California State Board of Optometry
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DEPARTMENT OF CONSUMER AFFAIRS • CALIFORNIA STATE BOARD OF OPTOMETRY
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ISSUE MEMORANDUM

DATE	December 8, 2023
TO	Board Members, California State Board of Optometry (CSBO)
FROM	Gregory Pruden, Executive Officer
SUBJECT	Agenda Item #8 – Discussion and Possible Action on 2023 Legislation

Background and Update:
Presented below are the bills the board took positions on during 2023.

A. AB 1028 (McKinnor) Reporting of crimes: mandated reporters

Status: Amended 6-28-2023 / Senate Appropriations Committee.

AUTHOR REASON FOR THE BILL:
According to the Author: "AB 1028 will ensure survivors can access healthcare services by creating a survivor-centered, trauma-informed approach and limit non-consensual and potentially dangerous referrals to law enforcement. In addition, if a health provider knows or suspects a patient is experiencing any kind of domestic and sexual violence, not just physical, they will be required to offer a referral to a local domestic violence and sexual violence advocacy program or the National Domestic Violence hotline. This change will increase access to healthcare and ensure that survivors are provided the agency and information they need to be safe and healthy."

DESCRIPTION OF CURRENT LEGISLATION:
This bill would, on and after January 1, 2025, limit a health practitioner's duty to make a report of injuries to law enforcement to instances where: the injury is by a firearm, either self-inflicted; where the wound or physical injury was the result of child abuse; or where the wound or physical injury was the result of elder abuse. This bill also requires a health care practitioner, who in their professional capacity or within the scope of their employment, knows or reasonably suspects that their patient is experiencing any form of domestic violence or sexual violence, to provide brief counseling and offer a referral to domestic violence or sexual violence advocacy services before the end of the patient visit, to the extent that it is medically possible.

BACKGROUND:
This bill is a reintroduction of AB 2790 (Wicks), which was held in the Senate Appropriations Suspense File. Supporters argue existing mandating reporting law

dissuades many victims from seeking medical care or sharing information with health practitioners to avoid law enforcement involvement. Opponents argue the bill would lead to more domestic violence and have serious consequences.

ANALYSIS:
Under existing law, health practitioners employed by health facilities and other settings are required to report certain information to law enforcement officers. These reports are mandatory if the practitioner suspects that a patient has suffered a physical injury that is either self-inflicted, caused by a firearm, or caused by assaultive or abusive conduct. This bill would maintain mandatory reporting requirements for self-inflected or firearm injuries, child abuse, and elder abuse, but beginning January 1, 2025, it would eliminate the reporting requirements for suspected domestic violence or sexual violence. In its place, health practitioners who know or reasonably suspect that a patient is the victim of domestic or sexual violence would instead be required to provide brief counseling, education, or other support to the degree that is medically possible for the patient. They must also offer a warm handoff or referral to domestic or sexual violence advocacy services. Practitioners could satisfy this requirement by connecting the patient with a survivor advocate, either in-person or via a call, or sharing information with the patient about how to get in touch with such organizations and letting patients know how they can help.

Practitioners would not need to personally provide a handoff or referral, as the requirements would be met if such services are offered by a member of the health care team at the facility. Although this bill would eliminate mandatory reporting in many instances, it would still allow health practitioners to make a report to law enforcement if they believe it is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or the public. They could also make a report if they have the patient's consent.

UPDATE:
The bill was held on the Senate Appropriations Suspense File.

FISCAL:
None

BOARD POSITION:
Neutral.

Action Requested:

None.

Attachment 1: Senate Public Safety Committee Analysis
Attachment 2: Bill text

SENATE COMMITTEE ON PUBLIC SAFETY

Senator Aisha Wahab, Chair
2023 - 2024 Regular

Bill No:	AB 1028	**Hearing Date:**	July 11, 2023
Author:	McKinnor		
Version:	June 28, 2023		
Urgency:	No	**Fiscal:**	Yes
Consultant:	MK		

Subject: ***Reporting of crimes: mandated reporters***

HISTORY

Source: Futures Without Violence
California Partnership to End Domestic Violence
Alliance for Boys and Men of Color
UC Irvine Domestic Violence Law Clinic

Prior Legislation: AB 2790 (Wicks) Held in Sen Approps. 2022

Support: A Safe Place; ACLU California Action; California Academy of Family Physicians; California Consortium for Urban Indian Health; California Faculty Association; California Health+ Advocates: California Nurse Midwives Association; California State Council of Service Employees International Union (SEIU California); Center for Community Solutions; Coalition to Abolish Slavery & Trafficking (CAST); Communities United for Restorative Youth Justice (CURYJ); Community Resource Center; Community Solutions for Children, Families, and Individuals; Culturally Responsive Domestic Violence Network (CRDVN); Deafhope; Dignity and Power Now; Ella Baker Center for Human Rights; Empower Yolo; Family Violence Appellate Project; Family Violence Law Center; FreeFrom; Immigrant Legal Resource Center (UNREG); Initiate Justice (UNREG); Jenesee Center; Korean American Family Services, INC (KFAM); LA Defensa; Los Angeles LGBT Center; MILPA; National Association of Social Workers, California Chapter; Prevention Institute; Psychiatric Physicians Alliance of California; Safe Alternatives to Violent Environments; Strong Hearted Native Women's Coalition, INC.; The Collective Healing and Transformation Project; Woman INC; Youth Leadership Institute

Opposition: Arcadia Police Officers' Association; Board of Registered Nursing; Burbank Police Officer's Association; California District Attorneys Association; California Reserve Peace Officers Association; Claremont Police Officers Association; Corona Police Officers Association; Culver City Police Officers' Association; Deputy Sheriffs' Association of Monterey County; Fullerton Police Officers' Association; Grossmont Healthcare District; Los Angeles School Police Officers Association; Murrieta Police Officers' Association; Newport Beach Police Association; Novato Police Officers Association; Palos Verdes Police Officers Association; Placer County Deputy Sheriffs' Association; Pomona Police Officers' Association; Riverside Police Officers Association; Riverside Sheriffs' Association; San Diegans Against Crime; San Diego County District Attorney's Office; San Diego Deputy District Attorneys Association; Santa Ana Police

Officers Association; Upland Police Officers Association; Ventura County Office of the District Attorney; California Sexual Assault Forensic Examiner Association (unless amended); Multiple individuals

Assembly Floor Vote: 45 - 17

PURPOSE

***The purpose of this bill is to eliminate the duty of a health care practitioner to report assaultive or abusive conduct to law enforcement and instead requires the provider to refer the patient to supportive services*.**

Existing law requires a health practitioner, as defined, to make a report to law enforcement when they suspect a patient has suffered physical injury that is either self-inflicted, caused by a firearm, or caused by assaultive or abusive conduct, as specified. (Penal Code § 11160.)

Existing law punishes the failure of a health care practitioner to submit a mandated report by imprisonment in a county jail not exceeding six months, or by a fine not exceeding $1,000, or by both. (Penal Code § 11162)

Existing law provides that a health practitioner who makes a report in accordance with these duties shall not incur civil or criminal liability as a result of any report. (Penal Code § 11161.9 (a))

Existing law states that neither the physician-patient privilege nor the psychotherapist patient privilege apply in any court or administrative proceeding with regards to the information required to be reported. (Penal Code § 11163.2)

This bill limits a health practitioner's duty to make a report of injuries to law enforcement to instances where: the injury is by a firearm, either self-inflicted; where the wound or physical injury was the result of child abuse; or where the wound or physical injury was the result of elder abuse.

This bill requires a health care practitioner, who in their professional capacity or within the scope of their employment, knows or reasonably suspects that their patient is experiencing any form of domestic violence or sexual violence, to provide brief counseling and offer a referral to domestic violence or sexual violence advocacy services before the end of treatment, to the extent that it is medically possible.

This bill provides that the health practitioner shall have met the requirement when the brief counseling, education, or other support is provided and warm hand off or referral is offered by a member of the health care team.

This bill provides that if the health practitioner is providing medical services to the patient in the emergency department of a hospital, they shall also offer assistance to the patient in accessing a forensic evidentiary exam or reporting to law enforcement, if the patient wants to pursue these options.

This bill provides that a health practitioner may offer a warm hand off and referral to other available services including legal aid and community based services.

This bill provided that to the extent possible, health practitioners shall document all nonaccidental violent injuries and incidents of abuse in the medical record.

This bill provides that nothing limits or overrides the ability of a health care practitioner to alert law enforcement to an imminent or serious threat to health or safety of an individual or the public, pursuant to the privacy rules of HIPAA.

This bill defines "warm handoff" may include but is not limited to, the health practitioner establishing direct and live connection through a call with survivor advocate, in-person on site survivor advocate, in-person on-call survivor advocate, or some other form of tele-advocacy.

This bill provides the patient may decline the "warm hand-off".

This bill provides that "referral" may include, but is not limited to, the health practitioner sharing information about how a patient can get in touch with a local or national survivor advocacy organization, information about how the survivor advocacy organization information about how the survivor organization could be helpful for the patient, what the patient could expect when contacting the survivor organization, the survivor advocacy organizations contact information.

This bill contains findings and declarations.

This bill provides that a health practitioner shall not be civilly or criminally liable for acting in compliance with this section for any report that is made in good faith compliance with state law.

This bill makes conforming cross-references.

COMMENTS

1. Need for This Bill

According to the author:

> AB 1028 will ensure survivors can access healthcare services by creating a survivor-centered, trauma-informed approach and limit non-consensual and potentially dangerous referrals to law enforcement. In addition, if a health provider knows or suspects a patient is experiencing any kind of domestic and sexual violence, not just physical, they will be required to offer a referral to a local domestic violence and sexual violence advocacy program or the National Domestic Violence hotline. This change will increase access to healthcare and ensure that survivors are provided the agency and information they need to be safe and healthy.

2. Health Care worker: mandate reporters

Penal Code section 11160 requires a health care practitioner who treats a person brought in to a health care facility or clinic who is suffering from specified injuries to report that fact immediately, by telephone and in writing, to the local law enforcement authorities. The duty to report extends to physicians and surgeons, psychiatrists, psychologists, dentists, medical residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, marriage and family therapists, clinical social workers, professional clinical counselors,

emergency medical technicians, paramedics, and others. The duty to report is triggered when a health practitioner knows or reasonably suspects that the patient is suffering from a wound or other physical injury that is the result of assaultive or abusive conduct caused by another person, or when there is a gunshot wound or injury regardless of whether it self-inflicted or one cause by another person. Health practitioners are required to report if these triggering conditions are met, regardless of patient consent. Failure to make the required report is a misdemeanor.

This bill would eliminate the duty of a health care practitioner to report known or suspected assaultive or abusive conduct and instead provide that they should, whenever medically possible, refer the person to provide the person with counseling, a warm handoff, or a referral to local domestic violence services.

According to the background provided by the author, "[i]n a 2020 survey done by the National Domestic Violence Hotline of survivors who had experienced mandated reporting, 83.3% of survivors stated mandatory reporting made the situation much worse, somewhat worse, or did nothing to improve the DV situation. 27% of callers reported that they did not seek healthcare because of mandatory reporting requirements". A report by Futures Without Violence, a co-sponsor of this bill, notes with regards to mandated reporting laws:

> Most U.S. states have enacted mandatory reporting laws, which require the reporting of specified injuries and wounds, and very few have mandated reporting laws specific to suspected abuse or domestic violence for individuals being treated by a health care professional. Mandatory reporting laws are distinct from elder abuse or vulnerable adult abuse and child abuse reporting laws, in that the individuals to be protected are not limited to a specific group, but pertain to all individuals to whom specific health care professionals provide treatment or medical care, or those who come before the health care facility. The laws vary from state-to-state, but generally fall into four categories: states that require reporting of injuries caused by weapons; states that mandate reporting for injuries caused in violation of criminal laws, as a result of violence, or through non-accidental means; states that specifically address reporting in domestic violence cases; and states that have no general mandatory reporting laws.

(*Compendium of State and U.S. Territory Statutes and Policies on Domestic Violence and Health Care*, Fourth Ed. 2019 at pp.2-3, available https://www.futureswithoutviolence.org/wp-content/uploads/Compendium-4th-Edition-2019-Final.pdf.)

It should be noted that the duty to report known or suspected child abuse and neglect under the Child Abuse and Neglect Reporting Act, is separate from a health care practitioner's duty to report injuries generally. (See Penal Code § 11164 et. seq.) This bill does not eliminate the duty of health care practitioners under that Act. Similarly, the duty to report known or suspected abuse of an elder or a dependent adult is also separate from a health care provider's general duty to report injury. (See Welfare & Inst. Code,§ 15360.) This bill also does not eliminate the duty of health care practitioners under those provisions of law.

3. Prior Legislation

This bill is almost identical to AB 2790 (Wicks) which passed this Committee 4-1 in June 2022. The bill was subsequently held in Senate Appropriations Committee.

4. Argument in Support

A number of organizations that support this bill state:

> On behalf of Futures Without Violence, the Alliance for Boys and Men of Color, UC Irvine Law, the Culturally Responsive Domestic Violence Network, the California Partnership to End Domestic Violence and the Los Angeles LGBT Center, I write today as co-sponsors in support of Assembly Bill 1028 (McKinnor). This important legislation will modernize California's medical mandated reporting law for adult violent injuries to better ensure safety and healthcare access for survivors of domestic, sexual, and interpersonal violence. *This bill is a priority policy for our organizations this year.*
>
> Because domestic and sexual violence often remove one's ability to exercise control over their life, advocates help survivors achieve safety and healing by supporting their self-determination and empowerment. Not only does medical mandated reporting replicate harmful coercive patterns over survivors' lives, it puts them in greater danger: according to a study of callers to National Domestic Violence Hotline, **51% of survivors who had experienced mandatory reporting stated that it made their situations *much worse***, and another 32% stated that it either made things worse or did not help them at all.
>
> Domestic and sexual violence have been shown to be associated with increased risk of many health issues. Unfortunately, we have seen the ways in which medical mandated reporting requirements have kept survivors from seeking necessary healthcare in the first place, made survivors feel like they could never return to healthcare after they learned of the requirement, or made them feel like they could not share the reason for or extent of certain injuries or health issues with their provider.
>
> Not only does mandated reporting to law enforcement of adult domestic and sexual violence injuries create a barrier to healthcare, but medical mandated reporting to law enforcement can result in the escalation of abuse, survivors themselves being criminalized, exposure to immigration detention or deportation, undue child welfare involvement that separates children from abused parents, and more. Although a well-intentioned attempt to ensure domestic and sexual violence is taken seriously as a health issue, there is no research that suggests that medical mandated reporting requirements result in positive safety outcomes for survivors. Survivors in California deserve to be able to access trauma-informed healthcare separately from law enforcement. Domestic and sexual violence advocates are specifically trained to help survivors more safely access the criminal and civil legal systems should they want to. Because AB 1028 will require health providers to offer a warm hand off and referral to an advocacy organization, advocates will be able to respond before violence escalates. A warm and informed connection to confidential advocacy services will allow survivors to address their many different

safety needs - from crisis intervention to emergency housing to legal support - in an on-going and trauma-informed way.

5. Argument in Opposition

The San Diego County District Attorney's Office opposes this bill stating:

> The current mandated reporting law is a safety net for victims of domestic violence when their abuser is so controlling that they do not want to call for help themselves. The current laws establish a minimum standard of care for health care providers and recognize that without intervention, violence often escalates in both frequency and severity result in repeat visits to healthcare systems or death.
>
> Health care providers serve as gatekeepers to identify and report abuse where the family members and the abused themselves may not. These reporting laws ensure that a victim is protected, even if the abuser stands in the lobby of the hospital, demanding the victim lie about the abuse. A physician is duty bound to report suspicious injuries under the current law if they reasonably suspect the injuries were as a result of "abusive or assaultive conduct." This current language is broad enough, yet specific enough, and encompasses enough of the dangerous conduct that we as a society want "checked" on by a larger community response including law enforcement, advocacy services, and social services.
>
> California has long protected it's most vulnerable by legislating mandated reporting for domestic violence and child abuse, and more recently elder abuse. This bill *eliminates* physician-mandated reporting for any physical injury due to domestic violence other than the small percentage of domestic violence cases that result in injuries from firearms. This means that domestic violence victims who are bruised, attacked, stabbed, strangled, tortured, or maimed or are injured with weapons other than firearms, would not receive the current protection the law affords.
>
> Additionally, the bill doesn't follow California's trend of *broadening* the duty to report and protect our most vulnerable victims. We have mandated reporting for child abuse, mandated reporting for domestic violence, and mandated reporting for elder abuse. The elder abuse mandated reporting laws previously only required reports of report physical abuse, but they have expanded to financial and mental abuse, neglect, and isolation. This progression shows California is *more* protective of its vulnerable, not less. Why would we go backwards?
>
> An example of how this bill would drastically diminish the victim voice includes the following: imagine an attempted murder case where a domestic violence abuser strangled the victim to the point of unconsciousness and stabbed the victim repeatedly and brings the victim to the hospital, hovers over the victim, directs the victim what to do and say, not to report that it was abuse, either impliedly or expressly, and silences the victim even in the lobby of the emergency room. This bill would leave this victim with no protection by the health care provider who stands at the ready to help and report the suspicious injuries to law enforcement when that victim says, "I don't know who did this to me."

My county is the second largest in the state, and the 4th largest District Attorney's office in the nation. We see roughly 17,000 domestic violence incidents per year, and a subset of those only come to our attention because of the good work of health care providers doing their duty to report suspicious injuries. Domestic violence is already one of the most under reported crimes because of the dynamics of power and control within an intimate partner relationship. Why would we remove the very protection that helps give these victims a voice?

-- END –

AMENDED IN SENATE JUNE 28, 2023

AMENDED IN SENATE JUNE 27, 2023

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 1028

Introduced by Assembly Member McKinnor
(Coauthor: Assembly Member Wicks)
(Coauthor: Senator Wiener)

February 15, 2023

An act to amend, repeal, and add Sections 11160, 11161, 11163.2, and 11163.3 of the Penal Code, relating to reporting of crimes.

LEGISLATIVE COUNSEL'S DIGEST

AB 1028, as amended, McKinnor. Reporting of crimes: mandated reporters.

Existing law requires a health practitioner, as defined, to make a report to law enforcement when they suspect a patient has suffered physical injury that is inflicted by the person's own act or inflicted by another where the injury is by means of a firearm, or caused by assaultive or abusive conduct, including elder abuse, sexual assault, or torture. A violation of these provisions is punishable as a misdemeanor.

This bill would, on and after January 1, 2025, remove the requirement that a health practitioner make a report to law enforcement when they suspect a patient has suffered physical injury caused by assaultive or abusive conduct, and instead only require that report if the health practitioner suspects a patient has suffered a wound or physical injury inflicted by the person's own act or inflicted by another where the injury is by means of a firearm, a wound or physical injury resulting from child abuse, or a wound or physical injury resulting from elder abuse.

The bill would, on and after January 1, 2025, instead require a health practitioner who suspects that a patient has suffered physical injury that is caused by domestic violence, as defined, to, among other things, provide brief counseling, education, or other support, and a warm handoff, as defined, or referral to local and national domestic violence or sexual violence advocacy services, as specified. The bill would, on and after January 1, 2025, specify that a health practitioner is not civilly or criminally liable for any report that is made in good faith and in compliance with these provisions.

This bill would make other conforming changes.

Because a violation of these requirements would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Recognizing that abuse survivors often need to access health care and medical treatment apart from police reporting and criminal legal involvement, this bill replaces mandated police reporting by medical professionals with offering connection to survivor services.

(b) Health care providers play a critical role in prevention, identification, and response to violence. However, current law requiring health professionals in California to file reports to law enforcement when treating patients for all suspected violence-related injuries can have a chilling effect of preventing domestic and sexual violence survivors from seeking medical care, decreasing patient autonomy and trust, and resulting in health providers being reluctant to address domestic and sexual violence with their patients.

(c) Studies have shown that medical mandatory reporting of adult domestic and sexual violence may increase patient danger and insecurity, whereas being able to openly discuss abuse without

fear of police reporting can produce greater health and safety outcomes.

(d) Because of the complexity of interpersonal violence and impact of social inequities on safety, people who have experienced violence should be provided survivor-centered support and health care that results in better outcomes for patient safety. Doing so can improve the health and safety of patients already in care, decrease potential barriers to care, and promote trust between survivors and health providers.

