualify by personal examination, by examination of their responsible managing employee or managing officer, or partner of the applicant firm. (BPC § 19239(b))

72) Prohibits BHGS from issuing a household movers permit to any applicant that does not meet residency requirements, as specified. (BPC § 19239(g))

THIS BILL:

1) Allows RDHAPs working in a dental health professional shortage area to continue to provide dental hygiene services if the dental health professional shortage area certification is removed and requires those RDHAPs to annually provide patients treated at an existing practice with a list of dentists in the previous dental health professional shortage area who may be able to see the patient for comprehensive services.

2) Eliminates language requiring the DHBC to submit recommendations regarding scope of practice to the DBC for approval.

3) Adds references to osteopathic physicians and surgeons licensed by the OMBC to provisions of existing law generally prohibiting use of the terms "doctor," "physician," "Dr.," and "M.D." by persons who are not licensed physicians and surgeons.

4) Expressly prohibits a person from using the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D." or "D.O.," or any other terms or letters indicating or implying that the person is a physician and surgeon or practitioner in a health care setting that would lead a reasonable patient to determine that person is a licensed "M.D." or "D.O."

5) Clarifies that the above prohibitions do not apply to a person holding a current and active license under another healing arts board, to the extent the use of the title is consistent with the act governing the practice of that license.

6) Additionally allows a person who is not a physician and surgeon to use the word "doctor" or the prefix "Dr." if the use is not associated with any claim of entitlement to practice medicine or any other professional service for which the use of the title would be untrue or misleading.

7) Make changes to the MBC's process for approving licenses for individuals still enrolled in postgraduate training.

8) Makes the following changes to the requirements for NP practicing independent of standardized procedures:

    a) Amends the definition of "transition to practice" to delete the requirement that clinical experience must meet the requirements established by the BRN, clarify that clinical experience may not be limited to experience in a single category of NP practice, and exclude experience obtained before a person is certified as an NP.

    b) Authorizes the transition to practice to be completed in another state.

    c) Specifies that an NP who has been practicing as a nurse practitioner in direct patient care for a minimum of three full-time equivalent years or 4,600 hours within the last 5 years, as of the time of application, may be deemed to have satisfied the transition to practice requirement.

    d) Specifies the following for purposes of completion of the transition to practice:

        i) The BRN must receive proof of completion of a transition to practice on a form prescribed by the BRN as an attestation from either a licensed physician and surgeon or an NP authorized to practice independent of standardized procedures.

        ii) A licensed physician and surgeon or an NP who attests to the completion of a transition to practice is not required to specialize in the same category as the applicant.

        iii) A licensed physician and surgeon or an NP who attests to the completion of a transition to practice is not required to verify competence, clinical expertise, or any other standards related to the practice of the applicant and only attests to the completion of the transition to practice.

        iv) A licensed physician and surgeon or an NP who attests to the completion of a transition to practice is not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for providing an attestation or refusing to provide an attestation.

e) Deletes from the requirement that an NP practicing independent of standardized procedures inform all new patients in a language understandable to the patient that an NP is not a physician and surgeon that the NP do so verbally.

f) Deletes requirement that an NP nurse practitioner use the standardized phrase "enfermera especializada" with Spanish language speakers.

g) Specifies that an NP is not be required to tell a patient the patient has a right to see a physician and surgeon.

h) Clarifies that the disclosure requirements only apply to NPs practicing independently of standardized procedures.

9) Specifies that the occupational analysis performed by the BRN related to NP competencies and independent practice did not need to include NP certification examinations discontinued before January 1, 2017.

10) Extends respective dates for LVNs to complete patient-specific training, and for the RCB to promulgate regulations in consultation with the BVNPT, to January 1, 2028.

11) Authorizes, operative January 1, 2028, an LVN to perform respiratory care services identified by the RCB so long as they:

a) Complete patient-specific training satisfactory to their employer, and

b) Hold a current and valid certification of competency for each respiratory task to be performed from the California Association of Medical Product Suppliers, the California Society for Respiratory Care, or another organization identified by the board.

12) Authorizes, operative January 1, 2028, LVNs to perform respiratory care services identified by the RCB in the following settings:

a) At a congregate living health facility licensed by the CDPH that is designated as six beds or fewer.

b) At an intermediate care facility licensed by the CDPH that is designated as six beds or fewer.

c) At an adult day health care center licensed by the CDPH.

d) As an employee of a home health agency licensed by the CDPH or an individual nurse provider working in a residential home.

e) At a pediatric day health and respite care facility licensed by the CDPH.

f) At a small family home licensed by the State Department of Social Services that is designated as six beds or fewer.

g) As a private duty nurse as part of daily transportation and activities outside a patient's residence or family respite for home- and community-based patients.

