sors must review and evaluate the RPE applicant's performance on a monthly basis for the purpose of improving his/her professional expertise. The RPE supervisor must discuss the evaluations with the applicant and maintain written documentation of these evaluations. The written evaluations shall be signed by both the RPE supervisor and the RPE applicant. If the supervisor determines the applicant is not minimally competent for licensure, the applicant must be so informed orally and in writing. A written statement documenting the basis for the supervisor's determination shall be submitted with the final verification of experience to SPAEC.

Finally, SPAEC seeks to amend section 1399.180, which identifies acts constituting unprofessional conduct. SPAEC plans to repeal subsection (c), which classifies as unprofessional conduct "[d]iagnosing or treating individuals for speech-language or hearing disorders by mail or telephone unless the individual has been previously examined by the licensee and the diagnosis or treatment is related to such examination." In its statement of reasons, the Committee stated that "[m]andating that a licensee personally examines each individual is unnecessarily restrictive and expensive for consumers. Current technology in speech-language pathology and audiology render this regulation as unnecessarily restrictive."

At this writing, the Committee is scheduled to hold a public hearing on these proposed regulatory changes on June 25.

**SPAEC Implements Citation and Fine Program.** At the Committee's January 16 and March 20 meetings, Executive Officer Carol Richards updated SPAEC on the implementation of the Committee's citation and fine program, which became effective as of March 1 and permits the Executive Officer to assess administrative citations against licensees and nonlicensees for minor violation of the Committee's enabling act and regulations. *[11:1 CRLR 79; 10:1 CRLR 85–86]* Category A violations, which may carry a fine ranging from $1,100–$2,500, include unlicensed practice and unprofessional conduct substantially related to the functions of a licensee. Category B violations, which may carry a fine ranging from $100–$1,000, include false and misleading advertising and failure to register an RPE candidate or aide. Richards issued three citations during March and April, two of which were for unlicensed practice. SPAEC is also pursuing twelve enforcement actions, which are pending at various stages of review and/or investigation.

## LEGISLATION

**AB 1392 (Speier)**, as amended April 4, would require SPAEC to notify DCA whenever any complaint has gone thirty days without any investigative action, and would require the DCA Director to determine when a backlog of complaints justifies the use of DCA staff to assist in complaint investigation. *[A. Floor]*

**SB 993 (Kelley)**, as introduced March 5, would state the intent of the legislature that all legislation becoming effective on or after January 1, 1995, which either provides for the creation of new categories of health professionals who were not required to be licensed on or before January 1, 1994, or revises the scope of practice of an existing category of health professional, be supported by expert data, facts, and studies, including prescribed information, and be presented to all legislative committees hearing the legislation prior to its enactment. *[S. B&P]*

**SB 842 (Presley)**, as amended May 13, would permit SPAEC to issue interim orders of suspension and other license restrictions, as specified, against its licensees. (*See* agency update on DCA for more information.) *[A. CPGE&ED]*

## RECENT MEETINGS

SPAEC elected its 1993 officers at its January 16 meeting. Speech-language pathologist Robert E. Hall was reelected Committee Chair, and audiologist Gail Hubbard was elected Vice-Chair.

At its March 20 meeting, SPAEC discussed structural changes taking place within the Medical Board and DCA. Most importantly, the Medical Board appeared on the verge of approving a proposal to abolish its Division of Allied Health Professions (DAHP), of which SPAEC is a constituent allied health licensing program. Uncertainty about the fate of SPAEC if DAHP is eliminated caused members to direct staff to closely monitor these discussions. [*Editor's Note:* At its May meeting, the Medical Board voted to seek legislation abolishing DAHP; *see* agency report on MBC for related discussion.]

Also in March, SPAEC heard a presentation by Dr. Norman Hertz of DCA's Central Testing Unit (CTU) regarding an occupational analysis of speech-language pathology and audiology. Such an analysis would determine the actual scope of practice of speech-language pathologists and audiologists, for the purpose of validating existing licensing examinations and possibly for the purpose of creating a new oral exam for SPAEC. Dr. Hertz explained that an occupational analysis would cost approximately $20,000 and take one year to complete. SPAEC approved a motion to pursue an occupational analysis.

## FUTURE MEETINGS

October 8 in Sacramento.
January 7 in San Diego.
April 22 in Sacramento.

# BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

*Executive Officer: Ray F. Nikkel*
*(916) 263-2685*

Pursuant to Business and Professions Code section 3901 *et seq.*, the Board of Examiners of Nursing Home Administrators (BENHA) develops, imposes, and enforces standards for individuals desiring to receive and maintain a license as a nursing home administrator (NHA). The Board may revoke or suspend a license after an administrative hearing on findings of gross negligence, incompetence relevant to performance in the trade, fraud or deception in applying for a license, treating any mental or physical condition without a license, or violation of any rules adopted by the Board. BENHA's regulations are codified in Division 31, Title 16 of the California Code of Regulations (CCR). Board committees include the Administrative, Disciplinary, and Education, Training and Examination Committees.

The Board consists of nine members. Four of the Board members must be actively engaged in the administration of nursing homes at the time of their appointment. Of these, two licensee members must be from proprietary nursing homes; two others must come from nonprofit, charitable nursing homes. Five Board members must represent the general public. One of the five public members is required to be actively engaged in the practice of medicine; a second public member must be an educator in health care administration. Seven of the nine members of the Board are appointed by the Governor. The Speaker of the Assembly and the Senate Rules Committee each appoint one member. A member may serve for no more than two consecutive terms.

At its February 9 meeting, BENHA welcomed two new members recently appointed by Governor Wilson. Jon Pynoos, Ph.D., is a professor at the Andrus Gerontology Center at the University of Southern California. Orrin Cook, MD, is a retired plastic surgeon and former medical

administrator and vice-president for medical affairs at Sutter Health in Sacramento.

## MAJOR PROJECTS

**RCFE Administrator Licensing/Certification Program Update.** At its February 9 and April 28 meetings, BENHA continued its discussion of the possible transfer of the residential care facility for the elderly (RCFE) administrator certification program from the Department of Social Services (DSS) to BENHA. *[13:1 CRLR 58]* Board member Nancy Campbell reported that she, Board member Stroube Richardson, Executive Officer Ray Nikkel, and two representatives of the Department of Consumer Affairs (DCA) met with several DSS officials during the first week of March. As nothing significant resulted from this meeting, and as public comments received at two hearings last fall from residential care representatives were generally opposed to any transfer of responsibility for the RCFE administrator certification program from DSS to BENHA, Campbell stated the Board should decide whether it wants to pursue this matter.

At the Board's April meeting, staff noted that it had recently received 500 form letters from members of the Community Residential Care Association of California, all opposing the transfer. However, Board member Dr. Jon Pynoos stated that, due to pending changes regarding federal and state reimbursement for elder care and other factors, more and more people may be forced into the residential care option. He opined that BENHA should play a role in the regulation of RCFEs, stating that a regulatory body should serve the interests of the elderly by ensuring that RCFE staff have adequate training to recognize which residents can benefit from "assisted living" or residential care-type facilities, and which would be better served in a skilled nursing home. Board member Dr. Orrin Cook suggested that Executive Officer Nikkel look into the financial aspects of the transfer more closely and report back to the Board. BENHA took no action on this matter.

**Long-Term Care Demonstration Project.** At BENHA's February and April meetings, Ray Nikkel reported on his ongoing participation in the Quality of Long-Term Care Demonstration Project being sponsored by the Medical Board of California (MBC) and the Department of Aging's Ombudsman Program. *[13:1 CRLR 58]* Nikkel stated that the participants had proposed five recommendations to improve communication between health profession regulatory agencies and the Ombudsman and the quality of long-term care (LTC) provided to residents/patients:

(1) each regulatory agency should develop and annually update a packet of information for distribution to the Ombudsman which will assist the Ombudsman's staff in dealing appropriately with quality of care issues for residents in LTC facilities;

(2) the Ombudsman should be added to the mailing list of all the participant regulatory agencies, so that changes in agency licensees' scope of practice, policies, procedures, or standards related to health professional practice or facility licensing can be distributed to Department of Aging staff when they relate to LTC personnel or facilities;

(3) the Medical Board's regional Medical Quality Review Committees (MQRCs) should be used to assist LTC facilities and local Ombudsman staff in locating physicians willing to provide care to residents in LTC facilities, provide peer review counseling to physicians who are not providing adequate follow-up care to their LTC patients/residents, and participate in the review of the appropriateness of a physician's service to LTC residents in disputed cases or when a regulatory agency needs the assistance of a practicing physician from the community;

(4) each regulatory agency involved in the LTC Project should provide information to its licensees, at least annually, about issues affecting the care of residents in LTC facilities; and

(5) the Ombudsman should convene a meeting of representatives from the regulatory agencies every six months for a two-year period to monitor the effectiveness of the Project's referral system and modify it as needed.