(e) ~~Nothing in this act limits or overrides~~ *This act does not limit or override* the ability of a health practitioner to make reports permitted by subdivisions (c) or (j) of Section 164.512 of Title 45 of the Code of Federal Regulations, or at the patient's request. Providers must still follow reporting requirements for child abuse, pursuant to Section 11165 of the Penal Code, and elder and vulnerable adult abuse, pursuant to Section 15600 of the Welfare and Institutions Code. It is the intent of the Legislature to promote partnership between health facilities and domestic and sexual violence advocacy organizations, legal aid, county forensic response teams, family justice centers, and other community-based organizations that address social determinants of health in order to better ensure the safety and wellness of their patients and provide training for health practitioners. California has made strides to enhance health practitioners' capacity to address and prevent violence and trauma, including education for practitioners on how to assess for and document abuse as referenced in subdivision (h) of Section 2191 of, Section 2196.5 of, and Section 2091.2 of, the Business and Professions Code, Section 13823.93 of the Penal Code, and Section 1259.5 of the Health and Safety Code.

SEC. 2. Section 11160 of the Penal Code is amended to read:

11160. (a) A health practitioner, as defined in subdivision (a) of Section 11162.5, employed by a health facility, clinic, physician's office, local or state public health department, local government agency, or a clinic or other type of facility operated by a local or state public health department who, in the health practitioner's professional capacity or within the scope of the health practitioner's employment, provides medical services for a physical condition to a patient whom the health practitioner knows or reasonably suspects is a person described as follows, shall immediately make a report in accordance with subdivision (b):

(1) A person suffering from a wound or other physical injury inflicted by the person's own act or inflicted by another where the injury is by means of a firearm.

(2) A person suffering from a wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct.

(b) A health practitioner, as defined in subdivision (a) of Section 11162.5, employed by a health facility, clinic, physician's office, local or state public health department, local government agency, or a clinic or other type of facility operated by a local or state public health department shall make a report regarding persons described in subdivision (a) to a local law enforcement agency as follows:

(1) A report by telephone shall be made immediately or as soon as practically possible.

(2) A written report shall be prepared on the standard form developed in compliance with paragraph (4), and adopted by the Office of Emergency Services, or on a form developed and adopted by another state agency that otherwise fulfills the requirements of the standard form. The completed form shall be sent to a local law enforcement agency within two working days of receiving the information regarding the person.

(3) A local law enforcement agency shall be notified and a written report shall be prepared and sent pursuant to paragraphs (1) and (2) even if the person who suffered the wound, other injury, or assaultive or abusive conduct has expired, regardless of whether or not the wound, other injury, or assaultive or abusive conduct was a factor contributing to the death, and even if the evidence of the conduct of the perpetrator of the wound, other injury, or assaultive or abusive conduct was discovered during an autopsy.

(4) The report shall include, but shall not be limited to, the following:

(A) The name of the injured person, if known.

(B) The injured person's whereabouts.

(C) The character and extent of the person's injuries.

(D) The identity of any person the injured person alleges inflicted the wound, other injury, or assaultive or abusive conduct upon the injured person.

(c) For the purposes of this section, "injury" does not include any psychological or physical condition brought about solely

through the voluntary administration of a narcotic or restricted dangerous drug.

(d) For the purposes of this section, "assaultive or abusive conduct" includes any of the following offenses:

(1) Murder, in violation of Section 187.

(2) Manslaughter, in violation of Section 192 or 192.5.

(3) Mayhem, in violation of Section 203.

(4) Aggravated mayhem, in violation of Section 205.

(5) Torture, in violation of Section 206.

(6) Assault with intent to commit mayhem, rape, sodomy, or oral copulation, in violation of Section 220.

(7) Administering controlled substances or anesthetic to aid in commission of a felony, in violation of Section 222.

(8) Battery, in violation of Section 242.

(9) Sexual battery, in violation of Section 243.4.

(10) Incest, in violation of Section 285.

(11) Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure, in violation of Section 244.

(12) Assault with a stun gun or taser, in violation of Section 244.5.

(13) Assault with a deadly weapon, firearm, assault weapon, or machinegun, or by means likely to produce great bodily injury, in violation of Section 245.

(14) Rape, in violation of Section 261 or former Section 262.

(15) Procuring a person to have sex with another person, in violation of Section 266, 266a, 266b, or 266c.

(16) Child abuse or endangerment, in violation of Section 273a or 273d.

(17) Abuse of spouse or cohabitant, in violation of Section 273.5.

(18) Sodomy, in violation of Section 286.

(19) Lewd and lascivious acts with a child, in violation of Section 288.

(20) Oral copulation, in violation of Section 287 or former Section 288a.

(21) Sexual penetration, in violation of Section 289.

(22) Elder abuse, in violation of Section 368.

(23) An attempt to commit any crime specified in paragraphs (1) to (22), inclusive.

(e) When two or more persons who are required to report are present and jointly have knowledge of a known or suspected instance of violence that is required to be reported pursuant to this section, and when there is an agreement among these persons to report as a team, the team may select by mutual agreement a member of the team to make a report by telephone and a single written report, as required by subdivision (b). The written report shall be signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

(f) The reporting duties under this section are individual, except as provided in subdivision (e).

(g) A supervisor or administrator shall not impede or inhibit the reporting duties required under this section and a person making a report pursuant to this section shall not be subject to any sanction for making the report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established, except that these procedures shall not be inconsistent with this article. The internal procedures shall not require an employee required to make a report under this article to disclose the employee's identity to the employer.

(h) For the purposes of this section, it is the Legislature's intent to avoid duplication of information.

(i) For purposes of this section only, "employed by a local government agency" includes an employee of an entity under contract with a local government agency to provide medical services.

(j) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 3. Section 11160 is added to the Penal Code, to read:

11160. (a) A health practitioner, as defined in subdivision (a) of Section 11162.5, employed by a health facility, clinic, physician's office, local or state public health department, local government agency, or a clinic or other type of facility operated by a local or state public health department who, in the health practitioner's professional capacity or within the scope of the health practitioner's employment, provides medical services for a physical condition to a patient whom the health practitioner knows or reasonably suspects is a person suffering from any of the following

shall immediately make a report in accordance with subdivision (b):

(1) A wound or other physical injury inflicted by the person's own act or inflicted by another where the injury is by means of a firearm.

(2) A wound or other physical injury resulting from child abuse, pursuant to Section 11165.6.

(3) A wound or other physical injury resulting from abuse of an elder or dependent adult, pursuant to Section 15610.07 of the Welfare and Institutions Code.

(b) A health practitioner, as defined in subdivision (a) of Section 11162.5, employed by a health facility, clinic, physician's office, local or state public health department, local government agency, or a clinic or other type of facility operated by a local or state public health department shall make a report regarding persons described in subdivision (a) to a local law enforcement agency as follows:

(1) A report by telephone shall be made immediately or as soon as practically possible.

(2) A written report shall be prepared on the standard form developed in compliance with paragraph (4), and adopted by the Office of Emergency Services, or on a form developed and adopted by another state agency that otherwise fulfills the requirements of the standard form. The completed form shall be maintained in the medical record and sent to a local law enforcement agency within two working days of the patient receiving treatment.

(3) A local law enforcement agency shall be notified and a written report shall be prepared and sent pursuant to paragraphs (1) and (2) even if the person who suffered the wound or other injury has expired, regardless of whether or not the wound or other injury was a factor contributing to the death, and even if the evidence of the conduct of the perpetrator of the wound or other injury was discovered during an autopsy.

(4) The report shall include, but shall not be limited to, the following:

(A) The name of the injured person, if known.

(B) The injured person's whereabouts.

(C) The character and extent of the person's injuries.

(D) The identity of any person the injured person alleges inflicted the wound or other injury upon the injured person.

(c) If an adult seeking care for injuries related to domestic, sexual, or any nonaccidental violent injury, requests a report be sent to law enforcement, health practitioners shall adhere to the reporting process outlined in paragraph (3) of subdivision (b). The medical documentation of injuries related to domestic, sexual, or any nonaccidental violent injury shall be conducted and made available to the patient for use as outlined in the Health Insurance Portability and Accountability Act.

(d) For the purposes of this section, "injury" does not include any psychological or physical condition brought about solely through the voluntary administration of a narcotic or restricted dangerous drug.

(e) When two or more persons who are required to report are present and jointly have knowledge of a known or suspected instance of violence that is required to be reported pursuant to this section, and when there is an agreement among these persons to report as a team, the team may select by mutual agreement a member of the team to make a report by telephone and a single written report, as required by subdivision (b). The written report shall be signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

(f) The reporting duties under this section are individual, except as provided in subdivision (e).

(g) A supervisor or administrator shall not impede or inhibit the reporting duties required under this section and a person making a report pursuant to this section shall not be subject to any sanction for making the report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established, except that these procedures shall not be inconsistent with this article. The internal procedures shall not require an employee required to make a report under this article to disclose the employee's identity to the employer.

(h) (1) A health practitioner, as defined in subdivision (a) of Section 11162.5, employed by a health facility, clinic, physician's office, local or state public health department, local government agency, or a clinic or other type of facility operated by a local or state public health department who, in the health practitioner's professional capacity or within the scope of the health practitioner's employment, provides medical services to a patient whom the

health practitioner knows or reasonably suspects is experiencing any form of domestic violence, as set forth in Section 124250 of the Health and Safety Code, or sexual violence, as set forth in Sections 243.4 and 261, shall, to the degree that it is medically possible for the individual patient, provide brief counseling, education, or other support, and offer a warm handoff or referral to local and national domestic violence or sexual violence advocacy services, as described in Sections 1035.2 and 1037.1 of the Evidence Code, before the end of the patient visit. The health practitioner shall have met the requirements of this subdivision when the brief counseling, education, or other support is provided and warm handoff or referral is offered by a member of the health care team at the health facility.

(2) If the health practitioner is providing medical services to the patient in the emergency department of a general acute care hospital, they shall also offer assistance to the patient in accessing a forensic evidentiary exam or reporting to law enforcement, if the patient wants to pursue these options.

(i) A health practitioner may offer a warm handoff and referral to other available victim services, including, but not limited to, legal aid, community-based organizations, behavioral health, crime victim compensation, forensic evidentiary exams, trauma recovery centers, family justice centers, and law enforcement to patients who are suspected to have suffered any nonaccidental injury.

(j) To the extent possible, health practitioners shall document all nonaccidental violent injuries and incidents of abuse in the medical record. Health practitioners shall follow privacy and confidentiality protocols when documenting violence and abuse to promote the safety of the patient. If documenting abuse in the medical record increases danger for the patient, it may be marked confidential.

(k) This section does not limit or override the ability of a health care practitioner to make reports to law enforcement at the patient's request, or as permitted by the federal Health Insurance Portability and Accountability Act of 1996 in Section 164.512(c) of Title 45 of the Code of Federal Regulations, which permits disclosures about victims of abuse, neglect, or domestic violence, if the individual agrees, or pursuant to Section 164.512(j) of Title 45 of the Code of Federal Regulations, which permits disclosures to

prevent or limit a serious and imminent threat to a person or the public.

(*l*) For the purposes of this section, it is the Legislature's intent to avoid duplication of information.

(m) For purposes of this section only, "employed by a local government agency" includes an employee of an entity under contract with a local government agency to provide medical services.

(n) For purposes of this section, the following terms have the following meanings:

(1) "Warm handoff" may include, but is not limited to, the health practitioner establishing direct and live connection through a call with a survivor advocate, in-person onsite survivor advocate, in-person on-call survivor advocate, or some other form of teleadvocacy. When a telephone call is not possible, the warm handoff may be completed through an email. The patient may decline the warm handoff.

(2) "Referral" may include, but is not limited to, the health practitioner sharing information about how a patient can get in touch with a local or national survivor advocacy organization, information about how the survivor advocacy organization could be helpful for the patient, what the patient could expect when contacting the survivor advocacy organization, or the survivor advocacy organization's contact information.

(o) A health practitioner shall not be civilly or criminally liable for acting in compliance with this section and for any report that is made in good faith and in compliance with this section and all other applicable state and federal laws.

(p) This section shall become operative on January 1, 2025.

SEC. 4. Section 11161 of the Penal Code is amended to read:

11161. Notwithstanding Section 11160, the following shall apply to every physician and surgeon who has under their charge or care any person described in subdivision (a) of Section 11160:

(a) The physician and surgeon shall make a report in accordance with subdivision (b) of Section 11160 to a local law enforcement agency.

(b) It is recommended that any medical records of a person about whom the physician and surgeon is required to report pursuant to subdivision (a) include the following:

(1) Any comments by the injured person regarding past domestic violence, as defined in Section 13700, or regarding the name of any person suspected of inflicting the wound, other physical injury, or assaultive or abusive conduct upon the person.

(2) A map of the injured person's body showing and identifying injuries and bruises at the time of the health care.

(3) A copy of the law enforcement reporting form.

(c) It is recommended that the physician and surgeon refer the person to local domestic violence services if the person is suffering or suspected of suffering from domestic violence, as defined in Section 13700.

(d) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 5. Section 11161 is added to the Penal Code, to read:

11161. Notwithstanding Section 11160, the following shall apply to every health practitioner who has under their charge or care any person described in subdivision (a) of Section 11160:

(a) The health practitioner or member of the care team shall make a report in accordance with subdivision (b) of Section 11160 to a local law enforcement agency.

(b) It is recommended that any medical records of a person about whom the health practitioner or member of the care team is required to report pursuant to subdivision (a) include the following:

(1) Any comments by the injured person regarding past domestic violence, as defined in Section 13700, or regarding the name of any person suspected of inflicting the wound or other physical injury upon the person.

(2) A map of the injured person's body showing and identifying injuries and bruises at the time of the health care.

(3) A copy of the law enforcement reporting form.

(c) The health practitioner or member of the care team shall offer a referral to local domestic violence services if the person is suffering or suspected of suffering from domestic violence, as defined in Section 13700.

(d) This section shall become operative on January 1, 2025.

SEC. 6. Section 11163.2 of the Penal Code is amended to read:

11163.2. (a) In any court proceeding or administrative hearing, neither the physician-patient privilege nor the psychotherapist privilege applies to the information required to be reported pursuant to this article.

(b) The reports required by this article shall be kept confidential by the health facility, clinic, or physician's office that submitted the report, and by local law enforcement agencies, and shall only be disclosed by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by a report. In no case shall the person suspected or accused of inflicting the wound, other injury, or assaultive or abusive conduct upon the injured person or their attorney be allowed access to the injured person's whereabouts. Nothing in this subdivision is intended to conflict with Section 1054.1 or 1054.2.

(c) For the purposes of this article, reports of suspected child abuse and information contained therein may be disclosed only to persons or agencies with whom investigations of child abuse are coordinated under the regulations promulgated under Section 11174.

(d) The Board of Prison Terms may subpoena reports that are not unfounded and reports that concern only the current incidents upon which parole revocation proceedings are pending against a parolee.

(e) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 7. Section 11163.2 is added to the Penal Code, to read:

11163.2. (a) In any court proceeding or administrative hearing, neither the physician-patient privilege nor the psychotherapist-patient privilege applies to the information required to be reported pursuant to this article.

(b) The reports required by this article shall be kept confidential by the health facility, clinic, or physician's office that submitted the report, and by local law enforcement agencies, and shall only be disclosed by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by a report. In no case shall the person suspected or accused of inflicting the wound or other injury upon the injured person, or the attorney of the suspect or accused, be allowed access to the injured person's whereabouts. Nothing in this subdivision is intended to conflict with Section 1054.1 or 1054.2.

(c) For the purposes of this article, reports of suspected child abuse and information contained therein may be disclosed only to persons or agencies with whom investigations of child abuse are

coordinated under the regulations promulgated under Section 11174.

(d) The Board of Prison Terms may subpoena reports that are not unfounded and reports that concern only the current incidents upon which parole revocation proceedings are pending against a parolee.

(e) This section shall become operative on January 1, 2025.

SEC. 8. Section 11163.3 of the Penal Code is amended to read:

11163.3. (a) A county may establish an interagency domestic violence death review team to assist local agencies in identifying and reviewing domestic violence deaths and near deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases. Interagency domestic violence death review teams have been used successfully to ensure that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for community prevention and intervention initiatives to reduce and eradicate the incidence of domestic violence.

(b) (1) For purposes of this section, "abuse" has the meaning set forth in Section 6203 of the Family Code and "domestic violence" has the meaning set forth in Section 6211 of the Family Code.

(2) For purposes of this section, "near death" means the victim suffered a life-threatening injury, as determined by a licensed physician or licensed nurse, as a result of domestic violence.

(c) A county may develop a protocol that may be used as a guideline to assist coroners and other persons who perform autopsies on domestic violence victims in the identification of domestic violence, in the determination of whether domestic violence contributed to death or whether domestic violence had occurred prior to death, but was not the actual cause of death, and in the proper written reporting procedures for domestic violence, including the designation of the cause and mode of death.

(d) County domestic violence death review teams shall be comprised of, but not limited to, the following:

(1) Experts in the field of forensic pathology.

(2) Medical personnel with expertise in domestic violence abuse.

(3) Coroners and medical examiners.

(4) Criminologists.

(5) District attorneys and city attorneys.

(6) Representatives of domestic violence victim service organizations, as defined in subdivision (b) of Section 1037.1 of the Evidence Code.

(7) Law enforcement personnel.

(8) Representatives of local agencies that are involved with domestic violence abuse reporting.

(9) County health department staff who deal with domestic violence victims' health issues.

(10) Representatives of local child abuse agencies.

(11) Local professional associations of persons described in paragraphs (1) to (10), inclusive.

(e) An oral or written communication or a document shared within or produced by a domestic violence death review team related to a domestic violence death review is confidential and not subject to disclosure or discoverable by a third party. An oral or written communication or a document provided by a third party to a domestic violence death review team, or between a third party and a domestic violence death review team, is confidential and not subject to disclosure or discoverable by a third party. This includes a statement provided by a survivor in a near-death case review. Notwithstanding the foregoing, recommendations of a domestic violence death review team upon the completion of a review may be disclosed at the discretion of a majority of the members of the domestic violence death review team.

(f) Each organization represented on a domestic violence death review team may share with other members of the team information in its possession concerning the victim who is the subject of the review or any person who was in contact with the victim and any other information deemed by the organization to be pertinent to the review. Any information shared by an organization with other members of a team is confidential. This provision shall permit the disclosure to members of the team of any information deemed confidential, privileged, or prohibited from disclosure by any other statute.

(g) Written and oral information may be disclosed to a domestic violence death review team established pursuant to this section. The team may make a request in writing for the information sought and any person with information of the kind described in paragraph

(2) may rely on the request in determining whether information may be disclosed to the team.

(1) An individual or agency that has information governed by this subdivision shall not be required to disclose information. The intent of this subdivision is to allow the voluntary disclosure of information by the individual or agency that has the information.

(2) The following information may be disclosed pursuant to this subdivision:

(A) Notwithstanding Section 56.10 of the Civil Code, medical information.

(B) Notwithstanding Section 5328 of the Welfare and Institutions Code, mental health information.

(C) Notwithstanding Section 15633.5 of the Welfare and Institutions Code, information from elder abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed.

(D) Notwithstanding Section 11167.5 of the Penal Code, information from child abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed.

(E) State summary criminal history information, criminal offender record information, and local summary criminal history information, as defined in Sections 11075, 11105, and 13300 of the Penal Code.

(F) Notwithstanding Section 11163.2 of the Penal Code, information pertaining to reports by health practitioners of persons suffering from physical injuries inflicted by means of a firearm or of persons suffering physical injury where the injury is a result of assaultive or abusive conduct, and information relating to whether a physician referred the person to local domestic violence services as recommended by Section 11161 of the Penal Code.

(G) Notwithstanding Section 827 of the Welfare and Institutions Code, information in any juvenile court proceeding.

(H) Information maintained by the Family Court, including information relating to the Family Conciliation Court Law pursuant to Section 1818 of the Family Code, and Mediation of Custody and Visitation Issues pursuant to Section 3177 of the Family Code.

(I) Information provided to probation officers in the course of the performance of their duties, including, but not limited to, the

duty to prepare reports pursuant to Section 1203.10 of the Penal Code, as well as the information on which these reports are based.

(J) Notwithstanding Section 10850 of the Welfare and Institutions Code, records of in-home supportive services, unless disclosure is prohibited by federal law.

(3) The disclosure of written and oral information authorized under this subdivision shall apply notwithstanding Sections 2263, 2918, 4982, and 6068 of the Business and Professions Code, or the lawyer-client privilege protected by Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code, the physician-patient privilege protected by Article 6 (commencing with Section 990) of Chapter 4 of Division 8 of the Evidence Code, the psychotherapist-patient privilege protected by Article 7 (commencing with Section 1010) of Chapter 4 of Division 8 of the Evidence Code, the sexual assault counselor-victim privilege protected by Article 8.5 (commencing with Section 1035) of Chapter 4 of Division 8 of the Evidence Code, the domestic violence counselor-victim privilege protected by Article 8.7 (commencing with Section 1037) of Chapter 4 of Division 8 of the Evidence Code, and the human trafficking caseworker-victim privilege protected by Article 8.8 (commencing with Section 1038) of Chapter 4 of Division 8 of the Evidence Code.