13) Reschedules the Legislature's sunset review of CAMTC by providing for a January 1, 2026 repeal date.

14) Clarifies that only a member of CAMTC's board of directors may only be removed by their appointing authority and that any change to the appointing authority of a member shall not take effect until the completion of that member's term or until it is vacant.

15) Provides that CAMTC board members may not serve more than two terms, with a grace period of up to one additional year pending the appointment and qualification of their successor, and that current board members who have already exceeded these term limits will be required to vacate their appointments.

16) Authorizes pharmacists to continue furnishing COVID-19 oral therapeutics to patients who test positive for SARS-CoV-2, without a prior prescription, until January 1, 2026.

17) Requires a pharmacist who dispenses or furnishes a dangerous drug pursuant to a veterinary prescription to include, as part of the consultation, the option for a representative of an animal patient to also receive drug documentation specifically designed for veterinary drugs.

18) Recasts the authority of the BBC to charge a hairstylist application and examination fee to require the fee amount to be the actual cost to the board for developing, purchasing, grading, and administering the examination and establishes the fee for a hairstylist's initial license fee as $50.

19) Removes the authority for SCPB licensees to take an examination issued by the board in lieu of continuing education.

20) Authorizes BAR to issue a license to a federally recognized tribe, as defined, and makes additional conforming changes.

21) Exempts out-of-state household movers regulated by the BHGS from residency requirements if they provide an agent of service for process.

22) Exempts applicants for household mover permits that only conduct inter-state moves from BHGS exam requirements upon the applicant signing an affidavit declaring they will not conduct any intrastate moves.

23) Requires the BHGS to identify on its internet website those movers that can conduct intrastate moves and those that can conduct interstate moves.

24) Makes technical amendments to the licensing requirements section of the Household Movers Act.

25) Make conforming changes and waive fees for military and military spouse expedited licensure by various boards and bureaus under the DCA.

FISCAL EFFECT: Pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

Purpose. This bill is sponsored by the author, who is Chair of the Senate Committee on Business, Professions, and Economic Development. According to the author:

> "This bill is intended to be an omnibus bill which includes several changes to programs reviewed through the sunset review oversight process. Among other important clarifying provisions, SB 1451 addresses a number of practice areas impacting the ability for female-dominant healthcare professions to effectively provide safe and expanded access to care to California patients."

Background.

Registered Dental Hygienists in Alternative Practice. The DHBC maintains authority over all aspects of licensure, enforcement, and investigation of California dental hygienists. The DHBC regulates three categories of mid-level dental professionals. These categories include registered dental hygienists, registered dental hygienists in extended functions, and RDHAPs.

An RDHP is trained and authorized to provide unsupervised dental hygiene services in certain limited practice settings, including residences of the homebound, schools, residential facilities, and dental offices. RDHAPs are also authorized to provide services without supervision in certified dental health professional shortage areas. The original intent of this authority was to allow RDHAPs to perform unsupervised services on vulnerable and challenging populations, such as children, individuals with limited access to dental care, and patients with compromised mobility or other health concerns that impede their ability to get dental care in more traditional settings.

During the DHBC's sunset review in 2018, the board's sunset hearing background paper discussed the fact that while an RDHAP may set up practice in a dental health professional shortage area, the RDHAP must relocate their practice once that shortage is deemed to no longer exist. Health professional shortage areas are federal designations, certified in California by HCAI, and therefore decertification could in theory occur with little notice or public input. Assembly Bill 502 (Chau) of 2015 included language that would have allowed an RDHAP to continue practicing in an area that has lost its dental health professional shortage area designation; however, this language was subsequently removed from the bill.

This issue was again discussed during the DHBC's most recent sunset review in 2023. Issue #5 in the board's sunset hearing background paper discussed the question of whether current law should be amended to allow an RDHAP with a stand-alone dental hygiene practice site in a dental health professional shortage area to remain in practice even if the area's shortage area certification is removed. The background paper noted that "licensees are wary of opening a dental hygiene practice with the risk that they could lose the business if the designation is lifted by the federal government due to the dental hygiene services they are providing to the population." The DHBC opined that if this concern were addressed, more RDHAPs would potentially be willing to open new practices in these communities where their dental services are vitally needed the most.

This bill would address the concerns that were raised in the DHBC's prior sunset reviews by amending the law to allow an RDHAP that previously provided services without supervision in a dental health professional shortage area to continue to provide dental hygiene services in the event that the dental health professional shortage area certification is removed for that area. The bill would require RDHAPs to annually provide patients treated at an existing practice with a list of dentists in the previous dental health professional shortage area who may be able to see the patient for comprehensive services. While it is uncertain whether there is any imminent risk of the federal government removing a substantial number of dental health professional shortage area designations in the future, this authority will arguably help encourage RDHAPs to invest in opening practices in these communities, which would correspondingly result in underserved patients receiving access to dental hygiene services.