At BENHA's April meeting, Board members Dr. Pynoos and Dr. Cook agreed that physicians often display a lack of responsiveness to the needs of LTC facility residents, and that recommendation (3) above does not seem to adequately address this concern. *[9:2 CRLR 38–39, 60]* These observations appear particularly well-taken inasmuch as the Medical Board is considering the possible abolition of its MQRCs (*see* agency report on MBC for related discussion).

**Examination and Enforcement Statistics.** The pass rate for the January 14 state NHA exam was 73%; the national pass rate was 63%.

From December 1, 1992 to March 31, 1993, the Department of Health Services (DHS) referred to BENHA four "AA" violations and 86 "A" violations by nursing homes. Violations designated "AA" are facility violations which lead to a patient's death; "A" violations are those that seriously endanger a patient's safety with a substantial probability of death or serious bodily harm. During those four months, BENHA conducted one formal telephone counseling session with NHAs, 13 informal telephone counseling sessions, and requested two accusations against NHAs' licenses.

## LEGISLATION

**AB 1139 (Epple).** Existing law authorizes an attending physician and a skilled nursing or intermediate care facility to initiate a medical intervention, that requires the informed consent of the patient, for a resident of that facility when the physician has determined that the resident lacks the capacity to provide informed consent and after the facility conducts an interdisciplinary team review, as described, of the prescribed medical intervention. Under existing law, this authority expires on January 1, 1995. As amended April 22, this bill would require the state Department of Health Services to convene a committee of specified composition to assess the need for changes to the process for the initiation of medical intervention for the above-described long-term health care facility residents. This bill would require the committee to make recommendations to the legislature regarding any identified changes to be made to that process by January 1, 1995. *[A. W&M]*

**AB 1807 (Bronshvag),** as amended May 3, would revise the timing of renewals of NHAs' licenses to provide for biennial expiration of licenses on the last day of the birth month of the licensee in each even-numbered year. *[A. W&M]*

**SB 832 (Presley),** as amended April 13, would permit BENHA to issue interim orders of suspension and other license restrictions against its licensees. *[A. CPGE&ED]*

**SB 432 (Greene).** Existing law generally requires every prescription for a controlled substance classified in Schedule II to be in writing. One exception to this general requirement is when failure to issue a prescription for a controlled substance classified in Schedule II to a patient in a licensed skilled nursing facility, an intermediate care facility, or a licensed home health agency providing hospice care would, in the opinion of the prescriber, present an immediate hazard to the patient's health and welfare or result in intense pain and suffering to the patient; under these circumstances, the prescription may be dispensed upon an oral prescription. As amended May 19, this bill would instead provide that any order for a Schedule II controlled substance in a licensed skilled nursing facility, intermediate health care facility, or a licensed home

health agency providing hospice care may be dispensed upon an oral prescription. *[S. Jud]*

## FUTURE MEETINGS

To be announced.

# BOARD OF OPTOMETRY

*Executive Officer: Karen Ollinger (916) 323-8720*

Pursuant to Business and Professions Code section 3000 *et seq.*, the Board of Optometry is responsible for licensing qualified optometrists and disciplining malfeasant practitioners. The Board establishes and enforces regulations pertaining to the practice of optometry, which are codified in Division 15, Title 16 of the California Code of Regulations (CCR). The Board's goal is to protect the consumer patient who might be subjected to injury resulting from unsatisfactory eye care by inept or untrustworthy practitioners. The Board consists of nine members—six licensed optometrists and three public members.

## MAJOR PROJECTS

**Board Proposes Regulatory Changes.** At its February 18 meeting, the Board authorized staff to commence the rulemaking process to amend sections 1502 (delegation of functions), 1510 (professional inefficiency), and 1535 (examination results), and to adopt new sections 1566 (release of prescriptions: notice required), Division 15, Title 16 of the CCR.

Section 1502 currently delegates and confers upon the Board Secretary or, in his/her absence from the Board's office, the Executive Officer, enforcement-related functions involving the filing of accusations, issuing notices of hearings, statements to respondents, statements of issues, and other powers and duties conferred by law to the Board. The Board's proposed amendment would delete the role of the Board Secretary in these matters, and instead delegate those enforcement functions to the Board's Executive Officer.