(4) In near-death cases, representatives of domestic violence victim service organizations, as defined in subdivision (b) of Section 1037.1 of the Evidence Code, shall obtain an individual's informed consent in accordance with all applicable state and federal confidentiality laws, before disclosing confidential information about that individual to another team member as specified in this section. In death review cases, representatives of domestic violence victim service organizations shall only provide client-specific information in accordance with both state and federal confidentiality requirements.

(5) Near-death case reviews shall only occur after any prosecution has concluded.

(6) Near-death survivors shall not be compelled to participate in death review team investigations; their participation is voluntary. In cases of death, the victim's family members may be invited to participate, however they shall not be compelled to do so; their participation is voluntary. Members of the death review teams

shall be prepared to provide referrals for services to address the unmet needs of survivors and their families when appropriate.

(h) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 9. Section 11163.3 is added to the Penal Code, to read:

11163.3. (a) A county may establish an interagency domestic violence death review team to assist local agencies in identifying and reviewing domestic violence deaths and near deaths, including homicides and suicides, and facilitating communication among the various agencies involved in domestic violence cases. Interagency domestic violence death review teams have been used successfully to ensure that incidents of domestic violence and abuse are recognized and that agency involvement is reviewed to develop recommendations for policies and protocols for community prevention and intervention initiatives to reduce and eradicate the incidence of domestic violence.

(b) (1) For purposes of this section, "abuse" has the meaning set forth in Section 6203 of the Family Code and "domestic violence" has the meaning set forth in Section 6211 of the Family Code.

(2) For purposes of this section, "near death" means the victim suffered a life-threatening injury, as determined by a licensed physician or licensed nurse, as a result of domestic violence.

(c) A county may develop a protocol that may be used as a guideline to assist coroners and other persons who perform autopsies on domestic violence victims in the identification of domestic violence, in the determination of whether domestic violence contributed to death or whether domestic violence had occurred prior to death, but was not the actual cause of death, and in the proper written reporting procedures for domestic violence, including the designation of the cause and mode of death.

(d) County domestic violence death review teams shall be comprised of, but not limited to, the following:

(1) Experts in the field of forensic pathology.

(2) Medical personnel with expertise in domestic violence abuse.

(3) Coroners and medical examiners.

(4) Criminologists.

(5) District attorneys and city attorneys.

(6) Representatives of domestic violence victim service organizations, as defined in subdivision (b) of Section 1037.1 of the Evidence Code.

(7) Law enforcement personnel.

(8) Representatives of local agencies that are involved with domestic violence abuse reporting.

(9) County health department staff who deal with domestic violence victims' health issues.

(10) Representatives of local child abuse agencies.

(11) Local professional associations of persons described in paragraphs (1) to (10), inclusive.

(e) An oral or written communication or a document shared within or produced by a domestic violence death review team related to a domestic violence death review is confidential and not subject to disclosure or discoverable by a third party. An oral or written communication or a document provided by a third party to a domestic violence death review team, or between a third party and a domestic violence death review team, is confidential and not subject to disclosure or discoverable by a third party. This includes a statement provided by a survivor in a near-death case review. Notwithstanding the foregoing, recommendations of a domestic violence death review team upon the completion of a review may be disclosed at the discretion of a majority of the members of the domestic violence death review team.

(f) Each organization represented on a domestic violence death review team may share with other members of the team information in its possession concerning the victim who is the subject of the review or any person who was in contact with the victim and any other information deemed by the organization to be pertinent to the review. Any information shared by an organization with other members of a team is confidential. This provision shall permit the disclosure to members of the team of any information deemed confidential, privileged, or prohibited from disclosure by any other statute.

(g) Written and oral information may be disclosed to a domestic violence death review team established pursuant to this section. The team may make a request in writing for the information sought and any person with information of the kind described in paragraph (2) may rely on the request in determining whether information may be disclosed to the team.

(1) An individual or agency that has information governed by this subdivision shall not be required to disclose information. The intent of this subdivision is to allow the voluntary disclosure of information by the individual or agency that has the information.

(2) The following information may be disclosed pursuant to this subdivision:

(A) Notwithstanding Section 56.10 of the Civil Code, medical information.

(B) Notwithstanding Section 5328 of the Welfare and Institutions Code, mental health information.

(C) Notwithstanding Section 15633.5 of the Welfare and Institutions Code, information from elder abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed.

(D) Notwithstanding Section 11167.5, information from child abuse reports and investigations, except the identity of persons who have made reports, which shall not be disclosed.

(E) State summary criminal history information, criminal offender record information, and local summary criminal history information, as defined in Sections 11075, 11105, and 13300.

(F) Notwithstanding Section 11163.2, information pertaining to reports by health practitioners of persons suffering from physical injuries inflicted by means of a firearm or abuse, if reported, and information relating to whether a physician referred the person to local domestic violence services, as recommended by Section 11161.

(G) Notwithstanding Section 827 of the Welfare and Institutions Code, information in any juvenile court proceeding.

(H) Information maintained by the Family Court, including information relating to the Family Conciliation Court Law pursuant to Section 1818 of the Family Code, and Mediation of Custody and Visitation Issues pursuant to Section 3177 of the Family Code.

(I) Information provided to probation officers in the course of the performance of their duties, including, but not limited to, the duty to prepare reports pursuant to Section 1203.10, as well as the information on which these reports are based.

(J) Notwithstanding Section 10850 of the Welfare and Institutions Code, records of in-home supportive services, unless disclosure is prohibited by federal law.

(3) The disclosure of written and oral information authorized under this subdivision shall apply notwithstanding Sections 2263, 2918, 4982, and 6068 of the Business and Professions Code, or the lawyer-client privilege protected by Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code, the physician-patient privilege protected by Article 6 (commencing with Section 990) of Chapter 4 of Division 8 of the Evidence Code, the psychotherapist-patient privilege protected by Article 7 (commencing with Section 1010) of Chapter 4 of Division 8 of the Evidence Code, the sexual assault counselor-victim privilege protected by Article 8.5 (commencing with Section 1035) of Chapter 4 of Division 8 of the Evidence Code, the domestic violence counselor-victim privilege protected by Article 8.7 (commencing with Section 1037) of Chapter 4 of Division 8 of the Evidence Code, and the human trafficking caseworker-victim privilege protected by Article 8.8 (commencing with Section 1038) of Chapter 4 of Division 8 of the Evidence Code.

(4) In near-death cases, representatives of domestic violence victim service organizations, as defined in subdivision (b) of Section 1037.1 of the Evidence Code, shall obtain an individual's informed consent in accordance with all applicable state and federal confidentiality laws, before disclosing confidential information about that individual to another team member as specified in this section. In death review cases, representatives of domestic violence victim service organizations shall only provide client-specific information in accordance with both state and federal confidentiality requirements.

(5) Near-death case reviews shall only occur after any prosecution has concluded.

(6) Near-death survivors shall not be compelled to participate in death review team investigations; their participation is voluntary. In cases of death, the victim's family members may be invited to participate, however they shall not be compelled to do so; their participation is voluntary. Members of the death review teams shall be prepared to provide referrals for services to address the unmet needs of survivors and their families when appropriate.

(h) This section shall become operative on January 1, 2025.

SEC. 10. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school

district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

B. AB 1570 (Low) Optometry: certification to perform advanced procedures

Status: Introduced 2-17-2023 / 2-year bill.

AUTHOR REASON FOR THE BILL:
According to the author's statement on AB 2236 (2022), which is substantially similar: "Today's optometrists are trained to do much more than they are permitted in California. Optometrists in other states are performing minor surgical procedures, including the use of lasers to treat glaucoma with no adverse events and little to no requirements on training. This bill provides additional training that will be more rigorous than any other state and will ensure that patients will have access to the care they need. In some counties, Medi-Cal patients must wait months to get in with an ophthalmologist. Optometrists already provide 81 percent of the eye care under Medi-Cal. Optometrists are located in almost every county in California. Optometrists are well situated to bridge the provider gap for these eye conditions that are becoming more common as our population ages."

DESCRIPTION OF CURRENT LEGISLATION:
This bill is a reintroduction of AB 2236 (Low, 2022). It would create a new certificate type to allow optometrists to perform advanced laser surgical procedures, excision or drainage of nonrecurrent lesions of the adnexa, injections for treatment of chalazia and to administer anesthesia, and corneal crosslinking procedures. Prior to certification, optometrists would be required to meet specified training, pass an examination, and complete education requirements to be developed by the Board. It would also require optometrists to report any adverse treatment outcomes to the Board and require the Board to review these reports in a timely manner.

BACKGROUND:
Existing law provides that the practice of optometry includes the prevention, diagnosis, treatment, and management of disorders and dysfunctions of the visual system, as well as the provision of habilitative or rehabilitative optometric services, and specifically authorizes an optometrist who is certified to use therapeutic pharmaceutical agents to diagnose and treat the human eye for various enumerated conditions. (BPC § 3041) Existing law also requires an optometrist seeking certification to use therapeutic pharmaceutical agents and diagnose and treat specified conditions to apply for a certificate from the CBO and meet additional education and training requirements. (BPC § 3041.3)

ANALYSIS:
This bill would expand the scope of optometry and enable most licensed optometrists to provide optometric services in California consistent with their education and training. Specifically, the bill would:

• Authorize an optometrist certified to treat glaucoma to obtain certification to perform specified advanced procedures if the optometrist meets certain education, training, examination, and other requirements.

• Require the board to set a fee for the issuance and renewal of the certificate authorizing the use of advanced procedures, which would be deposited in the Optometry Fund.

• Require an optometrist who performs advanced procedures pursuant to these provisions to report certain information to the board, including any adverse treatment outcomes that required a referral to or consultation with another health care provider.

• Require the board to compile a report summarizing the data collected and make the report available on the Board's internet website.

To qualify for the certification proposed by the bill, the Board is required to designate Board-approved courses designed to provide education on the advanced procedures required of an optometrist who wishes to qualify for the certification. An additional requirement under the bill is the completion of a Board-approved training program conducted in California.

The bill also requires optometrists to report to the Board, within three weeks, any adverse treatment outcome that required a referral to or consultation with another health care provider. The bill authorizes this to be reported on a form or via a portal. The bill requires the Board to review these adverse treatment outcome reports in a timely manner, and request additional information, if necessary, impose additional training, or to restrict or revoke a certification.

This bill would have the following impact to the Board:
• A process for reviewing and approving Board-approved courses of at least 32 hours. These courses must include a written examination requirement. It is unclear who must design and administer the exam. The Board would need to amend or create new regulations to approve these courses.

• The bill provides discretion to the Board to waive the requirement that an applicant for certification pass both sections of the Laser and Surgical Procedures Examination of the National Board of Examiners in Optometry. The Board would likely need to develop criteria in regulation for this process.

• Applicants must complete a Board-approved training program conducted in California. The bill specifies that the Board is responsible for determining the percentage of required procedures that must be performed. The Board will need to implement this requirement in regulation.

• The bill requires the performance of procedures completed by an applicant for certification be certified on a form approved by the Board. The Board will have to implement this requirement in regulation.

• The bill requires a second form also be submitted to the Board certifying the optometrist is competent to perform advanced procedure and requires the Board to develop the form. The Board will have to implement this requirement in regulation.

• The bill requires optometrists to monitor and report to the Board, on either a form or an internet-based portal, at the time of license renewal or upon Board request, the number of and types of procedures performed and the diagnosis of the patient at the time the procedure was performed.

- It is unclear whether the Board must review or audit the information submitted at time of license renewal. The bill further requires within three (3) weeks of the event, any adverse treatment outcomes that required referral or consultation to another provider.
- The bill requires the Board to timely review these reports and make enforcement decisions to impose additional training or restrict or revoke the certification.
- Regulations and resources would be required to develop a process to receive and review these reports.

• The bill requires the Board to compile a report on adverse outcomes and publicly post the information on the website. It is unclear if this is a one-time report or an annual requirement.

• The bill requires the Board to develop in regulation the fees for the issuance and renewal of an advanced procedures certificate.

Significant resources and regulatory work would be required to implement the bill as written. It is likely that additional positions would be required to perform the work required by the bill, and a fee would be pursued that could be in the hundreds of dollars to support the workload requirements. The regulatory requirements would likely take at least two (2) years to complete, and it could be beyond 2026 when the first certificates are issued.

These costs and implementation items can likely be mitigated if less requirements are placed on the Board. For example, creating the application form and other forms in statute or including statutory language exempting the forms from the rulemaking process would help with implementation costs and resource requirements. Specifying or designating in law existing training programs that meet the requirements for advanced certification and any examination requirements, instead of requiring the Board to approve training courses, training programs, and determining the percentage of required procedures would reduce resource requirements and implementation timelines. Setting the fee in statute with a floor and including language that permissively allows it to be increased via regulation down the line, would implement the fee upon enactment and allow it to be adjusted in regulation.

UPDATE:
Board staff has met with the California Optometric Association (COA) and exchanged productive ideas on ways to reduce the implementation impact to the Board. Further conversations with COA and others are expected to occur in advance of the bill coming back up for consideration in 2024.

FISCAL:
Significant resources would be needed to implement.

BOARD POSITION:
Support if amended to address implementation concerns.

Action Requested:

None at this time.

Attachment 1: Bill text

ASSEMBLY BILL No. 1570

Introduced by Assembly Member Low

February 17, 2023

An act to amend Section 3041 of, and to add Section 3041.4 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1570, as introduced, Low. Optometry: certification to perform advanced procedures.

Existing law, the Optometry Practice Act, establishes the State Board of Optometry in the Department of Consumer Affairs for the licensure and regulation of the practice of optometry. Existing law makes a violation of the act a misdemeanor. Existing law excludes certain classes of agents from the practice of optometry unless they have an explicit United States Food and Drug Administration-approved indication, as specified.

This bill would add neuromuscular blockers to the list of excluded classes of agents. By expanding the scope of a crime, the bill would impose a state-mandated local program.

Existing law requires an optometrist who holds a therapeutic pharmaceutical agents certification and meets specified requirements to be certified to medically treat authorized glaucomas.

This bill would authorize an optometrist certified to treat glaucoma to obtain certification to perform specified advanced procedures if the optometrist meets certain education, training, examination, and other requirements, as specified. By requiring optometrists, qualified educators, and course administrators to certify or attest specified information relating to advanced procedure competency, thus expanding

the crime of perjury, the bill would impose a state-mandated local program. The bill would require the board to set a fee for the issuance and renewal of the certificate authorizing the use of advanced procedures, which would be deposited in the Optometry Fund. The bill would require an optometrist who performs advanced procedures pursuant to these provisions to report certain information to the board, including any adverse treatment outcomes that required a referral to or consultation with another health care provider. The bill would require the board to compile a report summarizing the data collected and make the report available on the board's internet website.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 3041 of the Business and Professions Code is amended to read:

3041. (a) The practice of optometry includes the diagnosis, prevention, treatment, and management of disorders and dysfunctions of the visual system, as authorized by this chapter, as well as the provision of habilitative or rehabilitative optometric services, and is the doing of any or all of the following:

(1) The examination of the human eyes and their adnexa, including through the use of all topical and oral diagnostic pharmaceutical agents that are not controlled substances, and the analysis of the human vision system, either subjectively or objectively.

(2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eyes, including the scope of their functions and general condition.

(3) The prescribing, using, or directing the use of any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.

(4) The prescribing, fitting, or adaptation of contact and spectacle lenses to, the human eyes, including lenses that may be

classified as drugs or devices by any law of the United States or of this state, and diagnostic or therapeutic contact lenses that incorporate a medication or therapy the optometrist is certified to prescribe or provide.

(5) For an optometrist certified pursuant to Section 3041.3, diagnosing and preventing conditions and diseases of the human eyes and their adnexa, and treating nonmalignant conditions and diseases of the anterior segment of the human eyes and their adnexa, including ametropia and presbyopia:

(A) Using or prescribing, including for rational off-label purposes, topical and oral prescription and nonprescription therapeutic pharmaceutical agents that are not controlled substances and are not antiglaucoma agents or limited or excluded by subdivision (b). For purposes of this section, "controlled substance" has the same meaning as used in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the United States Uniform Controlled Substances Act (21 U.S.C. Sec. 801 et seq.).

(B) Prescribing the oral analgesic controlled substance codeine with compounds, hydrocodone with compounds, and tramadol as listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the United States Uniform Controlled Substances Act (21 U.S.C. Sec. 801 et seq.), limited to three days, with referral to an ophthalmologist if the pain persists.

(C) If also certified under subdivision (c), using or prescribing topical and oral antiglaucoma agents for the medical treatment of all primary open-angle, exfoliation, pigmentary, and steroid-induced glaucomas in persons 18 years of age or over. In the case of steroid-induced glaucoma, the prescriber of the steroid medication shall be promptly notified if the prescriber did not refer the patient to the optometrist for treatment.

(D) If also certified under subdivision (d), independent initiation and administration of immunizations for influenza, herpes zoster virus, pneumococcus, and SARS-CoV-2 in compliance with individual Advisory Committee on Immunization Practices (ACIP) vaccine recommendations published by the federal Centers for Disease Control and Prevention (CDC) in persons 18 years of age or over.

(E) Utilizing the following techniques and instrumentation necessary for the diagnosis of conditions and diseases of the eye and adnexa:

(i) Laboratory tests or examinations ordered from an outside facility.

(ii) Laboratory tests or examinations performed in a laboratory with a certificate of waiver under the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) *(Public Law 100-578)* (42 U.S.C. Sec. ~~263a; Public Law 100-578),~~ *263a),* which shall also be allowed for:

(I) Detecting indicators of possible systemic disease that manifests in the eye for the purpose of facilitating appropriate referral to or consultation with a physician and surgeon.

(II) Detecting the presence of SARS-CoV-2 virus.

(iii) Skin testing performed in an office to diagnose ocular allergies, limited to the superficial layer of the skin.

(iv) X-rays ordered from an outside facility.

(v) Other imaging studies ordered from an outside facility subject to prior consultation with an appropriate physician and surgeon.

(vi) Other imaging studies performed in an office, including those that utilize laser or ultrasound technology, but excluding those that utilize radiation.

(F) Performing the following procedures, which are excluded from restrictions imposed on the performance of surgery by paragraph (6) of subdivision (b), unless explicitly indicated:

(i) Corneal scraping with cultures.

(ii) Debridement of corneal epithelium not associated with band keratopathy.

(iii) Mechanical epilation.

(iv) Collection of blood by skin puncture or venipuncture for laboratory testing authorized by this subdivision.

(v) Suture removal subject to comanagement requirements in paragraph (7) of subdivision (b).

(vi) Treatment or removal of sebaceous cysts by expression.

(vii) Lacrimal punctal occlusion using plugs, or placement of a stent or similar device in a lacrimal canaliculus intended to deliver a medication the optometrist is certified to prescribe or provide.

(viii) Foreign body and staining removal from the cornea, eyelid, and conjunctiva with any appropriate instrument. Removal of corneal foreign bodies and any related stain shall, as relevant, be limited to that which is nonperforating, no deeper than the midstroma, and not reasonably anticipated to require surgical repair.

(ix) Lacrimal irrigation and dilation in patients 12 years of age or over, excluding probing of the nasolacrimal tract. The board shall certify any optometrist who graduated from an accredited school of optometry before May 1, 2000, to perform this procedure after submitting proof of satisfactory completion of 10 procedures under the supervision of an ophthalmologist as confirmed by the ophthalmologist. Any optometrist who graduated from an accredited school of optometry on or after May 1, 2000, shall be exempt from the certification requirement contained in this paragraph.

(x) Administration of oral fluorescein for the purpose of ocular angiography.

(xi) Intravenous injection for the purpose of performing ocular angiography at the direction of an ophthalmologist as part of an active treatment plan in a setting where a physician and surgeon is immediately available.

(xii) Use of noninvasive devices delivering intense pulsed light therapy or low-level light therapy that do not rely on laser technology, limited to treatment of conditions and diseases of the adnexa.

(xiii) Use of an intranasal stimulator in conjunction with treatment of dry eye syndrome.

(G) Using additional noninvasive medical devices or technology that:

(i) Have received a United States Food and Drug ~~Administration approved~~ *Administration-approved* indication for the diagnosis or treatment of a condition or disease authorized by this chapter. A licensee shall successfully complete any clinical training imposed by a related manufacturer prior to using any of those noninvasive medical devices or technologies.

(ii) Have been approved by the board through regulation for the rational treatment of a condition or disease authorized by this chapter. Any regulation under this paragraph shall require a licensee to successfully complete an appropriate amount of clinical

training to qualify to use each noninvasive medical device or technology approved by the board pursuant to this paragraph.