This bill would also delete outdated language in the DHBC's practice act requiring any recommendations regarding scope of practice to be submitted to the DBC. While the DHBC was previously identified as a committee with implied subservience to the DBC, this has not been the practical effect of the law since the DHBC was created as a fully independent regulatory entity, and any language implying the DHBC must obtain approval from the DBC is arguably vestigial and unnecessary. Further, the DHBC is not authorized to make any decisions regarding scope of practice for its licensees without statutory change.

Restriction of Medical Terms. The Medical Practice Act currently prohibits any person from practicing or advertising as practicing medicine without a license. Statute specifically makes it a misdemeanor for any unlicensed person to use the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D.," or any other terms or letters indicating or implying that the person is a licensed physician and surgeon on any sign, business card, or letterhead, or, in an advertisement. To use these words, prefixes, or initials, a person's license must be valid, unrevoked, and unsuspended. The statute features three limited exceptions for individuals who are trained as physicians but not currently licensed in California.

General provisions governing health professional licensing boards make it unlawful for any healing arts licensee to publically communicate any false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of rendering professional services in connection with their licensed practice. Statute specifically prohibits a licensee from using "any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive." Practitioners may advertise that they are certified or that they limit their practice to specific fields; however, the term "board certified" reserve for physicians certified by an American Board of Medical Specialties member board.

Additionally, Section 17500 of the Business and Professions Code broadly prohibits false advertising of a product or service. Specifically, this law makes it unlawful for any person to make any statement or advertisement with intent to perform services, professional or otherwise, that is untrue or misleading. While this code section covers a wide range of false advertisements by sellers of goods or services, its provisions would be applicable to health care licensees.

While the Medical Practice Act expressly reserves use of the words "doctor" or "physician" for actively licensed physicians, this provision does not comprehensively reflect the current state of

the law. For example, while podiatrists are independently licensed by the Podiatric Medical Board of California, their formal title is "doctors of podiatric medicine." Similarly, the California Board of Naturopathic Medicine licenses and regulates a profession statutorily referred to as "naturopathic doctors." Optometrists, dentists, chiropractors, psychologists, and other practitioners possessing professional doctorates are also expressly authorized by law to use the term "doctor." "Dr." is also commonly used as a social honorific for anyone who has received a doctoral degree, including research doctorates not associated with licensure.

Current law also does not expressly exempt individuals who do not imply any authority to practice a healing art but who use the honorific "Dr." to recognize a nonprofessional doctorate or as part of an established nickname. For example, Dr. Dre is an American rapper and entrepreneur whose debut record as a solo performer, *The Chronic*, is widely recognized as a seminal hip hop album of the 1990s and credited with popularizing the G-funk rap subgenre. Born Andre Romell Young, the artist's moniker was inspired Julius Erving, a professional basketball player for the Philadelphia 76ers who is considered to be one of the greatest dunkers of all time and who is known by his nickname "Dr. J." Neither Dr. Dre nor Dr. J is a graduate of any medical school and neither holds a current license as a physician and surgeon from a state medical board. However, the MBC has not prosecuted Dr. Dre or Dr. J for violating the Medical Practice Act, likely because they are clearly not implying that they are physicians, which is the obvious intent of the law.

Under the status quo, it is apparent that someone who is not a physician and surgeon may nevertheless safely use the term "doctor" and its associated prefix without fear of incurring a misdemeanor conviction if they are authorized by another law to use that title (e.g. a person licensed under the Naturopathic Doctors Act); in possession of a doctoral degree (e.g. Dr. Jill Biden, Ed.D.); or clearly not implying any qualification to practice medicine (e.g. Dr. Demento). However, current law does not expressly reference any of these exemptions. Current law also does not reflect the fact that physicians and surgeons are not exclusively licensed as M.D.s by the MBC; osteopathic physicians and surgeons possess the same authority and scope as D.O.s licensed by the OMBC.

This bill would make several updates and clarifications to existing law restricting use of "doctor" and similar terms. Because osteopathic physicians and surgeons have the same scope of practice as physicians and surgeons licensed by the MBC and are regulated under the same chapter of code, this bill would provide them with the same title protection for the initials "D.O." that licensees of the MBC receive for "M.D." Additionally, the bill clarifies that exemptions in current law for graduates of medical schools apply equally to graduates of osteopathic medical schools. The bill would then expressly provide that no person may use words, initials, or other terms or letters indicating or implying that the person is a physician and surgeon, physician, surgeon, or practitioner in a health care setting that would lead a reasonable patient to determine that person is a licensed "M.D." or "D.O."

