SENATE COMMITTEE ON
BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
Senator Richard Roth, Chair
2023 - 2024 Regular

Bill No:	AB 470	**Hearing Date:**	June 5, 2023
Author:	Valencia		
Version:	March 13, 2023		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Sarah Mason		

Subject: Continuing medical education: physicians and surgeons

SUMMARY: Specifies how an association that accredits continuing medical education courses (CME) taken by Medical Board of California (MBC) licensed physicians and surgeons should update standards for those courses, if they choose to update any standards.

Existing law:

1) Establishes various practice acts in the Business and Professions Code (BPC) governed by various boards within the Department of Consumer Affairs (DCA) which provide for the licensing and regulation of health care professionals including physicians and surgeons (under the Medical Practice Act by MBC) and osteopathic physicians and surgeons (under the Osteopathic Medical Practice Act by the Osteopathic Medical Board of California (OMBC)), among others.

2) Authorizes MBC to establish CME standards for courses that serve to maintain, develop, or increase the knowledge, skills, and professional performance that a physician uses to provide care, or to improve the quality of care provided to patients, which must include cultural and linguistic competency and contain curriculum that includes the understanding of implicit bias. Allows educational activities accredited by the California Medical Association or Accreditation Council for Continuing Medical Education to meet CME standards. Requires associations that accredit CME courses to develop standards for compliance with CME course requirements and authorizes these associations to update standards as needed in conjunction with an advisory group with expertise in cultural and linguistic competency. (BPC § 2190.1)

3) Authorizes a MBC licensed physician and surgeon to meet CME standards and comprise up to 30 percent of their total CME hours through courses designed to provide better service to patients, including, but not limited to, the use of technology or clinical office workflow, designed to support managing a health care facility, including, but not limited to, coding or reimbursement in a medical practice, and that support educational methodology for physicians and surgeons teaching in a medical school. (BPC § 2190.15.)

4) Requires all general internists and family physicians who have a patient population of which over 25 percent are 65 years of age or older to complete at least 20 percent of all mandatory CME hours in a course in the field of geriatric medicine or the care of older patients. (BPC § 2190.3)

5) Requires all physicians and surgeons to complete a course in pain management and the treatment of terminally ill and dying patients, which must include the subject of the risks associated with the use of Schedule II drugs. Authorizes a physician and surgeon to complete a one-time course in the subjects of treatment and management of opiate-dependent patients as an alternative to the required course in pain management. (BPC §§ 2190.5 and 2190.6)

6) Requires MBC, in determining CME requirements, to consider including a course in: (BPC § 2190.1)

   a) Human sexuality and nutrition to be taken by those licensees whose practices may require knowledge in those areas.

   b) Child abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected children.

   c) Acupuncture to be taken by those licensees whose practices may require knowledge in the area of acupuncture and whose education has not included instruction in acupuncture.

   d) Nutrition, for every physician and surgeon, as part of his or her CME particularly a physician and surgeon involved in primary care.

   e) Elder abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected persons 65 years of age and older.

   f) The early detection and treatment of substance abusing pregnant women to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these women.

   g) The special care needs of drug addicted infants to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these infants.

   h) Guidelines on how to routinely screen for signs exhibited by abused women, particularly for physicians and surgeons in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. In the event the MBC establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

   i) The special care needs of individuals and their families facing end-of-life issues, including, but not limited to, pain and symptom management, the psycho-social dynamics of death, dying and bereavement and hospice care.

   j) Pain management and the risks of addiction associated with the use of Schedule II drugs.

k) Geriatric care for emergency room physicians and surgeons.

l) Integrating HIV/AIDS pre-exposure prophylaxis and post-exposure prophylaxis medication maintenance and counseling in primary care settings.

m) Integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues in children and young adults and their appropriate care and treatment.

n) Maternal mental health, which shall address best practices in screening for maternal mental health disorders, including cultural competency and unintended bias as a means to build trust with mothers; the range of maternal mental health disorders; the range of evidence-based treatment options, including the importance of allowing a mother to be involved in developing the treatment plan and; when an obstetrician or a primary care doctor should consult with a psychiatrist versus making a referral.

7) Prohibits educational activities that are not directed toward the practice of medicine, or are directed primarily toward the business aspects of medical practice, including, but not limited to, medical office management, billing and coding, and marketing from meeting the CME standards for physicians and surgeons. (BPC § 2190.1(f))

8) Requires OMBC to adopt and administer standards for the continuing education (CE) of OMBC licensed osteopathic physician and required licensees to demonstrate satisfaction of the CE as a condition for the renewal of a license at intervals of not less than one year nor more than two years. OMBC requires each licensed osteopathic physician and surgeon to complete a minimum of 50 hours of American Osteopathic Association CE hours during each two-year cycle, of which 20 hours shall be completed in American Osteopathic Association Category 1 CE hours and the remaining 30 hours shall be either American Osteopathic Association or American Medical Association accredited as a condition for renewal of an active license. Requires OMBC licensed osteopathic physicians and surgeons to complete a course on the risks of addiction associated with the use of Schedule II drugs. (BPC § 2454.5)

This bill authorizes associations that accredit CME courses to update standards, in conjunction with an advisory group that has expertise in cultural and linguistic competency issues and is informed of federal and state statutory threshold language requirements, with prioritization of languages in proportion to the state population's most prevalent primary languages spoken by 10 percent or more of the state population, as well as to ensure program standards meet the needs of California's changing demographics and properly address language disparities as they emerge.

FISCAL EFFECT: This bill is keyed fiscal by Legislative Counsel. According to the Assembly Committee on Appropriations, this bill does not have any state costs.