(b) Exceptions or limitations to the provisions of subdivision (a) are as follows:

(1) Treatment of the following is excluded from the practice of optometry in a patient under 18 years of age, unless explicitly allowed otherwise:

(A) Anterior segment inflammation, which shall not exclude treatment of:

(i) The conjunctiva.

(ii) Nonmalignant ocular surface disease, including dry eye syndrome.

(iii) Contact lens-related inflammation of the cornea.

(iv) An infection of the cornea.

(B) Conditions or diseases of the sclera.

(2) Use of any oral prescription steroid anti-inflammatory medication for a patient under 18 years of age shall be done pursuant to a documented, timely consultation with an appropriate physician and surgeon.

(3) Use of any nonantibiotic oral prescription medication for a patient under five years of age shall be done pursuant to a documented, prior consultation with an appropriate physician and surgeon.

(4) The following classes of agents are excluded from the practice of optometry unless they have an explicit United States Food and Drug Administration-approved indication for treatment of a condition or disease authorized under this section:

(A) Antiamoebics.

(B) Antineoplastics.

(C) Coagulation modulators.

(D) Hormone modulators.

(E) Immunomodulators.

(F) Neuromuscular blockers.

(5) The following are excluded from authorization under subparagraph (G) of paragraph (5) of subdivision (a):

(A) A laboratory test or imaging study.

(B) Any noninvasive device or technology that constitutes surgery under paragraph (6).

(6) Performing surgery is excluded from the practice of optometry. “Surgery” means any act in which human tissue is cut,

altered, or otherwise infiltrated by any means. It does not mean an act that solely involves the administration or prescribing of a topical or oral therapeutic pharmaceutical.

(7) (A) Treatment with topical and oral medications authorized in subdivision (a) related to an ocular surgery shall be comanaged with the ophthalmologist that performed the surgery, or another ophthalmologist designated by that surgeon, during the customary preoperative and postoperative period for the procedure. For purposes of this subparagraph, this may involve treatment of ocular inflammation in a patient under 18 years of age.

(B) Where published, the postoperative period shall be the "global" period established by the federal Centers for Medicare and Medicaid Services, or, if not published, a reasonable period not to exceed 90 days.

(C) Such comanaged treatment may include addressing agreed-upon complications of the surgical procedure occurring in any ocular or adnexal structure with topical and oral medications authorized in subdivision (a). For patients under 18 years of age, this subparagraph shall not apply unless the patient's primary care provider agrees to allowing comanagement of complications.

(c) An optometrist certified pursuant to Section 3041.3 shall be certified to medically treat authorized glaucomas under this chapter after meeting the following requirements:

(1) For licensees who graduated from an accredited school of optometry on or after May 1, 2008, submission of proof of graduation from that institution.

(2) For licensees who were certified to treat glaucoma under this section before January 1, 2009, submission of proof of completion of that certification program.

(3) For licensees who completed a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, submission of proof of satisfactory completion of the case management requirements for certification established by the board.

(4) For licensees who graduated from an accredited school of optometry on or before May 1, 2008, and who are not described in paragraph (2) or (3), submission of proof of satisfactory completion of the requirements for certification established by the board under Chapter 352 of the Statutes of 2008.

(d) An optometrist certified pursuant to Section 3041.3 shall be certified to administer authorized immunizations, as described in subparagraph (D) of paragraph (5) of subdivision (a), after the optometrist meets all of the following requirements:

(1) Completes an immunization training program endorsed by the federal Centers for Disease Control and Prevention (CDC) or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and maintains that training.

(2) Is certified in basic life support.

(3) Complies with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.

(4) Applies for an immunization certificate in accordance with Section 3041.5.

(e) Other than for prescription ophthalmic devices described in subdivision (b) of Section 2541, any dispensing of a therapeutic pharmaceutical agent by an optometrist shall be without charge.

(f) An optometrist licensed under this chapter is subject to the provisions of Section 2290.5 for purposes of practicing telehealth.

(g) For the purposes of this chapter, all of the following definitions shall apply:

(1) "Adnexa" means the eyelids and muscles within the eyelids, the lacrimal system, and the skin extending from the eyebrows inferiorly, bounded by the medial, lateral, and inferior orbital rims, excluding the intraorbital extraocular muscles and orbital contents.

(2) "Anterior segment" means the portion of the eye anterior to the vitreous humor, including its overlying soft tissue coats.

(3) "Ophthalmologist" means a physician and surgeon, licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, specializing in treating eye disease.

(4) "Physician and surgeon" means a physician and surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(5) “Prevention” means use or prescription of an agent or noninvasive device or technology for the purpose of inhibiting the development of an authorized condition or disease.

(6) “Treatment” means use of or prescription of an agent or noninvasive device or technology to alter the course of an authorized condition or disease once it is present.

(h) In an emergency, an optometrist shall stabilize, if possible, and immediately refer any patient who has an acute attack of angle closure to an ophthalmologist.

SEC. 2. Section 3041.4 is added to the Business and Professions Code, to read:

3041.4. (a) An optometrist certified to treat glaucoma pursuant to subdivision (c) of Section 3041 shall be certified to perform the following set of advanced procedures after meeting the requirements in subdivision (b) after graduating from an accredited school of optometry:

(1) Laser trabeculoplasty.

(2) Laser peripheral iridotomy for the prophylactic treatment of a clinically significant narrow drainage angle of the anterior chamber of the eye.

(3) Laser posterior capsulotomy after cataract surgery.

(4) Excision or drainage of nonrecurrent lesions of the adnexa evaluated consistent with the standard of care by the optometrist to be noncancerous, not involving the eyelid margin, lacrimal supply, or drainage systems, no deeper than the orbicularis muscle, excepting chalazia, and smaller than five millimeters in diameter. Tissue excised that is not fully necrotic shall be submitted for surgical pathological analysis.

(5) Closure of a wound resulting from a procedure described in paragraph (4).

(6) Injections for the treatment of chalazia and to administer local anesthesia required to perform procedures delineated in paragraph (4).

(7) Corneal crosslinking procedure, or the use of medication and ultraviolet light to make the tissues of the cornea stronger.

(b) An optometrist shall satisfy the requirements specified in paragraphs (1) and (2) to perform the advanced procedures specified in subdivision (a).

(1) Within two years prior to beginning the requirements in paragraph (2), an optometrist shall satisfy both of the following:

(A) Complete a California State Board of Optometry-approved course of at least 32 hours that is designed to provide education on the advanced procedures delineated in subdivision (a), including, but not limited to, medical decisionmaking that includes cases that would be poor surgical candidates, an overview and case presentations of known complications, practical experience performing the procedures, including a detailed assessment of the optometrist's technique, and a written examination for which the optometrist achieves a passing score.

(B) Pass both sections of the Laser and Surgical Procedures Examination of the National Board of Examiners in Optometry, or, in the event this examination is no longer offered, its equivalent, as determined by the California State Board of Optometry. At the California State Board of Optometry's discretion, the requirement to pass the Laser and Surgical Procedures Examination may be waived if an optometrist has successfully passed both sections of the examination previously.

(2) Within three years, complete a California State Board of Optometry-approved training program conducted in California, including the performance of all required procedures that shall involve sufficient direct experience with live human patients to permit certification of competency, by an accredited California school of optometry that shall contain the following:

(A) Hands-on instruction on no less than the following number of simulated eyes before performing the related procedure on live human patients:

(i) Five for each laser procedure set forth in clauses (i), (ii), and (iii) of subparagraph (B).

(ii) Five to learn the skills to perform excision and drainage procedures and injections authorized by this section.

(iii) Five to learn the skills related to corneal crosslinking.

(B) The performance of at least 43 complete surgical procedures on live human patients, as follows:

(i) Eight laser trabeculoplasties.

(ii) Eight laser posterior capsulotomies.

(iii) Five laser peripheral iridotomies.

(iv) Five chalazion excisions.

(v) Four chalazion intralesional injections.

(vi) Seven excisions of an authorized lesion of greater than or equal to two millimeters in size.

(vii) Five excisions or drainages of other authorized lesions.

(viii) One surgical corneal crosslinking involving removal of epithelium.

(C) (i) If necessary to certify the competence of the optometrist, the program shall require sufficient additional experience to that specified in subparagraph (B) performing complete procedures on live human patients.

(ii) One time per optometrist seeking initial certification under this section, a procedure required by clause (i) to (vii), inclusive, of subparagraph (B) may be substituted for a different procedure required by clause (i) to (vii), inclusive, of subparagraph (B) to achieve the total number of complete surgical procedures required by subparagraph (B) if the procedures impart similar skills. The course administrator shall determine if the procedures impart similar skills.

(D) The training required by this section shall include at least a certain percent of the required procedures in subparagraph (B) performed in a cohort model where, for each patient and under the direct in-person supervision of a qualified educator, each member of the cohort independently assesses the patient, develops a treatment plan, evaluates the clinical outcome posttreatment, develops a plan to address any adverse or unintended clinical outcomes, and discusses and defends medical decisionmaking. The California State Board of Optometry-approved training program shall be responsible for determining the percentage of the required procedures in subparagraph (B).

(E) Any procedures not completed under the terms of subparagraph (D) may be completed under a preceptorship model where, for each patient and under the direct in-person supervision of a qualified educator, the optometrist independently assesses the patient, develops a treatment plan, evaluates the clinical outcome posttreatment, develops a plan to address any adverse or unintended clinical outcomes, and discusses and defends medical decisionmaking.

(F) The qualified educator shall certify the competent performance of procedures completed pursuant to subparagraphs (D) and (E) on a form approved by the California State Board of Optometry.

(G) Upon the optometrist’s completion of all certification requirements, the course administrator, who shall be a qualified

educator for all the procedures authorized by subdivision (a), on behalf of the program and relying on the certifications of procedures by qualified educators during the program, shall certify that the optometrist is competent to perform advanced procedures using a form approved by the California State Board of Optometry.

(c) The optometrist shall make a timely referral of a patient and all related records to an ophthalmologist or, in an urgent or emergent situation and an ophthalmologist is unavailable, a qualified center to provide urgent or emergent care, after stabilizing the patient to the degree possible if either of the following occur:

(1) The optometrist makes an intraoperative determination that a procedure being performed does not meet a specified criterion required by this section.

(2) The optometrist receives a pathology report for a lesion indicating the possibility of malignancy.

(d) This section does not authorize performing blepharoplasty or any cosmetic surgery procedure, including injections, with the exception of removing acrochordons that meet other qualifying criteria.

(e) An optometrist shall monitor and report the following information to the California State Board of Optometry on a form provided by the California State Board of Optometry or using an internet-based portal:

(1) At the time of license renewal or in response to a request of the California State Board of Optometry, the number and types of procedures authorized by this section that the optometrist performed and the diagnosis of the patient at the time the procedure was performed.

(2) Within three weeks of the event, any adverse treatment outcomes that required a referral to or consultation with another health care provider.

(f) (1) With each subsequent license renewal after being certified to perform the advanced procedures delineated in subdivision (a), the optometrist shall attest that they have performed each of the delineated procedures in subparagraph (B) of paragraph (2) of subdivision (b) during the period of licensure preceding the renewal.

(2) If the optometrist fails to attest to performance of any of the advanced procedures specified in paragraph (1), the optometrist's advanced procedure certification shall no longer authorize the

optometrist to perform that procedure until, with regard to that procedure, the optometrist performs at least the number of the specific advanced procedures required to be performed in subparagraph (B) of paragraph (2) of subdivision (b), as applicable, under the supervision of a qualified educator through either the cohort or preceptorship model outlined in subparagraphs (D) and (E) of paragraph (2) of subdivision (b), subject to subparagraph (F) of paragraph (2) of subdivision (b), and the qualified educator certifies that the optometrist is competent to perform the specific advanced procedures. The qualified educator may require the optometrist to perform additional procedures if necessary to certify the competence of the optometrist. The optometrist shall provide the certification to the California State Board of Optometry.

(g) The California State Board of Optometry shall review adverse treatment outcome reports required under subdivision (e) in a timely manner, requesting additional information as necessary to make decisions regarding the need to impose additional training, or to restrict or revoke certifications based on its patient safety authority. The California State Board of Optometry shall compile a report summarizing the data collected pursuant to subdivision (e), including, but not limited to, percentage of adverse outcome distributions by unidentified licensee and California State Board of Optometry interventions, and shall make the report available on its internet website.

(h) The California State Board of Optometry may adopt regulations to implement this section.

(i) The California State Board of Optometry, by regulation, shall set the fee for issuance and renewal of a certificate authorizing the use of advanced procedures at an amount no higher than the reasonable cost of regulating optometrists certified to perform advanced procedures pursuant to this section.

(j) For the purposes of this section, the following definitions apply:

(1) “Complete procedure” means all reasonably included steps to perform a surgical procedure, including, but not limited to, preoperative care, informed consent, all steps of the actual procedure, required reporting and review of any specimen submitted for pathologic review, and postoperative care. Multiple surgical procedures performed on a patient during a surgical session shall be considered a single surgical procedure.

(2) "Qualified educator" means a person nominated by an accredited California school of optometry as a person who is believed to be a suitable instructor, is subject to the regulatory authority of that person's licensing board in carrying out required responsibilities under this section, and is either of the following:

(A) A California-licensed optometrist in good standing certified to perform advanced procedures approved by the California State Board of Optometry who has been continuously certified for three years and has performed at least 10 of the specific advanced procedures for which they will serve as a qualified educator during the preceding two years.

(B) A California-licensed physician and surgeon who is board-certified in ophthalmology, in good standing with the Medical Board of California, and in active surgical practice an average of at least 10 hours per week.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

C. AB 1707 (Pachecho) Health professionals and facilities: adverse actions based on another state's law

Status: Signed into law. Chapter 258, Statutes of 2023.

DESCRIPTION OF CURRENT LEGISLATION:
This bill would prohibit CSBO and all healing arts boards under the Department of Consumer Affairs from denying an application for a license or imposing discipline upon a licensee solely on the basis of a civil judgment, criminal conviction, or disciplinary action in another state that is based on the application of another state's law that interferes with a person's right to receive care that would be lawful in California. The bill would similarly prohibit a health facility from denying staff privileges to, removing from medical staff, or restricting the staff privileges of a licensed health professional solely on the basis of such a civil judgment, criminal conviction, or disciplinary action imposed by another state. The bill would exempt a civil judgment, criminal conviction, or disciplinary action imposed by another state for which a similar claim, charge, or action would exist against the applicant or licensee under the laws of this state.

BACKGROUND:
Existing law requires all applicants for licensure as an optometrist or optician to be fingerprinted and successfully pass a criminal background check. General speaking, a criminal conviction or disciplinary action is not automatically disqualifying depending on the conviction or discipline and other factors. But past criminal history or disciplinary action could be prohibitive to receiving a license or may lead to conditions of licensure being imposed, depending on the circumstances. State actions around issues such as reproductive rights and gender affirming care have raised new threats for licensed healing arts practitioners and this bill would aim to protect those professionals from having their professional license, or application for professional license, at risk for performing actions that would be lawful if performed in California.

ANALYSIS:
Practicing healing arts professionals in some states have their professional licenses at risk due to changes in state law around issues of reproductive rights and gender affirming care. This bill could impact applicants for California licensure who held a license in another state that was subject to a disciplinary action based on activities in that state that would be legal if performed in California. This bill would prohibit those matters from being used for purposes of denying licensure or imposing discipline upon a licensee in California. However, the bill provides that this exemption does not apply to civil judgments, criminal convictions, or disciplinary actions imposed by another state for which a similar claim, charge, or action would exist against the applicant or licensee under the laws of California.

The impact of this bill is largely minimal to the practice of optometry given its distance from most of these issues. As part of the licensing process, any applicant for which a background check came back with criminal convictions would be subject to an enforcement review and determination as to whether licensure was suitable. The same would be true for licensees for whom the board receives DOJ subsequent arrest notifications for.

UPDATE:
The bill was signed into law on September 27, 2023.

FISCAL:
None

BOARD POSITION:
Support.

Action Requested:

None.

Attachment 1: Assembly Floor Analysis
Attachment 2: Bill text

CONCURRENCE IN SENATE AMENDMENTS
AB 1707 (Pacheco)
As Amended August 22, 2023
Majority vote

SUMMARY

Protects licensed health care professionals, clinics, and health facilities from being denied a license or subjected to discipline on the basis of a civil judgment, criminal conviction, or disciplinary action imposed by another state based solely on the application of a law that interferes with a person's right to receive sensitive services that would be lawful in California.

Senate Amendments
Clarifies the exemption for a civil judgment, criminal conviction, or disciplinary action imposed in another state for which there is a similar claim, charge, or action under California law.

COMMENTS

In 2002, the Legislature enacted the Reproductive Privacy Act, which grants every woman in California with the fundamental right to choose to bear a child or to choose to obtain an abortion. Under the Act, the state may not deny or interfere with that right prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the woman. The only restriction on abortion is when, in the good faith medical judgment of a physician, the fetus is viable and there is no risk to the life or health of the pregnant woman associated with continuing the pregnancy.

The Reproductive Privacy Act codifies the right to choose whether to have an abortion as a form of exercising the implicit right to privacy under the Fourteenth Amendment of the United States Constitution, as affirmed by the Supreme Court of the United States in *Roe v. Wade*, which found that Texas's criminal abortion statute violated the Due Process Clause. The Court in *Roe* ruled that during the first trimester, "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician." The Court ruled that during the second trimester, a state may only choose to "regulate the abortion procedure in ways that are reasonably related to maternal health," but that states may ban abortion altogether during the third trimester, "except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."

Recent judicial action in the United States has nationally imperiled the protections in *Roe*. In 2021, the Texas Legislature passed Senate Bill 8, referred to as the Texas Heartbeat Act. That bill criminalized abortion after the detection of embryonic or fetal cardiac activity, essentially banning abortion after approximately six weeks. The constitutionality of that bill was challenged in *Whole Woman's Health v. Jackson*, which sought to enforce the *Roe* precedent and overturn Senate Bill 8. However, the Court declined to enjoin the law, which many pro-choice advocates viewed as signaling a future decision by the Court to overturn or diminish the protections in *Roe*.

Subsequently, on December 1, 2021, the Court heard oral arguments in *Dobbs v. Jackson Women's Health Organization*, a case regarding a 2018 Mississippi state law that banned abortion after 15 weeks of pregnancy. *Dobbs* was a direct challenge to the legal precedent set in *Roe* and was the first new ruling from the Court on the constitutional right to pre-viability abortion. On June 24, 2022, the Court ruled that abortion is not a constitutional right. This effectively overturned *Roe* and left the question of whether and how to ban it to individual states.

Immediately after the Court's decision, State Senate President pro Tempore Toni Atkins sponsored SCA 10, which placed a proposition on the 2022 ballot titled *Constitutional Right to Reproductive Freedom*. Proposition 1 explicitly made abortion and access to contraceptives a constitutional right in California. The ballot proposition passed with over 66% of voters in favor, enshrining the protections of *Roe* into the state's constitution. While California law protects a pregnant person's right to choose in a manner consistent with *Roe*, it has been estimated that approximately 26 states would likely seek to ban abortion with *Roe* overturned, resulting in 36 million women and other people who may become pregnant losing access to abortion care nationwide. In spite of this, medical professionals may still choose to provide abortions in defiance of another state's law. This potentially includes professionals licensed in California who may travel to other states to provide these services.

To provide reassurance to California health care professionals that they would not be subjected to discipline for continuing to provide abortion care and other reproductive services, California enacted AB 2626 in 2022. That bill reiterated that licensing boards may not subject licensed health care professionals to serious discipline for performing an abortion that is legal under California law, protecting the license of those who provide abortions in states that have banned abortion or to patients who have traveled from those states to California to seek care. While California licensing boards do not have direct jurisdiction over care provided in other states, they are notified when a licensee was either convicted of a crime in another state or subjected to discipline by another state's licensing board. When notified, the California boards may decide whether to take disciplinary action. AB 2626 prohibited boards from suspending or revoking a license solely for performing an abortion in accordance with California law.

This bill would further protect health care professionals who perform care prohibited in other states that patients would have a right to in California. Specifically, the bill would ban healing arts boards from denying or disciplining a license solely on the basis of a civil judgment, criminal conviction, or disciplinary action in another state based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California. The bill would also enact similar prohibitions against discipline against health professionals by the CDPH or licensed health facilities. The protections in this bill are intended ensure that California provides safe harbor to health professionals who defend the rights of patients to receive essential care or services, even if other states have taken action to restrict those rights.