Additionally, this bill would further clarify existing law by adding two new exceptions to the restriction of these terms that are reflective of the status quo but not expressly referenced in the Medical Practice Act. First, the bill would confirm that licensees of other healing arts boards, such as optometrists, naturopathic doctors, and dentists, may continue to use words such as "doctor" to the extent the use of the title is consistent with the act governing the practice of that

license. Second, the bill would exempt any person whose use of the word "doctor" or the prefix "Dr." is not associated with any claim of entitlement to practice medicine or any other professional service for which the use of the title would be untrue or misleading pursuant to Section 17500. This clarification would capture both those who have earned the right to the title "doctor" by obtaining a doctoral degree and those who merely use the term as playful branding, as long as the use is outside any medical context that could be confusing to consumers.

Nurse Practitioners. An NP is a registered nurse (RN) who has additionally earned a postgraduate nursing degree, such as a Master's or Doctorate, and obtained a certificate from a certifying body. For state recognition to practice as an NP, the NP must also meet the educational standards established by the BRN. According to BRN regulations, an NP is an advanced practice registered nurse who meets BRN education and certification requirements and possesses additional advanced practice educational preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary care or acute care.

As RNs, NPs generally have the same base scope of practice as non-NP RNs, although their additional education and training allows them to perform more advanced functions under standardized procedures. Currently, all RNs practicing outside of the basic scope of nursing operate under a supervision mechanism known as a "standardized procedure." The standardized procedure authorizes functions that would otherwise be considered the practice of medicine and must be based on the guidelines jointly promulgated by the Medical Board of California and the BRN.

Standardized procedures must meet specified requirements, including that they:

1) Are developed with the organized healthcare system or physician.
2) Outline the scope of the functions allowed.
3) Specify the circumstances under which they may be performed.
4) Specify any training prerequisites.
5) Establish a method for initial and ongoing evaluation of the competence of the RN.
6) Specify the level of physician supervision required (e.g. indirect, on-site, present during the procedure).
7) Establish physician consultation protocols.
8) Specify any limitations on settings where the functions may be performed.
9) Specify record-keeping requirements and methods for periodic review.

As the result of the more advanced NP training, standardized procedures may authorize a greater number or difficulty of functions and settings while reducing the amount of supervision needed. The Nursing Practice Act also specifically authorizes NPs under standardized procedures to order durable medical equipment; certify disability; approve, modify, and add to a home health services treatment plan; furnish and order prescription drugs; and perform abortions by aspirations techniques with additional training.

DCA's Annual Report for Fiscal Year 2022-23 reported 36,092 actively licensed NPs and 32,780 NPs with a furnishing certificate authorizing them to furnish drugs.

Independent NPs and the "transition to practice" requirement. NPs who meet additional requirements, including the completion of a 3-year or 4600-hour "transition to practice," may

practice independently without standardized procedures. There are two categories of independent NPs, those who practice in licensed healthcare settings where physicians practice and those who practice in any setting. Due to the variety of NP educational pathways, in order to practice independently in any setting, an NP would be required to meet the above training requirements above as well as meet additional educational experience prerequisites.

Once an NP meets the transition to practice, the NP may perform the following functions independent of standardized procedures:

1) Conduct an advanced assessment.
2) Order, perform, and interpret diagnostic procedures, including radiologic procedures and specified laboratory procedures.
3) Establish primary and differential diagnoses.
4) Prescribe, order, administer, dispense, procure, and furnish therapeutic measures, including, but not limited to, the following:
    a) Diagnose, prescribe, and institute therapy or referral of patients to healthcare agencies, healthcare providers, and community resources.
    b) Prescribe, administer, dispense, and furnish pharmacological agents, including over-the-counter, legend, and controlled substances.
    c) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including, but not limited to, durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services, including, but not limited to, home health care, hospice, and physical and occupational therapy.
5) After performing a physical examination, certify disability pursuant to the Unemployment Insurance Code.
6) Delegate tasks to a medical assistant.

While there are still requirements in the law that specify when an independent NP would need to consult with a physician or refer a patient, the NP is not required to establish a relationship with a physician for those purposes before practicing without standardized procedures.

Transition to Practice in Other States. There are 24 states that authorize NPs to practice without standardized procedures. Of those, 10 require a transition to practice, ranging from six months of full-time practice or 1,000 hours to 3 years or 2,000 hours. The remaining 14 do not require a transition to practice.