COMMENTS:

1. **Purpose.** This bill is co-sponsored by the California Medical Association and AltaMed. According to the Author, "existing law does not take into account the linguistic inequities that exist in our healthcare system. This bill seeks to remedy the disparity between the number of California physicians who speak foreign languages and the patient populations whose first language is not English. According to a report released by the UCLA Latino Policy and Politics Initiative, there are only 62.1 Spanish-speaking physicians per 100,000 Limited English Proficient individuals. This is a staggering statistic given that at our state has at least 10 million residents that speak Spanish. Other language groups that are underrepresented in Californian's physician workforce are Vietnamese, Thai/Lao, and Tagalog. This data suggests that there can be challenges that come with mismatching a physician and patient who do not speak the same language, or the physician is unable to speak a patient's primary language. This may result in misdiagnoses, ineffective treatments, and long-term health implications. These statistics justify the need to update current law so that our physician workforce can appropriately care for patients of diverse backgrounds."

2. **Continuing Medical Education for Physicians.** All physicians and surgeons licensed by the MBC must complete a minimum of 50 hours of approved CME during each two-year license renewal cycle. CME requirements can be met by taking a variety of approved courses. The only exception to this requirement is for a physician who takes and passes a certifying or recertifying examination administered by a recognized specialty board; the individual can be granted credit for four consecutive years of CME credit for purposes of licensure renewal. Upon renewal, physicians are required to self-certify under penalty of perjury that they have met each of the CME requirements, that they have met the conditions exempting them from all or part of the requirements, or that they hold a permanent CME waiver. MBC is authorized to audit a random sample of physicians who have reported compliance with the CME requirements for verification purposes. MBC reports that it currently audits approximately one percent of the total number of renewing physicians per year.

   Approved CME consists of courses or programs designated by the American Medical Association or the Institute for Medical Quality/California Medical Association related to patient care, community health or public health, preventive medicine, quality assurance or improvement, risk management, health facility standards, the legal aspects of clinical medicine, bioethics, professional ethics or improvement of the physician-patient relationship.

   The only specifically required courses are a one-time, 12-hour training in pain management and the treatment of terminally ill patients, and a requirement that general internists and family physicians whose patient populations are over 25% 65 years of age and older must take at least 20% of their continuing education in the field of geriatric medicine. However, all approved continuing medical education courses must contain curriculum that includes cultural and linguistic competency in the practice of medicine and the understanding of implicit bias.

Cultural and Linguistic Competency. Since 2006, all CME courses approved by accrediting associations have been required to have standards to ensure compliance with a requirement under the Medical Practice Act that the courses contain curriculum that includes cultural and linguistic competency in the practice of medicine. However, the author and sponsors of this bill argue that current standards to not adequately promote education in underrepresented languages. The intent of this bill is to improve the ability of physicians to communicate with patients for whom English is not their primary language.

This bill would require the accrediting associations to update their program standards to ensure they meet the needs of California's changing demographics and properly address language disparities, as they emerge. The associations would be required to consult with an advisory group that has expertise in cultural and linguistic competency issues and is informed of federal and state statutory threshold language requirements. The bill also generally emphasizes the quality of physician-patient communication by adding reference to that priority in its listing of possible criteria for educational activities that meet continuing education standards.

3. **Arguments in Support.** Supporters note that language barriers between physicians and patients can lead to barriers in receiving quality health care and could potentially lead physicians to make harmful medical errors if they cannot communicate with their patients in a culturally and linguistically competent manner. They believe that this bill will reaffirm the importance of cultural competency and language fluency by encouraging physicians to take foreign language courses that are offered through CME providers. According to supporters, with such a wide variety of ethnic, racial, and religious backgrounds, it is critical that healthcare professionals can communicate with their patients clearly and effectively in a manner that is culturally appropriate and in the proper language. Similarly, patients should be able to receive the medical care they need without having to overcome language barriers.

4. **Clarifying Amendment.** Current law *authorizes* associations that accredit CME to updates standards in conjunction with advisory group, rather than mandates that standards be updated and that the process include an advisory group. This bill specifies requirements for a permissive activity.

   There is no guarantee that a CME accreditor will update standards to comply with CME laws and requirements, so this bill merely suggests what an entity has to do should they *choose* to update standards. There is also no enforcement mechanism to make certain that CME standards updates will include collaboration with an advisory group and will be updated to "meet the needs of California's changing demographics and properly address language disparities" as this bill intends. In order to achieve the goals and stated purpose, and to actually impose a requirement, the Author should consider amending the bill to strike "may" and replace it with "shall" to ensure that when standards are updated, that process will actually "remedy the disparity between the number of California physicians who speak foreign languages and the patient populations whose first language is not English", as the Author indicates the measure seeks to do.

   On page 3, in line 10, strike "may" and replace with "shall"

Associations that accredit continuing medical education courses shall develop standards before July 1, 2006, for compliance with the requirements of paragraph (1). The associations ~~may~~ ***shall*** update these standards, as needed, in accordance with the following requirements:
(A) The standards shall be updated in conjunction with an advisory group that has expertise in cultural and linguistic competency issues and is informed of federal and state statutory threshold language requirements, with prioritization of languages in proportion to the state population's most prevalent primary languages spoken by 10 percent or more of the state population.
(B) The standards shall be updated to ensure program standards meet the needs of California's changing demographics and properly address language disparities, as they emerge.

SUPPORT AND OPPOSITION:

Support:

Altamed Health Services
Altamed Health Services Corporation
California Academy of Family Physicians
California Commission on Aging
California Health+Advocates, a subsidiary of The California Primary Care Association
California Medical Association
California Rheumatology Alliance
California Society of Anesthesiologists
California State Association of Psychiatrists
Kaiser Permanente
Medical Board of California
National Latino/a Physician Day

Opposition:

None received

-- END --