According to the Author
"AB 1707 aims to protect California's reproductive health care providers by ensuring their ability to provide care is not at risk if they faced disciplinary action in another state related to reproductive health care services. California's health care providers are becoming increasingly essential for providing care to residents in other states and it is critical to ensure that providers in California, abiding by California laws, are protected from adverse actions based on another state's hostile law. To ensure that providers in California are protected from hostile laws in these other states – we must do everything we can to strengthen California law to protect provider licensure, facility licensure, and providers' ability to practice. The intent of this bill is to shore up protections so that care in California can remain consistent and ensure that California lives up to its declaration as a reproductive freedom state."

Arguments in Support
Planned Parenthood Affiliates of California (PPAC) is sponsoring this bill. According to PPAC: "AB 1707 builds on existing protections for health care providers who face disciplinary or legal actions in another state based on another state's law restricting services within comprehensive sexual and reproductive health care. Specifically, this bill ensures healing arts licensees, as well as clinics and hospitals are not faced with denial, suspension, or revocation of their license in California as the result of disciplinary action in another state related to providing care that is lawful here, and that health care providers are not faced with denial, suspension, or revocation of their hospital privileges as the result of disciplinary action in another state related to providing care that is lawful in California. This bill is critical to ensuring that states with hostile laws cannot attack providers for what is legal and permissible in California."

Arguments in Opposition
None on file.

FISCAL COMMENTS

Pursuant to Senate Rule 28.8, negligible state costs.

VOTES:

ASM BUSINESS AND PROFESSIONS: 14-2-2
YES: Berman, Alanis, Alvarez, Bonta, Gipson, Grayson, Irwin, Jackson, Lee, Lowenthal, McCarty, McKinnor, Stephanie Nguyen, Ting
NO: Flora, Joe Patterson
ABS, ABST OR NV: Chen, Dixon

ASM JUDICIARY: 8-2-1
YES: Maienschein, Connolly, Haney, Kalra, Pacheco, Papan, Reyes, Robert Rivas
NO: Essayli, Sanchez
ABS, ABST OR NV: Dixon

ASM APPROPRIATIONS: 12-2-2
YES: Holden, Bryan, Calderon, Wendy Carrillo, Mike Fong, Addis, Lowenthal, Papan, Pellerin, Robert Rivas, Weber, Wilson
NO: Megan Dahle, Sanchez
ABS, ABST OR NV: Dixon, Mathis

ASSEMBLY FLOOR: 62-12-6
YES: Addis, Aguiar-Curry, Alanis, Alvarez, Arambula, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Juan Carrillo, Wendy Carrillo, Cervantes, Connolly, Mike Fong, Friedman, Gabriel, Garcia, Gipson, Grayson, Haney, Hart, Holden, Irwin, Jackson, Jones-Sawyer, Kalra, Lee, Low, Lowenthal, Maienschein, McCarty, McKinnor, Muratsuchi, Stephanie Nguyen, Ortega, Pacheco, Papan, Pellerin, Petrie-Norris, Reyes, Luz Rivas, Robert Rivas, Rodriguez, Blanca Rubio, Santiago, Schiavo, Soria, Ting, Valencia, Villapudua, Wallis, Ward, Weber, Wicks, Wilson, Wood, Zbur, Rendon
NO: Megan Dahle, Essayli, Flora, Vince Fong, Gallagher, Hoover, Mathis, Jim Patterson, Joe Patterson, Sanchez, Ta, Waldron
ABS, ABST OR NV: Chen, Davies, Dixon, Lackey, Quirk-Silva, Ramos

SENATE FLOOR: 31-8-1
YES: Allen, Alvarado-Gil, Archuleta, Ashby, Atkins, Becker, Blakespear, Bradford, Caballero, Cortese, Dodd, Durazo, Eggman, Glazer, Gonzalez, Hurtado, Laird, Limón, McGuire, Menjivar, Min, Newman, Portantino, Roth, Rubio, Skinner, Smallwood-Cuevas, Stern, Umberg, Wahab, Wiener
NO: Dahle, Grove, Jones, Nguyen, Niello, Ochoa Bogh, Seyarto, Wilk
ABS, ABST OR NV: Padilla

UPDATED

VERSION: August 22, 2023

CONSULTANT: Robert Sumner / B. & P. / (916) 319-3301 FN: 0001774

Assembly Bill No. 1707

CHAPTER 258

An act to add Sections 805.9 and 850.1 to the Business and Professions Code, and to add Sections 1220.1 and 1265.11 to the Health and Safety Code, relating to health care.

[Approved by Governor September 27, 2023. Filed with Secretary of State September 27, 2023.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1707, Pacheco. Health professionals and facilities: adverse actions based on another state's law.

Existing law establishes various boards within the Department of Consumer Affairs to license and regulate various health professionals. Existing law prohibits the Medical Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, and the Physician Assistant Board from denying an application for licensure or suspending, revoking, or otherwise imposing discipline upon a licensee because the person was disciplined in another state in which they are licensed solely for performing an abortion in that state or because the person was convicted in another state for an offense related solely to performing an abortion in that state.

Existing law provides for the licensure of clinics and health facilities by the Licensing and Certification Division of the State Department of Public Health. Existing law makes a violation of these provisions punishable as a misdemeanor, except as specified.

This bill would prohibit a healing arts board under the Department of Consumer Affairs from denying an application for a license or imposing discipline upon a licensee or health care practitioner on the basis of a civil judgment, criminal conviction, or disciplinary action in another state that is based on the application of another state's law that interferes with a person's right to receive sensitive services, as defined, that would be lawful in this state, regardless of the patient's location. The bill would similarly prohibit a health facility from denying staff privileges to, removing from medical staff, or restricting the staff privileges of a licensed health professional on the basis of such a civil judgment, criminal conviction, or disciplinary action imposed by another state. The bill also would also prohibit the denial, suspension, revocation, or limitation of a clinic or health facility license on the basis of those types of civil judgments, criminal convictions, or disciplinary actions imposed by another state. The bill would exempt from the above-specified provisions a civil judgment, criminal conviction, or disciplinary action imposed by another state based upon conduct in another state that would subject an applicant, licensee, or health care practitioner to

a similar claim, charge, or action under the laws of this state. By imposing new prohibitions under the provisions related to clinics and health facilities, the violation of which is a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 805.9 is added to the Business and Professions Code, to read:

805.9. (a) A health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code shall not deny staff privileges to, remove from medical staff, or restrict the staff privileges of a person licensed by a healing arts board in this state on the basis of a civil judgment, criminal conviction, or disciplinary action imposed by another state if that judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive sensitive services that would be lawful if provided in this state.

(b) This section does not apply to a civil judgment, criminal conviction, or disciplinary action imposed in another state based upon conduct in another state that would subject a licensee to a similar claim, charge, or action under the laws of this state.

(c) For purposes of this section:

(1) "Healing arts board" means any board, division, or examining committee in the Department of Consumer Affairs that licenses or certifies health professionals.

(2) "Sensitive services" has the same meaning as in Section 56.05 of the Civil Code.

SEC. 2. Section 850.1 is added to the Business and Professions Code, to read:

850.1. (a) A healing arts board shall not deny an application for licensure or suspend, revoke, or otherwise impose discipline upon a licensee or health practitioner subject to this division on the basis of a civil judgment, criminal conviction, or disciplinary action in another state if that judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive sensitive services that would be lawful if provided in this state, regardless of the patient's location.

(b) This section does not apply to a civil judgment, criminal conviction, or disciplinary action imposed in another state based upon conduct in another state that would subject an applicant, licensee, or health care practitioner

subject to this division to a similar claim, charge, or action under the laws of this state.

(c) For purposes of this section:

(1) "Healing arts board" means any board, division, or examining committee in the Department of Consumer Affairs that licenses or certifies health professionals.

(2) "Sensitive services" has the same meaning as in Section 56.05 of the Civil Code.

SEC. 3. Section 1220.1 is added to the Health and Safety Code, to read:

1220.1. (a) An application for licensure made pursuant to this chapter shall not be denied, nor shall any license issued pursuant to this chapter be suspended, revoked, or otherwise limited, on the basis of a civil judgment, criminal conviction, or disciplinary action imposed by another state if that judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive sensitive services that would be lawful if provided in this state.

(b) This section does not apply to a civil judgment, criminal conviction, or disciplinary action imposed by another state based upon conduct in another state that would subject an applicant, licensee, or health care practitioner subject to this division to a similar claim, charge, or action under the laws of this state.

(c) For purposes of this section, "sensitive services" has the same meaning as in Section 56.05 of the Civil Code.

SEC. 4. Section 1265.11 is added to the Health and Safety Code, to read:

1265.11. (a) An application for licensure made pursuant to this chapter shall not be denied, nor shall any license issued pursuant to this chapter be suspended, revoked, or otherwise limited, on the basis of a civil judgment, criminal conviction, or disciplinary action imposed by another state if that judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive sensitive services that would be lawful if provided in this state.

(b) This section does not apply to a civil judgment, criminal conviction, or disciplinary action imposed by another state based upon conduct in another state that would subject an applicant, licensee, or health care practitioner subject to this division to a similar claim, charge, or action under the laws of this state.

(c) For purposes of this section, "sensitive services" has the same meaning as in Section 56.05 of the Civil Code.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime

within the meaning of Section 6 of Article XIII B of the California Constitution.

O

D. SB 340 (Eggman) Medi-Cal: eyeglasses: Prison Industry Authority

Status: Introduced 2-07-2023 / Two-year bill

AUTHOR REASON FOR THE BILL:
According to the author: "current DHCS policy requires that eyeglasses for the Medi-Cal program be obtained through CalPIA. Unfortunately, the delivery system is fraught with long delays and quality control issues. Medi-Cal beneficiaries often wait one to two months to receive their eyeglasses and thousands are suffering because they cannot see well enough to perform necessary life functions. School-age children experiencing lengthy delays for their glasses are visually handicapped in their classroom causing them to struggle academically. Recreational and other extra-curricular activities are also negatively impacted. Over 13 million Californians rely on the Medi-Cal program for health coverage including over 40% of the state's children, nearly 5.2 million kids. Because two thirds of Medi-Cal patients are people of color, the lack of timely access to eyeglasses in Medi-Cal is an equity concern. This bill, the Better Access to Better Vision Act, addresses the ongoing concerns with delays and quality of products by optometrists participating in the Medi-Cal program by authorizing the option of using a private entity when ordering eyeglasses. Expanding the source options for eyewear allows providers to better meet their patients' needs."

DESCRIPTION OF CURRENT LEGISLATION:
This bill, for purposes of Medi-Cal reimbursement for covered optometric services, would authorize a provider to obtain eyeglasses from a private entity, as an alternative to a purchase of eyeglasses from the Prison Industry Authority (PIA). The bill would condition implementation of this provision on the availability of federal financial participation.

BACKGROUND:
This bill is substantially similar to SB 1089 (Wilk,2022) which was sponsored by the California Optometric Association. The Board considered that bill in 2022 and took a support position on it. That bill was ultimately gut and amended into an entirely different topic and the language the Board had considered was not enacted.

ANALYSIS:
Optometry and eyeglasses for children are a mandatory benefit of the Medicaid program that states must provide if they participate in Medicaid. Optometry and eyeglasses for adults are an optional state benefit. The adult benefit has been cut in the past during times of budget distress. This last occurred during 2009-2020, with the adult benefit resuming in 2020, subject to an annual appropriation. For both adults and children, routine eye exam and eyeglasses are covered every 24 months.
For more than 30 years, California has required that glasses for Medi-Cal beneficiaries be exclusively made by incarcerated persons within the state's prisons. According to an August 18, 2022, article "California Prison Optometry Labs Under Pressure to Do Better," there were "295 prisoners in optical programs in three prisons, and the number will rise to 420 when the newest women's optometric program is fully underway in late summer 2022."

A July 8, 2022, article "Medi-Cal's Reliance on Prisoners to Make Cheaper Eyeglasses Proves Shortsighted" noted that between 2019 and 2021, orders for glasses from MediCal to the Prison Industry Authority nearly doubled, from 490,000 to 880,000; presumably most of this increase is due to the adult benefit resuming in 2020. According to the article, PIA contracts with nine private labs to help fulfill orders, five of these are not located in California, and in 2021, 54% of the 880,000 orders were sent to these contracted private labs.

The COVID-19 pandemic caused PIA service delivery issues leading to average wait times approaching 1.5 months. This compared to historical averages of approximately 1 week. According to recent PIA data, current wait times are averaging 5.5 days; however the March 27, 2023 Senate Health Committee analysis stated "according to a recent public records request shared with the Committee, in the last six months of 2022, nearly 40% of the glasses with a five-day turnaround were late and nearly 50% of the glasses with a ten-day turnaround were late."

According to the PIA, Medi-Cal pays $19.60 for every pair of glasses made. It is likely that glasses made by private parties will cost more; last year the Department of Health Care Services (DHCS) estimated that "based on fee-for-service rates, cost increase for reimbursement is estimated at a 141 percent increase per claim."

UPDATE:
This bill is a two-year bill. According to the author's office, they will attempt a narrower approach in 2024 owing to concerns expressed by the Department of Health Care Services that the data provided by PIA showed compliance with that department's standards.

FISCAL:
None.

Board Position:
Support.

Action Requested:

None at this time.

Attachment 1: Assembly Health Committee Analysis
Attachment 2: Bill text

Date of Hearing: June 27, 2023

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 340 (Eggman) – As Introduced February 7, 2023

SENATE VOTE: 40-0

SUBJECT: Medi-Cal: eyeglasses: Prison Industry Authority.

SUMMARY: Establishes the "Better Access to Better Vision Act," which permits a Medi-Cal provider to obtain eyeglasses from a private entity, as an alternative to eyeglasses purchased from the California Prison Industry Authority (CalPIA). Specifically, **this bill**:

1) Permits a provider participating in the Medi-Cal program to obtain eyeglasses from the CalPIA or private entities based on the provider's needs and assessment of quality and value, notwithstanding a provision of current law that requires state agencies to make maximum utilization of CalPIA-produced products.

2) Permits a provider, for purposes of Medi-Cal reimbursement for covered optometric services to obtain eyeglasses from a private entity, as an alternative to a purchase of eyeglasses from the CalPIA.

3) Implements this bill only to the extent that federal financial participation is available.

4) Names the act, and specifies it may be cited as, the "Better Access to Better Vision Act."

EXISTING LAW:

1) Establishes a schedule of benefits in the Medi-Cal program, which includes optometric services and eyeglasses as covered benefits, subject to utilization controls. [Welfare and Institutions Codes § 14132]

2) Requires the utilization controls for eyeglasses to allow replacement necessary because of loss or destruction due to circumstances beyond the beneficiary's control, but prohibits frame styles for eyeglasses replaced from changing more than once every two years, unless the Department of Health Care Services (DHCS) so directs. [*ibid.*]

3) States that every able-bodied person committed to the custody of the California Department of Corrections and Rehabilitation (CDCR) is obligated to work as assigned by CDCR staff and by personnel of other agencies to whom the inmate's custody and supervision may be delegated. Permits assignment to be up to a full day of work, or other programs including rehabilitative programs, as defined, or a combination of work or other programs. [California Code of Regulations (CCR), Title 15, § 3040 (a)]

4) Specifies that inmates of CDCR are expected to work or participate in rehabilitative programs and activities to prepare for their eventual return to society. Requires inmates who comply with the regulations and rules of CDCR and perform the duties assigned to them to earn Good Conduct Credit, as specified. (CCR Title 15, § 3043 (a))

5) Authorizes and empowers the CalPIA to operate industrial, agricultural, and service enterprises, which will provide products and services needed by the state, or any political subdivision thereof, or by the federal government, or any department, agency, or corporation thereof, or for any other public use. [Penal Code (PEN) § 2807(a)]

6) Permits products to be purchased by state agencies to be offered for sale to inmates of CDCR and to any other person under the care of the state who resides in state-operated institutional facilities. Requires state agencies to make maximum utilization of these products, and consult with the staff of the CalPIA to develop new products and adapt existing products to meet their needs. [PEN § 2807 (b)]

FISCAL EFFECT: According to Senate Appropriations Committee:

1) DHCS estimates costs for the Medi-Cal program of $6.5 million ($2.5 million General Fund (GF)) for six months in 2023-24, $28.3 million ($10.9 million General Fund) in 2024-25, and $29.1 million ($11.1 million GF) in 2025-26 and ongoing thereafter. DHCS estimates that while the current average CalPIA payment rate is $19.82 per pair of lenses, the non-PIA rate is estimated to be $47.76. DHCS also estimates costs of $148,000 ($74,000 GF) in 2023-24 and $139,000 ($69,000 GF) in 2024-25 and ongoing thereafter for state operations.

2) CalPIA indicates that incarcerated individuals who work in the optical enterprise can earn up to 12 weeks of sentence reduction for each year worked. If the program closed, 420 individual work assignments for incarcerated individual work assignments in the optical program would be eliminated. CalPIA estimates that by not having the opportunity to earn the 12 weeks of sentence reduction, the state could incur costs up to $12.3 million a year by keeping the individuals in prison.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, current DHCS policy requires that eyeglasses for the Medi-Cal program be obtained through CalPIA. Unfortunately, the author asserts, the delivery system is fraught with long delays and quality control issues. The author points out Medi-Cal beneficiaries often wait one to two months to receive their eyeglasses and thousands are suffering because they cannot see well enough to perform necessary life functions. The author notes it is particularly unacceptable that school-age children experience lengthy delays for their glasses, remaining visually handicapped in their classroom and struggling academically as a result. The author also notes that two-thirds of Medi-Cal patients are people of color, making the lack of timely access to eyeglasses in Medi-Cal is an equity concern. The author concludes this bill is intended to address these concerns by authorizing the option of using a private entity when ordering eyeglasses.

2) BACKGROUND.

a) Medi-Cal Vision Benefit. Vision benefits, including routine eye exam, eyeglass prescriptions, and eyeglasses (frame and lenses) are Medi-Cal benefits available in Medi-Cal managed care plans and fee-for-service Medi-Cal. The adult eyeglasses benefit (optometric and optician services, including services provided by a fabricating optical laboratory) was eliminated by AB 5 (Evans), Chapter 5, Statutes of 2009 and subsequently restored by SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, effective no sooner than January 1, 2020, contingent upon budget act

funding.

b) CalPIA Optical Program. Since 1988, DHCS has had an Interagency Agreement (IA) with CalPIA under which CalPIA furnishes prescription lenses for Medi-Cal beneficiaries. CalPIA is a self-funded state entity that provides training, certification, and work opportunities in a variety of different fields to approximately 7,000 incarcerated individuals at 34 CDCR prisons. Goods and services produced by CalPIA are sold to the state and other government entities. According to an evaluation conducted by University of California, Irvine, using statistically matched individuals not enrolled in CalPIA, participation in CalPIA is associated with reduced recidivism.

Under the IA, CalPIA does not provide eyeglass frames but makes the lenses and fits them into the frames. Optometrists participating in the Medi-Cal program must order the lenses from CalPIA unless the lens required cannot be accommodated by CalPIA. The Medi-Cal Provider Manual details certain specialized lenses that CalPIA does not manufacture, which are furnished by other optical labs.

Currently, CalPIA operates three optical laboratories located at California State Prison, Solano; Valley State Prison; and Central California Women's Facility (CCWF). CalPIA indicates it has made a substantial capital investment of $24.4 million to expand its optical enterprises at all three laboratories in preparation for the increased workload associated with the restoration of the Medi-Cal optical benefit for adults. This total includes a $7.6 million investment to open the laboratory at the CCWF in 2022, as well as investment in automation equipment at all three laboratories.

In the 2020 calendar year, CalPIA processed 642,252 jobs (1.2 million lenses) at a total funds cost of $12 million. In 2021, CalPIA processed 860,481 jobs (1.7 million lenses) at a total funds cost of $16.8 million. According to CalPIA, from 2008 to June 19, 2023, there have been 2,452 incarcerated individuals who have worked in a CalPIA optical position and 1,390 incarcerated individuals who have earned an Accredited Certification certificate in the optical program.

Currently, DHCS reimburses CalPIA an average of $19.82 per pair of Medi-Cal lenses.

c) Normal Timelines. The DHCS-CalPIA IA requires CalPIA to manufacture lenses within five business days, or ten business days for more complex orders, once an optical order is received. CalPIA states their current average turnaround time is approximately four business days.