BRN Transition to Practice Regulations. Existing law requires the BRN to establish requirements related to the transition to practice. Pursuant to that requirement, BRN regulations require that the transition to practice meet the following:

1) Be completed in the five years preceding application.
2) Be completed after initial certification as an NP by the BRN.
3) Be completed in direct patient care.
4) Be completed in a specified NP practice area (family/individual across the lifespan; adult-gerontology, primary care or acute care; neonatal; pediatrics, primary care, or acute care; women's health/gender-related; psychiatric-mental health).

The BRN's regulations also require that a physician or another NP authorized to practice independently who is practicing in the same practice area as the applicant NP to attest to the completion of the transition to practice. This bill codifies portions of those requirements and preempts others.

NP Disclosure Requirements. NPs under the independent practice provisions are statutorily required to make several disclosures to patients, including verbally informing all new patients in a language understandable to the patient that the NP is not a physician and surgeon and referring to themselves as "enfermera especializada" with Spanish language speakers. BRN regulations also require NPs to tell all patients they have the right to see a physician. This bill deletes "verbally" from the requirement that new patients are informed that an NP is not a physician and deletes the "enfermera especializada" requirement. This bill also prohibits requiring NPs to tell all patients they have the right to see a physician.

Respiratory Care and LVNs. In the 2022 sunset review of the RCB, a long-standing issue was raised related to the appropriate scope of practice between LVNs and respiratory care professionals in administering respiratory services for managing patients. While the RCB has historically contended that LVNs should not be administering any ventilator services, the BVNPT issued guidance to licensees permitting LVNs to adjust ventilator settings. The RCB has maintained this policy was not a formal regulation, and made numerous requests to rescind the policy, but the BVNPT has maintained the position that LVNs should be able to adjust ventilators.

In 2019, the two boards attempted to resolve this issue and worked collaboratively. From that work, the two boards issued a joint statement clarifying respiratory care professional and LVN roles relating to patient care on mechanical ventilators. After reactions and comments from a variety of facilities and organizations, there was momentum to further clarify its respective regulations regarding patient care. The boards hosted a stakeholder meeting to further discuss the joint statement and concerns grew about expanding places LVNs can conduct ventilator services to home based settings as well. According to the RCB, BVNPT backed out of the agreement and began exploring continuing to train LVNs to perform ventilator services in more settings.

As a result of this continuing issue, the 2022 sunset bill for the RCB (SB 1436, Roth, Ch. 624, Statutes of 2022) included provisions that respiratory care and services may be provided if an LVN completes, before January 1, 2025, patient-specific training satisfactory to their employer, and if that LVN is employed by a home health agency licensed by the CDPH. Additionally, the bill required that on or after January 1, 2025, the licensed vocational nurse has completed patient-specific training by the employer in accordance with guidelines that shall be promulgated by the board no later than January 1, 2025, in collaboration with the BVNPT. Stemming from this collaboration, this bill extends the respective deadlines for the RCB and BVNPT to promulgate regulations and for LVNs to complete training to January 1, 2028, and expands the circumstances under which an LVN can perform certain respiratory care practices to include, among other things: those working at licensed congregate living facilities designated as six beds or fewer, licensed adult day health care center, licensed pediatric day health and respite care facilities, and more.

Massage Therapy. CAMTC was first established in 2009. Unlike most regulatory bodies responsible for overseeing healing arts professionals in California, CAMTC is not a state agency

and does not function as part of the state's government. Instead, it is incorporated as a private nonprofit, governed by a board of appointed directors. CAMTC's sunset review background paper in 2021 outlined a number of issues arguably related to CAMTC's status as a nonprofit. These issues included the composition of CAMTC's board of directors, the compensation of its CEO, and the lack of applicability of various laws aimed at improving transparency and accountability for state regulators. Issue #27 in CAMTC's sunset review background paper asked whether the certification of massage professionals be continued by CAMTC in its current form.

The background paper concluded that from an administrative perspective, CAMTC has certainly delivered upon the promises inherent with the nongovernmental regulator model. The council is able to act swiftly, flexibly, and inexpensively in its operations, particularly when compared to analogous boards and bureaus under the DCA. However, as discussed throughout the sunset background paper, there are potential downsides to empowering an entity outside state government to exercise regulatory control over a profession, with the efficiencies boasted by CAMTC arguably coming at the cost of transparency, accountability, and due process secured through various "good government laws" applicable to state boards but not private nonprofits.

Proposals have been made to convert CAMTC into a state licensing board, or to revise the Massage Therapy Act to require the council to further emulate the state licensing board model in areas that would increase public confidence and allow the industry to more closely resemble other health care professionals. However, CAMTC's most recent sunset review ultimately did not substantially change how CAMTC is structured. Instead, CAMTC's sunset date was given a typical four-year extension with only minor changes made to the Massage Therapy Act.