Business and Professions Code section 3090 authorizes the Board to revoke or suspend an optometrist's certificate of registration for unprofessional conduct, gross ignorance, or inefficiency in his/her profession. Proposed amendments to section 1510 would provide that—among other things—inefficiency in the profession is indicated by the failure to inform any patient for whom treatment is prescribed, in terms understandable to that patient (or legal guardian, if appropriate), of the risks and benefits of the treatment.

Currently, the Board requires applicants examination for certificates of registration as optometrists to successfully complete the National Board Examination in Optometry as a condition of eligibility to take the Board's examination. Proposed amendments to section 1535 would provide that applicants for licensure must successfully complete the National Board Exam, the Board's practical exam, and the Board's law exam, and that applicants may fulfill these requirements in any sequence. However, the amendment states that in no case shall the total period in which the requirements are met exceed five years.

Finally, proposed new section 1566 would provide that each optometry office shall post in a conspicuous place a notice which clearly states the legal requirements and office policy regarding the release of eyeglass and contact lens prescriptions. *[13:1 CRLR 59]* The Board published notice of its intent to pursue these regulatory changes and, at this writing, is scheduled to hold a public hearing on the proposals on May 20 in San Diego.

In other rulemaking action, the Board decided at its February meeting not to attempt to overrule Department of Consumer Affairs (DCA) Director Jim Conran's rejection of its proposed amendments to section 1533 and repeal of section 1533.1, which would abolish the Board's examination appeal process. *[13:1 CRLR 59]* Instead, the Board will work with DCA's Central Testing Unit to arrive at an acceptable examination appeal process.

**UCLA Optometry Refresher Course Update.** The final segment of the optometry refresher course, designed by the Board in conjunction with UCLA, concluded in April. *[13:1 CRLR 60; 12:4 CRLR 114]* Students completing both the first segment on basic science and the second clinical segment participated in a May graduation ceremony at UCLA. Funding for the course was earmarked by the state for just one year; at this writing, there are no plans to repeat the course.

**Disclaimer Planned for Continuing Education.** At its February 18–19 meeting, the Board agreed to require all continuing education (CE) providers to provide a written or oral disclaimer clarifying whether participation in the course is for "information only," or whether the course qualifies the individual to perform a certain procedure. In recent disciplinary actions, optometrists have contended that they believed a particular procedure was within the scope of optometry in California because it was the subject of a Board-approved CE course. The disclaimer would clarify that participants in CE classes retain personal responsibility to verify whether state law allows the individual to include the procedure in his/her practice.

## LEGISLATION

**AB 1894 (Polanco)**, as introduced March 5, would authorize ancillary personnel who work under the supervision of an optometrist to assist in the preparation of the patient and the preliminary collection of data. The bill would prohibit an optometrist from permitting ancillary personnel to collect data requiring the exercise of professional judgment or skill of an optometrist, perform any subjective refraction procedures, contact tonometry, data analysis, or diagnosis, or prescribe and determine any treatment plan. *[A. Health]*

**AB 2020 (Isenberg)**, as amended May 19, would provide that the practice of optometry includes, among other things, the examination of the human eye, or its appendages and adnexa, and the analysis and diagnosis of conditions of the human vision system, either subjectively or objectively. This bill would delete an existing requirement that the Board designate pharmaceutical agents which may be used by optometrists in examining the human eye and instead authorize the use of specified diagnostic pharmaceutical agents. It would also authorize the use, prescribing, and dispensing of specified therapeutic pharmaceutical agents to a patient by an optometrist for the purposes of treating the human eye, or its appendages or adnexa, for any disease or pathological condition by an optometrist who meets specified requirements. The bill would establish a seven-member pharmaceutical advisory committee with a prescribed membership to provide advice to the Board as to the use of diagnostic and therapeutic agents. Under this bill, only optometrists who meet several examination and training requirements and agree to accept Medi-Cal patients are permitted to use, dispense, or prescribe therapeutic pharmaceutical agents. AB 2020 would also make it a misdemeanor for any person licensed as an optometrist to refer a patient to a pharmacy that is owned by the licensee or in which the licensee has proprietary interest. This bill is sponsored by the California Optometric Association and is opposed by the California Medical Association. *[A. Floor]*

**SB 908 (Calderon)**, as introduced March 4, would provide that the terms "license" and "certificate of registration"