Delivery time to and from the optical laboratory is not included in the average turnaround times. According to CalPIA, its contracts with courier services require these services to pick up frames from an optometrist and deliver them to CalPIA’s laboratory within two business days. These contracts also require shipping of finished orders from CalPIA’s laboratories back to the ordering provider within two business days.

d) COVID-19 Delays. For the nine-year period of January 2011 through February 2020, CalPIA data indicates the monthly average turnaround time was consistently at, or below the five-day target, with the exception of February 2012 and February 2013, when the average turnaround time was six days (one day over the target). CalPIA indicates the

COVID-19 pandemic increased turnaround times dramatically. According to data provided by CalPIA, turnaround time exceeded the five-day contractual maximum turnaround time for the period from August 2020 to February 2023. Turnaround time fluctuated throughout this period, but peaked three distinct times: in February 2021 at 20 days, in September 2021 at 15.6 days, and in February 2022 at 13.4 days. During this time, CalPIA indicates that it used back-up labs and other operational measures to address long turnaround times. These COVID-19 related delays have since been resolved.

e) Perceived Quality and Service Issues. According to the bill's sponsor, the California Optometric Association, their member optometrists report not only long delays, but also poor workmanship and poor customer service at CalPIA.

The only quality metric available is the "re-do rate," which includes any quality issue identified throughout the process that necessitates the order to be re-manufactured for any reason. CalPIA indicates the re-do rate includes processes under CalPIA's control as well as issues originating with the provider, such as misspecification of the order. Data provided by CalPIA indicates the re-do rate, as defined, has ranged from 0.69% to 1.49% over the last three years. The re-do rate has averaged at 0.92% over the last 12 months, and the most recent rate reported, for May 2023, is 0.75%. CalPIA indicates this rate is better than the industry standard.

There is no reliable data available to demonstrate the level of satisfaction with CalPIA's customer service. The IA describes a four-level complaint process for resolving provider complaints. DHCS indicates in recent years it has received complaints from only one individual Medi-Cal provider.

f) Prison Labor Generally. Individuals incarcerated in CDCR facilities are required to work or participate in rehabilitative or educational programs. Participating in work while incarcerated can promote rehabilitation by providing incarcerated individuals life skills and technical knowledge that can facilitate their reintegration in society. In addition, by producing items for use by government agencies, prison industry programs can reduce the cost of state services or offset the cost of prison operations. Some assignments can earn incarcerated individuals credit towards time served. For instance, incarcerated individuals who work in the CalPIA optical laboratories can earn up to 12 weeks of sentence reduction for each year worked. However, the use of prison labor is controversial. Some have raised ethical concerns against prison labor on grounds that it is innately exploitative and a violation of fundamental human rights. Additionally, some argue prison labor holds down wages for other workers, given wages are extremely low for prison jobs.

Pay rates for most prison jobs in California range from $0.11 to $0.32 per hour with monthly maximum pay of $12 to $20. CalPIA jobs are slightly higher paying than the standard job, and incarcerated individuals can receive industry-accredited certifications, credits, and training for jobs such as meat cutting, coffee roasting, optical and dental services, and health care facilities maintenance. CalPIA currently has a five-level pay scale with the lowest paid scale ranging from $0.35-$0.45 per hour and the highest scale ranging from $0.80 to $1 per hour.

g) Medi-Cal Provider Billing for Prescription Lenses.

i) **CalPIA Covered Lenses**. Because CalPIA manufactures the lenses needed for the glasses, providers do not bill for or receive reimbursement for lenses. Instead, providers bill DHCS or the applicable Medi-Cal managed care plan for related products and services, such as frames and the lens dispensing fees, and DHCS reimburses CalPIA for the lenses directly through the IA. CalPIA also maintains contracts with third-party providers as needed to produce the lenses; for instance, during the COVID-19 pandemic, CalPIA contracted with outside labs to produce a large portion of their total orders.

ii) **Non-CalPIA Covered Lenses**. DHCS currently allows providers to order from other labs outside the CalPIA, but only for medically necessary specialized lenses that the CalPIA does not manufacture. This is also a more administratively cumbersome process for the provider and for the state. DHCS specifies such lenses must be billed with Healthcare Common Procedure Coding System (HCPCS) code V2799 (vision item or service, miscellaneous), and this code requires pre-authorization from the DHCS Vision Services Branch prior to dispensing the lenses. In addition, providers must include a complete description of the lenses and justification for medical necessity. These unlisted eye appliances are priced "by report," which is based on the documented wholesale cost of the appliance. Therefore, laboratory invoices or catalog pages must be attached to the claim to allow DHCS to price the appliance individually using a manual process.

h) **Potential Effect of this Bill.** This bill would allow providers to use private laboratories to fabricate all lenses for Medi-Cal patients, instead of using CalPIA. Because the effect of the bill depends on the decisions of individual providers to place orders with either CalPIA or private laboratories, the effect of the bill on CalPIA's operations is not possible to identify with certainty. However, it seems plausible that optometrists would choose to use their preferred laboratories that currently fabricate lenses for their non-Medi-Cal clients, which would ultimately undermine CalPIA's ability to maintain the optical program. CalPIA has recently invested millions of dollars to open a new laboratory, upgrade equipment, and train individuals. If CalPIA's laboratories were reduced in size or closed, it would limit the usefulness of these recent investments and reduce opportunities for incarcerated individuals to participate in the program and receive optical training and reduce their sentences. On the other hand, over the long term, these impacts to incarcerated individuals could be mitigated if CalPIA developed other lines of business that created similar opportunities.

The use of private laboratories would also increase state costs by requiring higher Medi-Cal reimbursements than the rate paid to CalPIA. Costs are noted under "Fiscal Effect," above. Allowing optometric providers to choose which private laboratories manufacture lenses on their behalf would also limit DHCS's oversight and authority over the provision of lenses to Medi-Cal enrollees. For instance, DHCS would not be able to negotiate agreements on a statewide basis or provide direct oversight of the quality of the product.

3) **SUPPORT**. This bill is sponsored by the California Optometric Association (COA) to authorize an optometrist participating in the Medi-Cal program to obtain eyeglasses from CalPIA or a private entity/lab. Current DHCS policy requires the eyeglasses to be obtained only through the CalPIA. COA states this bill addresses a very serious problem in the Medi-

Cal program that is leaving its most vulnerable patients, including children, without access to eyeglasses for months.

COA states the CalPIA has been plagued with problems for years as the eyeglasses are often late, incorrect, or of poor quality, and the pandemic has made a bad situation much worse as some patients have had to wait for more than four months for their eyeglasses. COA states DHCS claims that the backlog resulting from prison closures have been cleared up, but that is not what optometrists report to COA. Each day, COA states it hears tragic stories from its patients about how their lives are affected, including children who are falling behind and parents who cannot work to provide for their families. Each day, COA states optometrists are having to deal with understandably frustrated patients who get aggressive, verbally abusive, and make threats because they are desperate for their glasses. COA states most of its members' Medi-Cal patients cannot afford to purchase eyewear out of pocket and so they are forced to put their lives on hold for months until the CalPIA lab returns their glasses. COA states its members tell them that the requirement to fabricate glasses through the CalPIA has reduced the number of providers willing to accept Medi-Cal.

4) **OPPOSITION.** The Prison Industry Board (PIB), the governing board that oversees CalPIA, writes in opposition that this bill would eliminate hundreds of rehabilitative job training positions annually and cost the state tens of millions of dollars in additional costs per year. PIB asserts impacts to the Optical Program caused by COVID have been resolved and there is no basis or reason for this bill. PIB notes CalPIA's program is back to normal, with its average turnaround times at four days, and that CalPIA's quality is better than the industry standard with the average redo rate for eyeglasses below one percent. PIB argues this bill will cost the state millions of dollars in higher incarceration costs, as this bill could eliminate rehabilitative job training for at least 420 incarcerated individuals each year, as well as potentially eliminate jobs of those who oversee the program. PIB argues that CalPIA's Optical program reduces recidivism, increases public safety, and saves the GF millions per year while receiving no appropriation from the Legislature. PIB notes CalPIA's Optical program produces many success stories, with formerly incarcerated individuals working as opticians, lab managers, and in other positions in the optical industry, helping individuals to break the cycle of recidivism and have the opportunity to attain a career that provides a livable wage. PIB concludes this bill would have negative impacts affecting the lives of the formerly incarcerated individuals, their families, the public, and taxpayers, and respectfully requests that this bill be withdrawn or defeated.

5) **PREVIOUS LEGISLATION**. SB 1089 (Wilk) of 2022 was substantially similar to this bill. SB 1089 was amended to an unrelated subject matter and ultimately chaptered.

6) **DOUBLE REFERRAL**. This bill is double referred. Upon passage in this Committee, this bill will be referred to the Assembly Committee on Public Safety.

7) **POLICY COMMENTS**.

   a) **Problem Definition.** According to the author and sponsor of this bill, optometry stakeholders "on the ground" have longstanding frustrations with perceived excessive delays, poor quality, and poor customer service. However, aside than acknowledged delays during the COVID-19 pandemic that have since been corrected, available data does not support these assertions. Therefore, the problem definition— in terms of time to

produce the order, quality, and customer service— is unclear. It is possible there truly are no problems, or that CalPIA and DHCS are not collecting the right data to identify the problems as articulated by individual optometrists interacting with CalPIA.

b) **Potential Alternative Approaches.** As noted, the problems this bill is intended to solve are based on anecdotal evidence of dissatisfaction of optometrists, including time delays, poor quality, and poor customer service. At least one of the potential issues— time delays and disruptions related to COVID-19, which were not unique to CalPIA— appear to have been resolved based on available data. To the extent further analysis revealed a more precise problem definition, there are a number of potential alternative approaches that could be considered to address narrower problems in a more targeted way, potentially at less state cost. As an alternative to authorizing the broad shift of lens fabrication to other entities as this bill proposes, CalPIA could instead be required to use outside labs if CalPIA's average processing time exceeds existing interagency contract standards in the prior month until the turnaround time meets existing interagency contract standards. Other approaches could target other issues, as appropriate and necessary. For instance, customer service metrics could be put into place and corrective action plans could be imposed if metrics fall below acceptable service level agreements, quality improvement approaches could be employed, or an end-to-end business analysis of the entire process could be conducted to analyze potential opportunities to increase efficiency.

REGISTERED SUPPORT / OPPOSITION:

Support

California Optometric Association (sponsor)
California Children's Vision Now Coalition
California State Society for Opticians
Children Now
Hero Practice Services
National Vision INC.
Slolionseye.org
Vision Center of Sana Maria

Opposition

CalPIA

Analysis Prepared by: Lisa Murawski / HEALTH / (916) 319-2097

SENATE BILL No. 340

Introduced by Senator Eggman
(Principal coauthor: Senator Wilk)

February 7, 2023

An act to amend Section 2807 of the Penal Code, and to add Section 14131.08 to the Welfare and Institutions Code, relating to optometry.

LEGISLATIVE COUNSEL'S DIGEST

SB 340, as introduced, Eggman. Medi-Cal: eyeglasses: Prison Industry Authority.

Existing law establishes the Prison Industry Authority within the Department of Corrections and Rehabilitation and authorizes it to operate industrial, agricultural, and service enterprises that provide products and services needed by the state, or any political subdivision of the state, or by the federal government, or any department, agency, or corporation of the federal government, or for any other public use. Existing law requires state agencies to purchase these products and services at the prices fixed by the authority. Existing law also requires state agencies to make maximum utilization of these products and consult with the staff of the authority to develop new products and adapt existing products to meet their needs.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including certain optometric services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill, for purposes of Medi-Cal reimbursement for covered optometric services, would authorize a provider to obtain eyeglasses from a private entity, as an alternative to a purchase of eyeglasses from

the Prison Industry Authority. The bill would condition implementation of this provision on the availability of federal financial participation.

The bill, notwithstanding the above-described requirements, would authorize a provider participating in the Medi-Cal program to obtain eyeglasses from the authority or private entities, based on the optometrist's needs and assessment of quality and value.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known, and may be cited, as the Better Access to Better Vision Act.

SEC. 2. Section 2807 of the Penal Code is amended to read:

2807. (a) The authority is hereby authorized and empowered to operate industrial, agricultural, and service enterprises ~~which~~ *that* will provide products and services needed by the state, or any political subdivision thereof, or by the federal government, or any department, agency, or corporation thereof, or for any other public use. Products may be purchased by state agencies to be offered for sale to inmates of the department and to any other person under the care of the state who resides in state-operated institutional facilities. Fresh meat may be purchased by food service operations in state-owned facilities and sold for onsite consumption.

(b) All things authorized to be produced under subdivision (a) shall be purchased by the state, or any agency thereof, and may be purchased by any county, city, district, or political subdivision, or any agency thereof, or by any state agency to offer for sale to persons residing in state-operated institutions, at the prices fixed by the authority. State agencies shall make maximum utilization of these products, and shall consult with the staff of the authority to develop new products and adapt existing products to meet their needs.

(c) All products and services provided by the authority may be offered for sale to a nonprofit organization, provided that all of the following conditions are met:

(1) The nonprofit organization is located in California and is exempt from taxation under Section 501(c)(3) of Title 26 of the United States Code.

(2) The nonprofit organization has entered into a memorandum of understanding with a local ~~educational~~ *education* agency. As used in this section, "local ~~educational~~ *education* agency" means a school district, county office of education, state special school, or charter school.

(3) The products and services are provided to public school students at no cost to the students or their families.

(d) Notwithstanding subdivision (b), the Department of Forestry and Fire Protection may purchase personal protective equipment from the authority or private entities, based on the Department of Forestry and Fire Protection's needs and assessment of quality and value.

(e) Notwithstanding subdivision (b), a provider participating in the Medi-Cal program may obtain eyeglasses from the authority or private entities, based on the provider's needs and assessment of quality and value.

SEC. 3. Section 14131.08 is added to the Welfare and Institutions Code, to read:

14131.08. For purposes of Medi-Cal reimbursement for covered optometric services pursuant to Section 14132 or 14131.10 or any other law, a provider may obtain eyeglasses from a private entity, as an alternative to a purchase of eyeglasses from the Prison Industry Authority pursuant to Section 2807 of the Penal Code. This section shall be implemented only to the extent that federal financial participation is available.

O

E. SB 457 (Menjivar) Vision care: consent by a minor

Status: Signed into law. Chapter 152, Statutes of 2023.

AUTHOR REASON FOR THE BILL:
According to the author: "For minors affected by homelessness, accessing vision care can be a challenge. Existing law clearly states when an unaccompanied minor can consent to certain medical, dental, reproductive, and sexual health treatments, but it is ambiguous on an unaccompanied minor's ability to consent to vision care. A child's ability to see and access to regular eye exams are foundational needs that are vital to a child's learning and reading comprehension. This bill will allow unaccompanied minors who are on their own to be able get their basic vision care needs met."

DESCRIPTION OF CURRENT LEGISLATION:
This bill would authorize minors not living with their parents or guardians to consent to their own vision care and would authorize an optometrist to advise the parent or guardian under the same conditions applicable to the provision of medical and dental care. The bill also defines "vision care."

BACKGROUND:
Under existing law, minors may consent to various medical services without the authorization of their parents or guardians. Minors 15 years or older, not living with their parent or guardian, and who manage their own financial affairs, are able to consent to medical and dental care. Because the law does not explicitly authorize these minors to consent to "vision care," some independent minors are denied care unless parental consent is provided.

ANALYSIS:
This bill would define "vision care" to mean the "diagnosis, prevention, treatment, and management of disorders, diseases, and dysfunctions of the visual system and the provision of habilitative or rehabilitative optometric services by an optometrist licensed" in California. This definition is consistent with the language in Business and Professions Code section 3041, which states "The practice of optometry includes the diagnosis, prevention, treatment, and management of disorders and dysfunctions of the visual system, as authorized by this chapter, as well as the provision of habilitative or rehabilitative optometric services…" There is no definition of medical care or dental care provided in or otherwise cited by the bill.

UPDATE:
Signed into law on September 1, 2023.

FISCAL:
None.

BOARD POSITION:
Support.

Action Requested:

None.

Attachment 1: Assembly Floor Analysis
Attachment 2: Bill text

SENATE THIRD READING
SB 457 (Menjivar and Ashby)
As Amended March 20, 2023
Majority vote

SUMMARY

Permits certain minors to consent to vision care, as specified.

Major Provisions

1) Authorizes a minor 15 years of age or older to consent to vision care, as defined, if the minor is living separate and apart from the minor's parents or guardian and the minor is managing their own financial affairs, as specified.

2) Permits an optometrist, with or without the consent of the minor patient, to advise the minor's parent or guardian of the treatment given or needed if the optometrist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian.

3) Defines "vision care" to mean the diagnosis, prevention, treatment, and management of disorders, diseases, and dysfunctions of the visual system and the provision of habilitative or rehabilitative optometric services by a licensed optometrist.

COMMENTS

As a general rule, under existing law, a person cannot consent to medical procedures until they reach the "age of majority," which in California and most other states is set at 18 years of age. However, the Legislature has made several common sense exemptions to this general rule, especially in those relatively rare circumstances where the parent's consent to, and knowledge of, the procedure poses a substantial risk of harm to the minor. For example, under appropriate circumstances, the law permits a minor to obtain treatment for abortion or sexually transmitted diseases if there is a substantial risk that parental knowledge could endanger the minor. For similar reasons, existing law permits minors to obtain mental health or drug counseling if the professional providing treatment determines that the minor is mature enough to consent and obtaining parental consent would endanger the minor. Most of these laws contain provisions requiring the treating professional to notify parents if it can be done without endangering the minor. Finally, and most relevant to this bill, existing law recognizes that some youth are homeless or otherwise estranged from parents or guardians, such that obtaining parental consent is nearly impossible. For example, existing law permits a minor who is 15 years of age or older to consent to medical and dental care, if the minor is living separate and apart from the minor's parents or guardian and the minor is managing their own financial affairs.

Unfortunately, despite the apparent need, the existing law that permits homeless or estranged youth who are at least 15 years of age to obtain medical or dental care without parental consent does not expressly allow such minors to consent to vision care, even though vision care is generally less intrusive and permanent than medical or dental care. This bill would correct that omission by simply adding "vision care" to the existing statute, thereby authorizing licensed optometrists to provide care in the same manner as physicians, surgeons, and dentists do. Consistent with existing law, this bill would permit the optometrist, with or without the minor's consent, to notify the minor's parents or guardian if the optometrist knows their whereabouts. In other words, this bill, like existing law, presumes that whenever possible parents and guardians

should be notified of, and grant consent for, any medical, dental, or vision treatments provided to their minor children. But also like existing law, the bill recognizes that there are situations where obtaining consent is not always possible or advisable.

While this bill makes a modest addition to existing law, it is nonetheless an important change. According to the American Optometric Association, and other studies cited by the author and supporters, vision care is essential for minors and young adults, as poor vision not only affects quality of life, but also adversely impacts reading, learning, and overall educational achievement. (See e.g. American Optometric Association, *Executive Summary Pediatric Eye Exam Guidelines*, 2018, available at optometryweb.com.) Another study estimated that vision problems are prevalent in 25% of all schoolchildren in the United States and are among the most handicapping conditions that minors face. (Joel Zoba, "Children's Vision Care in the 21st Century: It's Impact on Education, Literacy, Social Issues, and the Workplace," *Journal of Behavioral Optometry* 22 (2011).)

According to the Author
According to the author, for "minors affected by homelessness, accessing vision care can be a challenge. Existing law clearly states when an unaccompanied minor can consent to certain medical, dental, reproductive, and sexual health treatments, but it is ambiguous on an unaccompanied minor's ability to consent to vision care. A child's ability to see and access to regular eye exams are foundational needs that are vital to a child's learning and reading comprehension. This bill will allow unaccompanied minors who are on their own to be able to get their basic vision care needs met."

Arguments in Support
According to the California Coalition for Youth (CCY), existing law "allows minors to consent to medical and dental care but is silent on whether they can consent to their vision care. SB 457 will make it clear that an unaccompanied minor is able to consent to these services." CCY contends that proper vision development "is vital for a minor's growth, and if left untreated, can lead to vision challenges that impact their educational and social development." CCY adds that while schools and some other agencies provide vision screening, "current law does not allow an unaccompanied minor to correct the eye problem" that might be detected by this screening because of the inability to obtain parental consent. While in most cases it is reasonable to require such consent, CCY points out that not all youth have "the advantages of supportive and engaged families. Homeless youth are not homeless by choice; their family environments have been unhealthy and either they have been kicked out or feel forced out." This bill, CCY concludes, will "allow youth who are on their own to be able to receive an eye examination and receive corrective lenses as needed so they can safely see the world around them."

Arguments in Opposition
No opposition on file.