In the years following CAMTC's most recent sunset review, further scrutiny to its operations has been elicited by actions taken by the council that appear to reflect a deliberate circumvention of transparency and accountability. In November 2022, CAMTC increased its certificate fees by fifty percent, despite having indicated to the Legislature during its sunset review that it was sufficiently funded. Additionally, as described in a subsequent letter sent from members of the California State Assembly to CAMTC's leadership, the logistics of the vote to increase fees appeared "intentionally intended to obstruct public discussion."

Further concerns were subsequently raised by members of CAMTC's board of directors about the council's operations, including its staff compensation, spending, and political activities. During a June 2024 board meeting, there appeared to be a concerted effort by CAMTC's leadership to remove several directors from the board who had questioned the council's actions. Following this meeting, it became apparent that CAMTC's board of directors was expected to loyally affirm the decisions of the council's staff, rather than provide independent oversight of its functions on behalf of the public.

This bill would ensure that CAMTC is subjected to an appropriate level of transparency and accountability by moving its sunset review by the Legislature up one year so that it would be scheduled for repeal on January 1, 2026. In the meantime, this bill would additionally clarify that CAMTC cannot remove board members appointed by other entities pursuant to statute, either directly or by changing a member's appointing authority midterm. This bill would further prohibit CAMTC board members from serving more than two terms, applied retroactively so that a more independent board of directors will be in place during the council's next sunset review.

COVID-19 Therapeutics. The federal Food and Drug Administration (FDA) has authorized two oral antiviral pills for the treatment of mild-to-moderate COVID-19. Paxlovid, developed by Pfizer, is a combination formulation of two protease inhibitor medications: nirmatrelvir and ritonavirhas. Molnupiravir, developed by Merck & Co., is sold under the brand name Lagevrio. Both therapeutics have been shown to prevent hospitalization or death in high-risk patients with mild to moderate COVID-19.

As antiviral therapeutics for COVID-19 became available at the beginning of 2022, the CDPH and other public health entities pushed to make those treatments accessible, particularly to high-risk patients. Therapeutics were made free to all Californians, including the uninsured. COVID-19 therapeutics are most effective when taken within days of a patient developing symptoms, so beginning treatment immediately upon receipt of a positive test is the most efficacious way of prevent a patient's condition from becoming more severe.

On September 14, 2021, the Secretary of the federal Department of Health and Human Services, Xavier Becerra, issued a declaration authorizing pharmacists to independently order and administer any COVID-19 therapeutic in compliance with FDA authorization. On July 6, 2022, the FDA announced that it had revised the Emergency Use Authorization (EUA) for Paxlovid (nirmatrelvir and ritonavir) to authorize state-licensed pharmacists to prescribe Paxlovid to eligible patients. This authority was effectuated in California through a waiver issued by the Director of DCA, which waived any provisions of law prohibiting a pharmacist from independently initiating and furnishing Paxlovid consistent with the EUA.

While the EUAs for both Paxlovid and Lagevrio were expected to remain in effect until the FDA completed its full approval of these therapeutics, it was determined that pharmacists would likely only remain authorized to furnish the drugs directly to patients until the federal stockpile established during the EUA has expired. AB 1341 (Berman) was subsequently passed by the Legislature to preserve the ability of pharmacists in California to continue furnishing these drugs directly to patients after the federal authorization has ended, until January 1, 2025. This bill would further extend that sunset date by one additional year, authorizing pharmacists to furnish oral therapeutics for COVID-19 until January 1, 2026.

Veterinary Prescriptions. Licensed veterinarians are permitted to order, prescribe, and administer certain controlled substances so long as they perform an in-person examination of the patient and confirm such a substance is medically necessary. In addition, RVTs and veterinary assistants that possess a valid controlled substances permit issued by the VMB, may obtain and administer a controlled substance to a patient. Importantly, law expressly prohibits veterinarians from ordering, prescribing or furnishing a controlled substance to themselves or any human.

During the VMB's 2016 sunset review, it was made clear that, though a common practice amongst the veterinary community, veterinarians were not explicitly required to provide a consultation to clients regarding information about drugs and medicines they prescribe to patients. As a result, omnibus legislation authored by then-Senator Jerry Hill (SB 1480, Ch. 571, Stats. of 2018) added a requirement to law that veterinarians must offer a consultation to any client whom they prescribe, administer or otherwise furnish a drug to, and provide any available drug documentation upon request. This bill requires licensed pharmacists who dispense a drug pursuant to a veterinary prescription to, as part of consultation, offer documentation with information specific to the veterinary drug to the client.

Hairstylist License. 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 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.

During the BBC's most recent sunset review in 2021, a number of reforms were passed through the BBC's sunset extension vehicle (SB 803, Roth). These included adding further specificity to the composition of the BBC, recasting the scope of practice for skincare, and authorizing cosmetology students to obtain more clock hours through paid externships. The BBC's sunset bill also created a new hairstylist license, which allows licensees to provide certain basic hair services after meeting lower education and training requirements than are needed for barbering or cosmetology license.

The Barbering and Cosmetology Act generally prohibits the BBC from charging fees beyond what is necessary to cover the expenses of the board in performing its duties. SB 803 authorized the BBC to charge an application and examination fee to individuals seeking licensure as hairstylists. Statute currently provides the BBC with two options: they can either charge $50, or they can charge a different amount that does not exceed either $50 or the reasonable cost of developing, purchasing, grading, and administering the examination. This bill would remove the BBC's authority to charge $50 if that is not the amount that it determines to be its actual costs of developing, purchasing, grading, and administering the examination. This bill would then additionally cap the initial fee for a hairstylist's license at $50.

Structural Pest Control. This bill makes minor, yet substantive, changes to the Structural Pest Control Act, which is administered by the SPCB. All licensees under the SPCB must, as a condition of their license renewal, submit proof of completion of continuing education (CE) that as deemed satisfactory by the board. Under current law, SPCB allows licensees to pass a board-administered examination in lieu of completing CE in order to obtain license renewal. However, the U.S. Environmental Protection Agency amended federal law in 2017 to tighten requirements related to restricted use pesticides and those certified to utilize them. Specifically, the EPA clarified that if individuals are certified - or in California's case, licensed – based on written examination, the respective state must ensure the examination is adequately developed to demonstrate competencies required by federal law.

The SPCB surmises that aligning competency examinations with this new standard will be onerous, as they do not have staff within the agency itself qualified to develop the exam to a defensible standard, and deem that engagement with the DCA's Office of Professional Examination Services (OPES) would be too costly. As a result, this bill deletes the competency examination as an alternative for completing CE, thus eliminating the SPCB's need to continue developing or administering such an examination.

Automotive Repair Licensure of Tribes. Current law does not authorize BAR, which licenses and regulates automotive repair dealers as well as Smog Check stations, repair technicians, and inspectors, to issue a license to a federally recognized tribe. BPC § 9880.1 defines "automotive repair dealer" as "a person who, for compensation, engages in the business of repairing or

diagnosing malfunctions of motor vehicles, or engages in the business of collecting compensation for automotive repair services that are referred or sublet to someone other than the dealer or their employees." However, BPC 9880.1(i) defines "person" as "a firm, partnership, association, limited liability company, or corporation." The omission of federally recognized tribes creates a barrier to licensure for federally recognized tribes. Other boards share similar challenges associated with issuing licenses to tribal businesses including the Bureau of Security and Investigative Services (BSIS) and the Contractors State License Board (CSLB). SB 1454 (Ashby) and SB 1455 (Ashby) of this year would both authorize the BSIS and CSLB to issue a license to a federally recognized tribe. This bill would similarly provide a pathway for licensure for tribes that wish to be licensed by BAR.

Household Movers. Under California law, all individuals or businesses offering household moving services must obtain a permit from the Bureau of Household Goods and Services (BHGS) authorizing them to do so. Among other prerequisites, applicants for a household movers permit must meet specified residency requirements, and pass an examination as directed by the BHGS.

Prior to 2018, the household moving industry in California was regulated by the state's Public Utilities Commission (PUC). PUC code provided certain exemptions for those movers who were solely performing interstate moves, including waiving the examination requirement, and exempting them from residency requirements so long as the applicant provided an agent of service. On July 1, 2018, regulatory authority was transferred to the BHGS, but these statutory exemptions for interstate movers were not carried over. As a result, it has been harder in recent years for state regulators to reasonably administer interstate moves, and the technical clean-up in this bill has been a long-standing request from BHGS staff to better regulate interstate household movers.

Current Related Legislation.

SB 1526 (Business, Professions, and Economic Development Committee) makes numerous technical and clarifying changes to acts within the DCA. *This bill is in the Assembly.*

Prior Related Legislation.