FISCAL COMMENTS

None

VOTES

SENATE FLOOR: 39-0-1
YES: Allen, Alvarado-Gil, Archuleta, Ashby, Atkins, Becker, Blakespear, Bradford, Caballero, Cortese, Dodd, Durazo, Eggman, Glazer, Gonzalez, Grove, Hurtado, Jones, Laird, Limón, McGuire, Menjivar, Min, Newman, Nguyen, Niello, Ochoa Bogh, Padilla, Portantino, Roth, Rubio, Seyarto, Skinner, Smallwood-Cuevas, Stern, Umberg, Wahab, Wiener, Wilk
ABS, ABST OR NV: Dahle

ASM JUDICIARY: 9-0-2
YES: Maienschein, Connolly, Dixon, Haney, Kalra, Pacheco, Papan, Reyes, Robert Rivas
ABS, ABST OR NV: Essayli, Sanchez

UPDATED

VERSION: March 20, 2023

CONSULTANT: Tom Clark / JUD. / (916) 319-2334 FN: 0001059

Senate Bill No. 457

CHAPTER 152

An act to amend Section 6922 of, and to add Section 6904 to, the Family Code, relating to minors.

[Approved by Governor September 1, 2023. Filed with Secretary of State September 1, 2023.]

LEGISLATIVE COUNSEL'S DIGEST

SB 457, Menjivar. Vision care: consent by a minor.

Existing law authorizes a minor 15 years of age or older to consent to the minor's medical care or dental care, if the minor is living separate and apart from the minor's parents or guardian and the minor is managing their own financial affairs, as specified. Existing law authorizes a physician and surgeon or dentist, with or without the minor's consent, to advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon has reason to know the parent's or guardian's whereabouts, based on information given by the minor. Under existing law, a parent or guardian is not liable for care provided according to these provisions.

This bill additionally would authorize minors to consent to their own vision care, and would authorize an optometrist to advise a minor's parent or guardian of the care given or needed, under the same conditions applicable to the provision of medical care and dental care. The bill would define "vision care" as the diagnosis, prevention, treatment, and management of disorders, diseases, and dysfunctions of the visual system and the provision of habilitative or rehabilitative optometric services by a licensed optometrist, as specified.

The people of the State of California do enact as follows:

SECTION 1. Section 6904 is added to the Family Code, to read:

6904. "Vision care" means the diagnosis, prevention, treatment, and management of disorders, diseases, and dysfunctions of the visual system and the provision of habilitative or rehabilitative optometric services by an optometrist licensed pursuant to Article 1 (commencing with Section 3000) of Chapter 7 of Division 2 of the Business and Professions Code.

SEC. 2. Section 6922 of the Family Code is amended to read:

6922. (a) A minor may consent to the minor's medical care, vision care, or dental care if all of the following conditions are satisfied:

(1) The minor is 15 years of age or older.

(2) The minor is living separate and apart from the minor's parents or guardian, whether with or without the parent's or guardian's consent and regardless of the duration of the separate residence.

(3) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income.

(b) The parents or guardian are not liable for medical care, vision care, or dental care provided pursuant to this section.

(c) A physician and surgeon, optometrist, or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon, optometrist, or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian.

O

F. SB 544 (Laird) Bagley-Keene Open Meeting Act: teleconferencing

Status: Signed into law. Chapter 216, Statutes of 2023.

AUTHOR REASON FOR THE BILL:
According to the author: "In response to the COVID-19 pandemic and the widespread shutdown, the Governor signed an executive order to provide flexibility so state boards and commissions could continue to serve Californians remotely and safely. Although meant to be temporary, we saw significant benefits of remote meetings such as increased participation and reduced operating costs to the state. Senate Bill 544 codifies the Governor's Executive Order allowing state boards and commissions the opportunity to continue holding virtual meetings without being required to list the private address of each remote member, or providing public access to private locations. The additional flexibility and safeguards may also help attract and retain appointees, who provide invaluable perspective. This bill will promote equity and public participation by removing barriers to Californians that experience challenges attending physical meetings, such as people with disabilities, caretakers, seniors, low-income individuals, and those living in rural or different areas of the state."

DESCRIPTION OF CURRENT LEGISLATION:
This bill would amend portions of the Bagley-Keene Open Meeting Act (Act) to remove the teleconference requirements that a state body post agendas at all teleconference locations, that each teleconference location be identified in the notice and agenda of the meeting or proceeding, and that each teleconference location be accessible to the public. The bill would require a state body to provide a means by which the public may remotely hear audio of the meeting, remotely observe the meeting, or attend the meeting by providing on the posted agenda a teleconference telephone number, an internet website or other online platform, and a physical address for at least one site, including, if available, access equivalent to the access for a member of the state body participating remotely. The bill would require a majority of the members of the state body to be physically present at the same location for at least $^1/_2$ of the meetings of that state body. And, the provisions sunset on January 1, 2026.

ANALYSIS:
The Act regulates meetings held by state bodies and it guarantees the public the right to access these meetings subject to specific exceptions. To ensure this right, the public is entitled to attend, monitor, and participate in state agencies' meetings where actions and deliberations are being conducted unless there is a specific reason to exclude the public. Promoting public participation in the form of open meetings is in both the governments and the public's best interest and provides transparency in government functions. This bill incorporates the use of modern technology in the Act, making it easier for all Californians and people from all over the world to not only view but actively participate in public meetings.

NOTE:
There is no urgency clause in the bill, thus it would take effect on 1-1-2024.

FISCAL:
Significant costs due to planning and logistics for physical board and committee meetings. By meeting in a hybrid way, with an in-person meeting and a virtual option, the board saved approximately 90 percent of it's travel costs in the recently concluded fiscal year.

Board Position:
Support.

UPDATE:
The bill was signed into law on September 22, 2023.

The amendments to the bill still allow for greater flexibility to meet virtually than under current law but are more restrictive than the prior law that expired July 1, 2023. Requiring a quorum of the board to be physically present at fifty percent of the meetings each year will require board's who desire to meet virtually to design a system to determine who is in person and who will be virtual, to track, and likely report, this information. It could also present problematic situations for conducting unexpected meetings, if the prior meetings did not meet the fifty percent in-person requirement, the unplanned meeting may not be able to be held virtually.

Action Requested:

None.

Attachment 1: Senate Floor Analysis
Attachment 2: Bill text

Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

UNFINISHED BUSINESS

Bill No: SB 544
Author: Laird (D)
Amended: 9/8/23
Vote: 21

SENATE GOVERNMENTAL ORG. COMMITTEE: 13-1, 4/11/23
AYES: Dodd, Wilk, Alvarado-Gil, Archuleta, Ashby, Bradford, Glazer, Nguyen, Ochoa Bogh, Padilla, Portantino, Roth, Rubio
NOES: Jones
NO VOTE RECORDED: Seyarto

SENATE JUDICIARY COMMITTEE: 9-0, 4/25/23
AYES: Umberg, Wilk, Allen, Ashby, Durazo, Laird, Min, Niello, Wiener
NO VOTE RECORDED: Caballero, Stern

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

SENATE FLOOR: 26-3, 5/15/23
AYES: Allen, Archuleta, Ashby, Atkins, Becker, Blakespear, Bradford, Cortese, Dodd, Durazo, Glazer, Gonzalez, Hurtado, Laird, Limón, McGuire, Min, Newman, Padilla, Portantino, Roth, Skinner, Stern, Umberg, Wahab, Wilk
NOES: Caballero, Jones, Wiener
NO VOTE RECORDED: Alvarado-Gil, Dahle, Eggman, Grove, Menjivar, Nguyen, Niello, Ochoa Bogh, Rubio, Seyarto, Smallwood-Cuevas

ASSEMBLY FLOOR: 50-15, 9/13/23 - See last page for vote

SUBJECT: Bagley-Keene Open Meeting Act: teleconferencing

SOURCE: California Commission on Aging

DIGEST: This bill revises and repeals, until January 1, 2026, certain teleconference requirements under the Bagley-Keene Open Meeting Act (Bagley-Keene), which requires all meetings of a state body be open and public.

Assembly Amendments add a sunset date, require members of the state body to visibly appear on camera during the open portion of the meeting, require at least one member of the state body to be physically present at each teleconference location, and authorize a member's remote participation if the member has a need related to a disability and notifies the state body, as specified.

ANALYSIS:

Existing law:

1) Requires, pursuant to Bagley-Keene, with specified exceptions, that all meetings of a state body be open and public and all person be permitted to attend any meeting of a state body.

2) Authorizes a state body to elect to conduct a meeting or proceeding by teleconference, and requires that state agency to post agendas at all teleconference locations and conduct teleconference meetings in a manner that protects the rights of any party or member of the public appearing before the state body.

3) Requires each teleconference location to be identified in the notice and agenda of the meeting or proceeding, and each teleconference location to be accessible to the public.

4) Requires the agenda to provide an opportunity for members of the public to address the state body directly at each teleconference location, and requires at least one member of the state body to be physically present at the location specified in the notice of the meeting.

This bill:

1) Provides, in addition to the authorization to hold a meeting by teleconference pursuant to current Bagley-Keene provisions, a state body may hold an open or closed meeting by teleconference, as described, provided the meeting complies with specified requirements:

    a) A majority of the members of the state body shall be physically present at the same teleconference location. Additional members of the state body in excess of a majority of the members may attend and participate in the

meeting from a remote location. A remote location is not required to be accessible to the public. The notice and agenda shall not disclose information regarding a remote location.

b) Authorize a member's remote participation, if the member has a need related to a disability and notifies the state body, as specified. Under the bill, that member would be counted toward the majority of members required to be physically present at the same teleconference location.
c) If a member of the state body attends the meeting by teleconference from a remote location, the member shall disclose whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.
d) The members of the state body shall visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform, as provided.
e) All votes taken during the teleconferenced meeting shall be by rollcall. The state body shall publicly report any action taken and the vote or abstention on that action of each member present for the action.
f) Upon discovering that a means of remote public access and participation required has failed during a meeting and cannot be restored, the state body shall end or adjourn the meeting, as defined.
g) Defines "Teleconference" to mean a meeting of a state body, the members of which are at different locations, connected by electronic means, through either audio or both audio and video.
h) Defines "Teleconference location" to mean a physical location that is accessible to the public and from which members of the public may participate in the meeting.
i) Defines "Remote location" to mean a location from which a member of a state body participates in a meeting other than a teleconference location.
j) Defines "Participate remotely" to mean participation by a member of the body in a meeting at a remote location other than a teleconference location designated in the notice of the meeting.
k) These specified requirements, as described, shall remain in effect until January 1, 2026, and as of that date is repealed.

2) Authorizes an additional means of holding a meeting by teleconference by an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body, as prescribed, under specified requirements:

a) The location of a member of a state body who will participate remotely is not required to be disclosed in the public notice or email and need not be accessible to the public.
b) Provides the state body shall designate the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting, observe and hear the meeting, and participate.
c) Provides, at least one staff member of the state body shall be present at the primary physical meeting location during the meeting. The state body shall post the agenda at the primary physical meeting location, but need not post the agenda at a remote location.
d) States when a member of a state body participates remotely in a meeting, as defined, the state body shall provide a means by which the public may remotely hear audio of the meeting or remotely observe the meeting, including, if available, equal access equivalent to members of the state body participating remotely.
e) Provides that the applicable teleconference phone number or internet website, or other information indicating how the public can access the meeting remotely, shall be in the 24-hour notice, as described.
f) Provides, the members of the state body shall visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform.
g) Defines "Participate remotely" to mean participation in a meeting at a location other than the physical location designated in the agenda of the meeting.
h) Defines "Remote location" to means a location other than the primary physical location designated in the agenda of a meeting.
i) Defines "Teleconference" to mean a meeting of a state body, the members of which are at different locations, connected by electronic means, through either audio or both audio and video.
j) The state body shall provide notice to the public at least 24 hours before the meeting that identifies any member who will participate remotely by posting the notice on its internet website, as specified. A member of a state body who participates in a teleconference meeting from a remote location subject to this section's requirements shall be listed in the minutes of the meeting.
k) This bill does not limit or affect the ability of a state body to hold a teleconference meeting under another provision of the Act.
l) These specified requirements, as described, shall remain in effect until January 1, 2026, and as of that date is repealed.

3) Exempts from current law an internet website or other online platform that may require the submission of information to log into a teleconferenced meeting. The bill would permit a person to submit a pseudonym or other anonymous information when using the internet website or other online platform to attend the meeting.

4) Restates current provisions of the Bagley-Keene when the above-described requirements sunset on January 1, 2026.

5) Makes technical and clarifying changes.

Background

Purpose of the Bill. According to the author's office, "in response to the COVID-19 pandemic and the widespread shutdown, the Governor signed an executive order to provide flexibility so state boards and commissions could continue to serve Californians remotely and safely. Although meant to be temporary, we saw significant benefits of remote meetings, such as increased participation and reduced operating costs to the state. This bill will promote equity and public participation by removing barriers to Californians that experience challenges attending physical meetings, such as people with disabilities, caretakers, seniors, low-income individuals, and those living in rural or different areas of the state. The bill will protect the personal, private information of public officials and their families while preserving the public's right to access information concerning the conduct of the people's business."

The Bagley-Keene Opening Meeting Act of 1967. Bagley-Keene originated as a response to growing concerns about transparency and public involvement in the decision-making process of state agencies. Bagley-Keene aims to ensure that state boards, commissions, and agencies conduct their business openly and transparently, allowing the public to be informed and participate in the decision-making process.

Bagley-Keene generally requires state bodies to conduct their meetings openly and make them accessible to the public. The law also requires state bodies to provide advance notice of their meetings and agendas and to allow public comments on matters under consideration. The act includes certain exceptions, such as closed sessions for discussing personnel issues or pending litigation, to protect the privacy and legal interests of individuals and the state.

The act applies to state bodies, which include boards, commissions, committees, councils, and any other public agencies created by state statute or executive order, with some exceptions. The law does not apply to individual officials, advisory committees with no decision-making authority, or the California State Legislature.

The Americans with Disabilities Act of 1990. The ADA is a federal civil rights law that prohibits discrimination against people with disabilities in everyday activities. The ADA prohibits discrimination on the basis of disability just as other civil rights laws prohibit discrimination on the basis of race, color, sex, national origin, age, and religion. The ADA guarantees that people with disabilities have the same opportunities as everyone else to enjoy employment opportunities, purchase goods and services, and participate in state and local government programs. The ADA contains specific requirements for state and local governments to ensure equal access for people with disabilities.

COVID-19 and Executive Order N-29-20. On March 4, 2020, Governor Newsom proclaimed a State of Emergency in California as a result of what at the time was a novel and rapidly growing COVID-19 pandemic. Despite early efforts, the virus continued to spread. On March 17, 2020, Governor Newsom issued Executive Order (EO) N-29-20 citing the fact that strict compliance with various statutes and regulations on open meetings of state bodies would have prevented, hindered, or delayed appropriate actions to prevent and mitigate the effects of the COVID-19 pandemic.

In order to practice social distancing, facilitate remote work, and protect the population against the COVID-19 pandemic, EO N-29-20 authorized a state body to hold public meetings via teleconferencing. The executive order required public meetings be accessible telephonically or otherwise electronically to all members of the public seeking to observe and to address the local legislative body or state body. All requirements in both the Bagley-Keene Open Meeting Act and the Brown Act expressly or impliedly requiring the physical presence of members, the clerk or other personnel of the body, or of the public as a condition of participation in or quorum for a public meeting were temporarily waived.

Temporary Teleconferencing Extension in 2022. SB 189 (Committee on Budget and Fiscal Review, Chapter 48, Statutes of 2022), among other things, provided a temporary statutory extension for state bodies in California to hold public meetings through teleconferencing, such as phone or video calls, instead of in-person gatherings. The law suspends certain requirements that would typically apply to

in-person meetings, such as having a physical location for the public to attend and providing access to all remote teleconference locations until July 1, 2023.

In order to maintain accessibility and public participation in these remote meetings, state bodies must follow certain guidelines. They must provide advance notice of the meetings and include information on how the public can observe and participate in them, such as by offering public comment. Additionally, state bodies must establish procedures to accommodate people with disabilities, in accordance with the ADA.

State bodies are encouraged to use their best judgment when holding teleconferenced meetings, and to make an effort to follow the other provisions of Bagley-Keene as closely as possible. This helps ensure that these remote meetings remain transparent and accessible to the public. This section of the law is temporary, set to expire on July 1, 2023. After that date, the suspended requirements will come back into effect, and state bodies will need to return to following the standard provisions of Bagley-Keene.

Assembly Amendments. This bill was amended upon passage from the Assembly Governmental Organization Committee to address concerns raised in that committee's analysis and by opponents. Amendments include imposition of the January 1, 2026, sunset date to "allow further analysis of the implementation and overall impact of this and previous Bagley-Keene waivers."

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: No

According to the Assembly Appropriations Committee, likely cost savings across state bodies to be able to continue a modified version of the now-expired teleconference meeting requirements authorized by executive order during the COVID-19 pandemic and under SB 189 (Committee on Budget and Fiscal Review), Chapter 48, Statutes of 2022. Some state bodies note that this bill's physical presence requirements would result in less cost savings than what was realized under the expired policy. For example, the physical location must have sufficient technology to connect to the teleconference system and there may be other rental, equipment, or travel costs to meet in-person requirements. However, state bodies are not required to hold meetings by teleconference and incur such hybrid meeting costs.

SUPPORT: (Verified 9/12/23)

California Commission on Aging (source)

AARP
Advisory Council for Sourcewise
Agency on Aging – Area 4
Alcoholic Beverage Control Appeals Board
Alzheimer's Association State Policy Office
Association of California State Employees With Disabilities
Board of Barbering and Cosmetology
Board of Behavioral Sciences
Board of Registered Nursing
California Acupuncture Board
California Architects Board
California Association of Area Agencies on Aging
California Board of Accountancy
California Foundation for Independent Living Centers
California Senior Legislature
California State Board of Optometry
California State Board of Pharmacy
California Structural Pest Control Board
Dental Board of California
Dental Hygiene Board of California
Disability Rights California
Disability Rights Education & Defense Fund
Health Officers Association of California
Little Hoover Commission
Medical Board of California
Osteopathic Medical Board of California
Physical Therapy Board of California
Physician Assistant Board
SCDD
Seamless Bay Area
Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board
State Bar of California
The Veterinary Medical Board

OPPOSITION: (Verified 9/12/23)

ACLU California Action
American Chemistry Council
American Composites Manufacturers Association
California Association of Winegrape Growers
Californians Aware

California Broadcasters Association
California Common Cause
California Manufacturers & Technology Association
California News Publishers Association
Californians Aware: the Center for Public Forum Rights
CCNMA Latino Journalists of California
First Amendment Coalition
Glass Packaging Institute
Greater Los Angeles Pro Chapter of the Society of Professional Journalists
Howard Jarvis Taxpayers Association
Institute of Governmental Advocates
Media Alliance
National Press Photographers Association
NLGJA: Association of LGBTQ+ Journalists, Los Angeles Chapter
Orange County Press Club
Pacific Media Workers Guild, News Guild-Communications Workers of America Local 39521
Radio Television Digital News Association
San Diego Pro Chapter of The Society of Professional Journalists
San Franciscans for Sunshine
Society of Professional Journalists, Northern California Chapter, Freedom of Information Committee

ARGUMENTS IN SUPPORT: In support of the bill, the California Commission on Aging writes that, "Bagley-Keene currently allows for remote teleconference participation by members of a board or commission. However, the Act requires that all teleconference locations be posted to the agenda. As a result, members who must attend the meeting by teleconference must post the address of their private residence or office in order to participate. Additionally, Bagley-Keene requires that the locations are accessible to the public. This means that state body members who are required to teleconference from their home must allow public access to their private residence and must ensure that their home is in compliance with the Americans with Disabilities Act."

Further, "SB 544 seeks to extend the provisions in the Executive Order by eliminating the requirement to post addresses of all teleconference locations in Bagley-Keene. Teleconference meetings will be required to post a teleconference telephone number, an internet website or other online platform, which the public can access and participate remotely. State bodies will be required to post at least one physical location where the public can participate in the meeting if they are

unable to access the meeting through teleconference, and one staff member will be required to be present at the physical location."

Finally, "[t]his bill will increase transparency and promote public participation in State government by expanding the pool of candidates interested in serving. Older adults and individuals with disabilities will no longer be barred from attending meetings or participating in State government simply because they are limited from attending physically. The bill will also remove impediments for low-income, rural California residents, and caregivers who find it challenging or impossible to travel to one physical location."

ARGUMENTS IN OPPOSITION: In opposition to the bill, a coalition of business groups led by the Glass Packaging Institute writes that, "SB 544 continues a slow diminution of California's landmark open meeting and government accountability laws. Government decision making, debates, and voting should be done in person and at a single location so the public can petition and address the government body in one place. With the end of the pandemic, there is no adequate public policy reason to continue to allow remote meeting participation and voting by state boards and commissions are making consequential decisions that quite literally affect the life, liberty, and property of business and individuals. Those decisions should be made face-to-face, in full view of the public, media, and affected parties. It simply is not enough to sit in front of a computer screen at home or other undisclosed remote location while making such important decisions."

Further, "[w]hile the pandemic taught us that remote work and work from home is technologically feasible, it also showed that it is not an ideal situation for government decision-making and advocacy. Remote participation eliminates eye-to-contact, discourages back and forth dialogue during debates, and stifles pre and post meeting discussions. The stated need for this bill is that the convenience of remote participation and voting by board members will lead to more participation in government decision-making by those who will be making decisions on behalf of government. This is not a path forward to ensure a transparent and accountable democracy."

ASSEMBLY FLOOR: 50-15, 9/13/23
AYES: Addis, Alvarez, Arambula, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bryan, Calderon, Juan Carrillo, Wendy Carrillo, Cervantes, Mike Fong, Friedman, Garcia, Gipson, Grayson, Haney, Hart, Irwin, Jones-Sawyer, Kalra, Lee, Low, Lowenthal, McCarty, McKinnor, Muratsuchi, Stephanie

Nguyen, Ortega, Pacheco, Papan, Pellerin, Ramos, Rendon, Reyes, Luz Rivas, Rodriguez, Santiago, Schiavo, Soria, Ting, Valencia, Waldron, Ward, Weber, Wilson, Wood, Robert Rivas

NOES: Alanis, Chen, Megan Dahle, Dixon, Essayli, Vince Fong, Gallagher, Hoover, Mathis, Joe Patterson, Petrie-Norris, Quirk-Silva, Sanchez, Ta, Wallis

NO VOTE RECORDED: Aguiar-Curry, Bonta, Connolly, Davies, Flora, Gabriel, Holden, Jackson, Lackey, Maienschein, Jim Patterson, Blanca Rubio, Villapudua, Wicks, Zbur

Prepared by: Brian Duke / G.O. / (916) 651-1530
9/14/23 12:01:04

****** END ******

Senate Bill No. 544

CHAPTER 216

An act to amend Section 11124 of, to amend, repeal, and add Section 11123.5 of, and to add and repeal Section 11123.2 of, the Government Code, relating to state government.

[Approved by Governor September 22, 2023. Filed with Secretary of State September 22, 2023.]

LEGISLATIVE COUNSEL'S DIGEST

SB 544, Laird. Bagley-Keene Open Meeting Act: teleconferencing.

Existing law, the Bagley-Keene Open Meeting Act, requires, with specified exceptions, that all meetings of a state body be open and public and all persons be permitted to attend any meeting of a state body. The act authorizes meetings through teleconference subject to specified requirements, including, among others, that the state body post agendas at all teleconference locations, that each teleconference location be identified in the notice and agenda of the meeting or proceeding, that each teleconference location be accessible to the public, that the agenda provide an opportunity for members of the public to address the state body directly at each teleconference location, and that at least one member of the state body be physically present at the location specified in the notice of the meeting.

This bill would enact an additional, alternative set of provisions under which a state body may hold a meeting by teleconference. The bill would require at least one member of the state body to be physically present at each teleconference location, defined for these purposes as a physical location that is accessible to the public and from which members of the public may participate in the meeting. The bill would, under specified circumstances, authorize a member of the state body to participate from a remote location, which would not be required to be accessible to the public and which the bill would prohibit the notice and agenda from disclosing. Specifically, the bill would authorize a member's remote participation if the other members who are physically present at the same teleconference location constitute a majority of the state body. The bill would also authorize a member's remote participation if the member has a need related to a disability and notifies the state body, as specified. Under the bill, that member would be counted toward the majority of members required to be physically present at the same teleconference location. The bill would require a member who participates from a remote location to disclose whether any other individuals 18 years of age or older are present in the room at the remote location with the member and the general nature of the member's relationship with those individuals.

This bill would require the members of the state body to visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform unless the appearance would be technologically impracticable, as specified. The bill would require a member who does not appear on camera due to challenges with internet connectivity to announce the reason for their nonappearance when they turn off their camera.

This bill would also require the state body to provide a means by which the public may remotely hear audio of the meeting, remotely observe the meeting, remotely address the body, or attend the meeting by providing on the posted agenda a teleconference telephone number, an internet website or other online platform, and a physical address for each teleconference location. The bill would require the telephonic or online means provided to the public to access the meeting to be equivalent to the telephonic or online means provided to a member of the state body participating remotely. The bill would require any notice required by the act to specify the applicable teleconference telephone number, internet website or other online platform, and physical address of each teleconference location, as well as any other information indicating how the public can access the meeting remotely and in person. If the state body allows members of the public to observe and address the meeting telephonically or otherwise electronically, the bill would require the state body to implement and advertise, as prescribed, a procedure for receiving and swiftly resolving requests for reasonable modification or accommodation from individuals with disabilities, as specified. The bill would impose requirements consistent with the above-described existing law provisions, including a requirement that the agenda provide an opportunity for members of the public to address the state body directly, as specified. The bill would entitle members of the public to exercise their right to directly address the state body during the teleconferenced meeting without being required to submit public comments before the meeting or in writing.

This bill would provide that it does not affect prescribed existing notice and agenda requirements and would require the state body to post an agenda on its internet website and, on the day of the meeting, at each teleconference location designated in the notice of the meeting.

This bill would require the state body, upon discovering that a means of remote participation required by the bill has failed during the meeting and cannot be restored, to end or adjourn the meeting in accordance with prescribed adjournment and notice provisions, including information about reconvening.

Existing law authorizes a multimember state advisory body to hold an open meeting by teleconference pursuant to an alternative set of provisions that are in addition to the above-described provisions generally applicable to state bodies. Under those alternative provisions, a quorum of the members of the state advisory body must be in attendance at the primary physical meeting location, as specified, and all decisions taken during the meeting must be by rollcall vote.

This bill would remove the rollcall vote requirement and the requirement for a quorum in attendance at the primary physical meeting location. The bill, instead, would require at least one staff member of the state body to be present at the primary physical meeting location. The bill would require the members of the state body to visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform unless the appearance would be technologically impracticable, as specified. The bill would require a member who does not appear on camera due to challenges with internet connectivity to announce the reason for their nonappearance when they turn off their camera.

This bill would repeal the above-described provisions on January 1, 2026.

Existing law prohibits requiring a person, as a condition of attendance at a meeting of a state body, to register their name, to provide other information, to complete a questionnaire, or otherwise to fulfill any condition precedent to their attendance. Existing law requires an attendance list, register, questionnaire, or other similar document posted at or near the entrance to the room where the meeting is to be held, or circulated to persons present during the meeting, to state clearly that the signing, registering, or completion of the document is voluntary, and that all persons may attend the meeting regardless of whether a person signs, registers, or completes the document.

This bill would exempt from those provisions an internet website or other online platform that may require the submission of information to log into a teleconferenced meeting. The bill would permit a person to submit a pseudonym or other anonymous information when using the internet website or other online platform to attend the meeting.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The people of the State of California do enact as follows:

SECTION 1. Section 11123.2 is added to the Government Code, to read:

11123.2. (a) For purposes of this section, the following definitions apply:

(1) "Teleconference" means a meeting of a state body, the members of which are at different locations, connected by electronic means, through either audio or both audio and video.

(2) "Teleconference location" means a physical location that is accessible to the public and from which members of the public may participate in the meeting.

(3) "Remote location" means a location from which a member of a state body participates in a meeting other than a teleconference location.

(4) "Participate remotely" means participation by a member of the body in a meeting at a remote location other than a teleconference location designated in the notice of the meeting.

(b) (1) In addition to the authorization to hold a meeting by teleconference pursuant to subdivision (b) of Section 11123 and Section 11123.5, a state body may hold an open or closed meeting by teleconference as described in this section, provided the meeting complies with all of this section's requirements and, except as set forth in this section, it also complies with all other applicable requirements of this article relating to the specific type of meeting.

(2) This section does not limit or affect the ability of a state body to hold a teleconference meeting under another provision of this article, including Sections 11123 and 11123.5.

(c) The portion of the teleconferenced meeting that is required to be open to the public shall be visible and audible to the public at each teleconference location.

(d) (1) The state body shall provide a means by which the public may remotely hear audio of the meeting, remotely observe the meeting, remotely address the body, or attend the meeting by providing on the posted agenda a teleconference telephone number, an internet website or other online platform, and a physical address for each teleconference location. The telephonic or online means provided to the public to access the meeting shall be equivalent to the telephonic or online means provided to a member of the state body participating remotely.

(2) The applicable teleconference telephone number, internet website or other online platform, and physical address of each teleconference location, as well as any other information indicating how the public can access the meeting remotely and in person, shall be specified in any notice required by this article.

(3) If the state body allows members of the public to observe and address the meeting telephonically or otherwise electronically, the state body shall do both of the following:

(A) Implement a procedure for receiving and swiftly resolving requests for reasonable modification or accommodation from individuals with disabilities, consistent with the federal Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12101 et seq.), and resolving any doubt whatsoever in favor of accessibility.

(B) Advertise that procedure each time notice is given of the means by which members of the public may observe the meeting and offer public comment.

(e) This section does not prohibit a state body from providing members of the public with additional locations from which the public may observe or address the state body by electronic means, through either audio or both audio and video.

(f) (1) The agenda shall provide an opportunity for members of the public to address the state body directly pursuant to Section 11125.7.

(2) Members of the public shall be entitled to exercise their right to directly address the state body during the teleconferenced meeting without being required to submit public comments before the meeting or in writing.

(g) The state body shall post the agenda on its internet website and, on the day of the meeting, at each teleconference location.

(h) This section does not affect the requirement prescribed by this article that the state body post an agenda of a meeting in accordance with the applicable notice requirements of this article, including Section 11125, requiring the state body to post an agenda of a meeting at least 10 days in advance of the meeting, Section 11125.4, applicable to special meetings, and Sections 11125.5 and 11125.6, applicable to emergency meetings.

(i) At least one member of the state body shall be physically present at each teleconference location.

(j) (1) Except as provided in paragraph (2), a majority of the members of the state body shall be physically present at the same teleconference location. Additional members of the state body in excess of a majority of the members may attend and participate in the meeting from a remote location. A remote location is not required to be accessible to the public. The notice and agenda shall not disclose information regarding a remote location.

(2) A member attending and participating from a remote location may count toward the majority required to hold a teleconference if both of the following conditions are met:

(A) The member has a need related to a physical or mental disability, as those terms are defined in Sections 12926 and 12926.1, that is not otherwise reasonably accommodated pursuant to the federal Americans with Disability Act of 1990 (42 U.S.C. Sec. 12101 et seq.).

(B) The member notifies the state body at the earliest opportunity possible, including at the start of a meeting, of their need to participate remotely, including providing a general description of the circumstances relating to their need to participate remotely at the given meeting.

(3) If a member notifies the body of the member's need to attend and participate remotely pursuant to paragraph (2), the body shall take action to approve the exception and shall request a general description of the circumstances relating to the member's need to participate remotely at the meeting, for each meeting in which the member seeks to participate remotely. The body shall not require the member to provide a general description that exceeds 20 words or to disclose any medical diagnosis or disability, or any personal medical information that is already exempt under existing law, such as the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(4) If a member of the state body attends the meeting by teleconference from a remote location, the member shall disclose whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.

(k) (1) Except as provided in paragraph (2), the members of the state body shall visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform.

(2) The visual appearance of a member of the state body on camera may cease only when the appearance would be technologically impracticable, including, but not limited to, when the member experiences a lack of reliable broadband or internet connectivity that would be remedied by joining without video, or when the visual display of meeting materials, information, or speakers on the internet or other online platform requires the visual appearance of a member of a state body on camera to cease.

(3) If a member of the state body does not appear on camera due to challenges with internet connectivity, the member shall announce the reason for their nonappearance when they turn off their camera.

(*l*) All votes taken during the teleconferenced meeting shall be by rollcall.

(m) The state body shall publicly report any action taken and the vote or abstention on that action of each member present for the action.

(n) The portion of the teleconferenced meeting that is closed to the public shall not include the consideration of any agenda item being heard pursuant to Section 11125.5.

(o) Upon discovering that a means of remote public access and participation required by subdivision (d) has failed during a meeting and cannot be restored, the state body shall end or adjourn the meeting in accordance with Section 11128.5. In addition to any other requirements that may apply, the state body shall provide notice of the meeting's end or adjournment on the state body's internet website and by email to any person who has requested notice of meetings of the state body by email under this article. If the meeting will be adjourned and reconvened on the same day, further notice shall be provided by an automated message on a telephone line posted on the state body's agenda, internet website, or by a similar means, that will communicate when the state body intends to reconvene the meeting and how a member of the public may hear audio of the meeting or observe the meeting.

(p) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

SEC. 2. Section 11123.5 of the Government Code is amended to read:

11123.5. (a) For purposes of this section, the following definitions apply:

(1) "Participate remotely" means participation in a meeting at a location other than the physical location designated in the agenda of the meeting.

(2) "Remote location" means a location other than the primary physical location designated in the agenda of a meeting.

(3) "Teleconference" has the same meaning as in Section 11123.

(b) In addition to the authorization to hold a meeting by teleconference pursuant to subdivision (b) of Section 11123 or Section 11123.2, any state body that is an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body may hold an open meeting by teleconference as described in this section, provided

the meeting complies with all of the section's requirements and, except as set forth in this section, it also complies with all other applicable requirements of this article.

(c) A member of a state body as described in subdivision (b) who participates in a teleconference meeting from a remote location subject to this section's requirements shall be listed in the minutes of the meeting.

(d) The state body shall provide notice to the public at least 24 hours before the meeting that identifies any member who will participate remotely by posting the notice on its internet website and by emailing notice to any person who has requested notice of meetings of the state body under this article. The location of a member of a state body who will participate remotely is not required to be disclosed in the public notice or email and need not be accessible to the public. The notice of the meeting shall also identify the primary physical meeting location designated pursuant to subdivision (f).

(e) This section does not affect the requirement prescribed by this article that the state body post an agenda of a meeting at least 10 days in advance of the meeting. The agenda shall include information regarding the physical meeting location designated pursuant to subdivision (f), but is not required to disclose information regarding any remote location.

(f) A state body described in subdivision (b) shall designate the primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting, observe and hear the meeting, and participate. At least one staff member of the state body shall be present at the primary physical meeting location during the meeting. The state body shall post the agenda at the primary physical meeting location, but need not post the agenda at a remote location.

(g) When a member of a state body described in subdivision (b) participates remotely in a meeting subject to this section's requirements, the state body shall provide a means by which the public may remotely hear audio of the meeting or remotely observe the meeting, including, if available, equal access equivalent to members of the state body participating remotely. The applicable teleconference phone number or internet website, or other information indicating how the public can access the meeting remotely, shall be in the 24-hour notice described in subdivision (b) that is available to the public.

(h) (1) Except as provided in paragraph (2), the members of the state body shall visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform.

(2) The visual appearance of a member of a state body on camera may cease only when the appearance would be technologically impracticable, including, but not limited to, when the member experiences a lack of reliable broadband or internet connectivity that would be remedied by joining without video, or when the visual display of meeting materials, information, or speakers on the internet or other online platform requires the visual appearance of a member of a state body on camera to cease.

(3) If a member of the body does not appear on camera due to challenges with internet connectivity, the member shall announce the reason for their nonappearance when they turn off their camera.

(i) Upon discovering that a means of remote access required by subdivision (g) has failed during a meeting, the state body described in subdivision (b) shall end or adjourn the meeting in accordance with Section 11128.5. In addition to any other requirements that may apply, the state body shall provide notice of the meeting's end or adjournment on its internet website and by email to any person who has requested notice of meetings of the state body under this article. If the meeting will be adjourned and reconvened on the same day, further notice shall be provided by an automated message on a telephone line posted on the state body's agenda, or by a similar means, that will communicate when the state body intends to reconvene the meeting and how a member of the public may hear audio of the meeting or observe the meeting.

(j) This section does not limit or affect the ability of a state body to hold a teleconference meeting under another provision of this article.

(k) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

SEC. 3. Section 11123.5 is added to the Government Code, to read:

11123.5. (a) In addition to the authorization to hold a meeting by teleconference pursuant to subdivision (b) of Section 11123, any state body that is an advisory board, advisory commission, advisory committee, advisory subcommittee, or similar multimember advisory body may hold an open meeting by teleconference as described in this section, provided the meeting complies with all of the section's requirements and, except as set forth in this section, it also complies with all other applicable requirements of this article.

(b) A member of a state body as described in subdivision (a) who participates in a teleconference meeting from a remote location subject to this section's requirements shall be listed in the minutes of the meeting.

(c) The state body shall provide notice to the public at least 24 hours before the meeting that identifies any member who will participate remotely by posting the notice on its internet website and by emailing notice to any person who has requested notice of meetings of the state body under this article. The location of a member of a state body who will participate remotely is not required to be disclosed in the public notice or email and need not be accessible to the public. The notice of the meeting shall also identify the primary physical meeting location designated pursuant to subdivision (e).

(d) This section does not affect the requirement prescribed by this article that the state body post an agenda of a meeting at least 10 days in advance of the meeting. The agenda shall include information regarding the physical meeting location designated pursuant to subdivision (e), but is not required to disclose information regarding any remote location.

(e) A state body described in subdivision (a) shall designate the primary physical meeting location in the notice of the meeting where members of

the public may physically attend the meeting and participate. A quorum of the members of the state body shall be in attendance at the primary physical meeting location, and members of the state body participating remotely shall not count towards establishing a quorum. All decisions taken during a meeting by teleconference shall be by rollcall vote. The state body shall post the agenda at the primary physical meeting location, but need not post the agenda at a remote location.

(f) When a member of a state body described in subdivision (a) participates remotely in a meeting subject to this section's requirements, the state body shall provide a means by which the public may remotely hear audio of the meeting or remotely observe the meeting, including, if available, equal access equivalent to members of the state body participating remotely. The applicable teleconference phone number or internet website, or other information indicating how the public can access the meeting remotely, shall be in the 24-hour notice described in subdivision (a) that is available to the public.

(g) Upon discovering that a means of remote access required by subdivision (f) has failed during a meeting, the state body described in subdivision (a) shall end or adjourn the meeting in accordance with Section 11128.5. In addition to any other requirements that may apply, the state body shall provide notice of the meeting's end or adjournment on its internet website and by email to any person who has requested notice of meetings of the state body under this article. If the meeting will be adjourned and reconvened on the same day, further notice shall be provided by an automated message on a telephone line posted on the state body's agenda, or by a similar means, that will communicate when the state body intends to reconvene the meeting and how a member of the public may hear audio of the meeting or observe the meeting.

(h) For purposes of this section:

(1) "Participate remotely" means participation in a meeting at a location other than the physical location designated in the agenda of the meeting.

(2) "Remote location" means a location other than the primary physical location designated in the agenda of a meeting.

(3) "Teleconference" has the same meaning as in Section 11123.

(i) This section does not limit or affect the ability of a state body to hold a teleconference meeting under another provision of this article.

(j) This section shall become operative on January 1, 2026.

SEC. 4. Section 11124 of the Government Code is amended to read:

11124. (a) No person shall be required, as a condition to attendance at a meeting of a state body, to register their name, to provide other information, to complete a questionnaire, or otherwise to fulfill any condition precedent to their attendance.

(b) If an attendance list, register, questionnaire, or other similar document is posted at or near the entrance to the room where the meeting is to be held, or is circulated to persons present during the meeting, it shall state clearly that the signing, registering, or completion of the document is voluntary,

and that all persons may attend the meeting regardless of whether a person signs, registers, or completes the document.

(c) This section does not apply to an internet website or other online platform that may require the submission of information to log into a teleconferenced meeting, provided, however, that a person required to submit such information shall be permitted to submit a pseudonym or other anonymous information when using the internet website or other online platform to attend the meeting.

SEC. 5. The Legislature finds and declares that Sections 1, 2, 3, and 4 of this act, which add and repeal Section 11123.2 of, amend, repeal, and add Section 11123.5 of, and amend Section 11124 of, the Government Code, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

(a) By removing the requirement for agendas to be placed at the location of each public official participating in a public meeting remotely, including from the member's private home or hotel room, this act protects the personal, private information of public officials and their families while preserving the public's right to access information concerning the conduct of the people's business.

(b) During the COVID-19 public health emergency, audio and video teleconference were widely used to conduct public meetings in lieu of physical location meetings, and those public meetings have been productive, increased public participation by all members of the public regardless of their location and ability to travel to physical meeting locations, increased the pool of people who are able to serve on these bodies, protected the health and safety of civil servants and the public, and have reduced travel costs incurred by members of state bodies and reduced work hours spent traveling to and from meetings.

(c) Conducting audio and video teleconference meetings enhances public participation and the public's right of access to meetings of the public bodies by improving access for individuals who often face barriers to physical attendance.

O