AB 765 (Wood) of 2023 would have prohibited any person who is not a licensed physician and surgeon from using various medical specialty titles or otherwise implying that they are a physician and surgeon. *This bill died on suspense in the Assembly Committee on Appropriations.*

SB 817 (Roth) of 2023 would have recast provisions of law authorizing the BBC to charge a hairstylist license application and examination fee to require that the fee be the actual cost, not to exceed $50. *This bill was not set for a hearing in the Assembly Committee on Appropriations.*

SB 1436 (Roth, Chapter 624, Statutes of 2022) extended until January 1, 2027, the provisions establishing the RCB and makes additional technical changes and reforms in response to issues raised during the RCB's sunset review oversight process.

AB 2684 (Berman, Chapter 2684, Statutes of 2022) was the BRN's 2022 sunset review bill and, among other things, added technical, clarifying and conforming changes to the Nursing Practice Act to assist with implementation of AB 890.

AB 890 (Wood, Chapter 265, Statutes of 2020) authorized an NP to provide specified services in specified settings, without standardized procedures, if the NP meets additional education, examination, and training requirements; required the BRN to adopt regulations defining a transition to practice; required the BRN to establish a Nurse Practitioner Advisory Committee to advise and make recommendations to the BRN on NP all issues; and required the BRN and the DCA to identify or develop an examination that tests for independent practice competency.

ARGUMENTS IN SUPPORT:

Close the Provider Gap and a coalition of organizations representing nurse practitioners, hospitals, labor groups, and nonprofits write in support of this bill's provisions related to NPs: "To address the urgent health needs of our state in a sustainable and equitable manner, we must ensure NPs are able to close the provider gap. By providing clarifying guidance, SB 1451 will help streamline the application process and enable California's most experienced NPs to expand access to quality, affordable care. We must close the provider gap – the Californians we serve don't have the time to wait any longer. Through SB 1451, we can ensure our state's communities and families – especially those in health care deserts – can access the high-quality, timely care they need and deserve."

The *California Dental Hygienists' Association* (CDHA) supports this bill's provisions related to RDHAPs, writing: "It is a goal of the DHPSA designation to attract enough oral health providers to the shortage area. Prohibiting a provider from providing services in the area is counter to the legislature's goals of increasing access to oral healthcare for the underserved areas of the state. There is no harm to patients to have more than enough providers in an area. In fact, patients and consumers only benefit by having more than enough oral health providers available."

ARGUMENTS IN OPPOSITION:

The *California Medical Association* (CMA) has taken an "oppose unless amended" position on the provisions in this bill related to NPs. The CMA writes: "This bill eliminates the requirement that a nurse practitioner must complete a variation of a three-year training requirement in one of six different specialty categories. Amendments have been suggested to have this section removed or restored with a requirement to demonstrate that a nurse practitioner has completed some portion of their three years of clinical experience in a specific category before being approved for independent practice." The CMA additionally writes that the organization "is supportive of the section regarding the usage of the term doctor; updating the statute to ensure only M.D.'s and D.O.'s are using the term doctor in a health care setting."

The *American Association of Nurse Practitioners* (AANP) opposes the provisions in this bill relating to the restriction of medical terms such as "doctor," writing: "A strength of today's healthcare workforce is the growing number of healthcare providers holding doctoral and advanced graduate preparation. More than a dozen health professional disciplines –including nurse practitioners, osteopathic physicians, pharmacists, physical therapists, and psychologists— are educated at the doctoral level. The American Association of Nurse Practitioners supports the

use of the title doctor in conjunction with licensure title for doctorly prepared nurses and other health care providers in the clinical setting and advertising. California clinicians are already prohibited from falsely identifying themselves and from providing fraudulent or purposeful misinformation to patients."

REGISTERED SUPPORT:

Association of California Healthcare Districts
Bay Area Cancer Connections
Board of Barbering and Cosmetology
California Access Coalition
California Alliance of Child and Family Services
California Association for Nurse Practitioners
California Association of Alcohol and Drug Program Executives
California Association of Medical Product Suppliers
California Community Pharmacy Coalition
California Dental Hygienists' Association
California Health Collaborative
California Hospital Association
California Moving and Storage Association
California Nurses Association
Center for Inherited Blood Disorders
Chronic Disease Coalition
Close the Provider Gap
Dental Hygiene Board of California
ElderHelp
Leading Age California
Little Lobbyists
Liver Coalition of San Diego
Madera Community Hospital
Mental Health America of California
Michelle's Place Cancer Resource Center
Patient Advocates United in San Diego County
Pediatric Day Health Care Coalition
Respiratory Care Board of California
SEIU California State Council
Senior Care Clinic Medical House Calls
26 individuals

REGISTERED OPPOSITION:

American Association of Nurse Practitioners
American Nurses Association of California
California Dental Association
California Medical Association
California Nurse-Midwives Association
California Society of Dermatology & Dermatologic Surgery

California State Oriental Medical Association
Osteopathic Medical Board of California

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