BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • CALIFORNIA STATE BOARD OF OPTOMETRY
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ISSUE MEMORANDUM

DATE	April 5, 2024
TO	Committee Members, California State Board of Optometry (CSBO)
FROM	Gregory Pruden, Executive Officer
SUBJECT	Agenda Item #4 –Discussion and Possible Action on 2023-24 Legislation

Background and Update:
The Legislature reconvened on January 3, 2024. New bills were introduced until February 21, 2024, and staff monitored bill introductions for possible impacts to the Board. At this time, the following legislation has been identified with impacts to the Board, for discussion and possible action at this meeting. Click the red link to go directly to each bill in the PDF.

a. AB 1028 (McKinnor) Reporting of crimes: mandated reporters
b. AB 1570 (Low) Optometry: certification to perform advanced procedures
c. AB 1991 (Bonta) Licensee and registrant records
d. AB 2327 (Wendy Carrillo) Optometry: mobile optometric offices: regulations
e. AB 3137 (Flora) Department of Consumer Affairs
f. SB 340 (Eggman) Medi-Cal: eyeglasses: Prison Industry Authority
g. SB 1310 (Grove) Serious felonies
h. SB 1468 (Ochoa Bogh and Roth) Healing arts boards: informational and educational materials for prescribers of narcotics: federal "Three Day Rule"
i. SB 1485 (Gonzalez) Consumer complaints

The Legislation and Regulation Committee is responsible for recommending legislative and regulatory priorities to the Board and assisting staff with drafting language for Board-sponsored legislation and recommending official positions on current legislation. The committee also recommends regulatory additions and amendments.

For the benefit of newer committee members, presented on the next few pages are information about the California legislative process and the role of the Board in taking positions on proposed legislation.

California's Legislative Process

The California State Legislature consists of two houses: the Senate and the Assembly. The Senate has 40 members and the Assembly has 80 members.

All legislation begins as an idea or concept. Should the Board take an idea to legislation, it will act as its sponsor.

In order to move an idea or concept toward legislation the Board must attain a Senator or Assembly Member to author it as a bill. Once a legislator has been identified as an author, the legislation will proceed to the Legislative Counsel where a bill is drafted. The legislator will introduce the bill in a house (if a Senator authors a bill, it will be introduced to the Senate; if an Assembly Member authors a bill, it will be introduced to the Assembly). This house is called the House of Origin.

Once a bill is introduced on the floor of its house, it is sent to the Office of State Printing. At this time, it may not be acted upon until 30 days after the date that it was introduced. After the allotted time has lapsed, the bill moves to the Rules Committee of its house to be assigned to a corresponding Policy Committee for hearing.

During committee hearing, the author presents the bill to the committee and witnesses provide testimony in support or opposition of the bill. At this time, amendments may be proposed and/or taken. Bills can be amended multiple times. Additionally, during these hearings, a Board representative (Board Chair, Executive Officer, and/or staffer) may be called upon to testify in favor of (or in opposition to) the bill.

Following these proceedings, the committee votes to pass the bill, pass it as amended, or defeat it. The bill may also be held in the committee without a vote, if it appears likely that it will not pass. In the case of the Appropriations (or "Fiscal") Committee, the bill may be held in the "Suspense File" if the committee members determine that the bill's fiscal impact is too great, as weighed against the priorities of other bills that also impact the state's finances. A bill is passed in committee by a majority vote.

If the bill is passed by committee, it returns to the floor of its House of Origin and is read a second time. Next, the bill is placed on third reading and is eligible for consideration by the full house in a floor vote. Bill analyses are prepared prior to this reading. During the third reading, the author explains the bill and members discuss and cast their vote. Bills that raise taxes, take effect immediately or place a proposition on the ballot require a 2/3 vote, which would require 27 votes in the Senate and 54 votes (two-thirds vote) in the Assembly to be passed. Other bills require majority vote. If a bill is defeated, its author may seek reconsiderations and another vote.

Once a bill has been approved by the House of Origin, it is submitted to the second house where the aforementioned process is repeated. Here, if an agreement is not reached, the bill dies or is sent to a two-house committee where members can come to a compromise. However, if an agreement is made, the bill is returned to both houses as a conference report to be voted upon.

Should both houses approve a bill, it proceeds to the Governor who can either sign the bill to law, allow it to become law without signature, or veto it. If the legislation is passed during the course of the regular session, the Governor must act within 12 days. However, the Governor has 30 days to sign bills that are passed during the final days of the legislative year, usually in August or early September. A two-thirds vote from both houses can override the Governor's decision to veto a bill.

Bills that are passed by the legislature and approved by the Governor are assigned a chapter number by the Secretary of State. Chaptered bills typically become part of the California Codes and the Board may enforce it as statute once it becomes effective. Most bills are effective on the first day of January the following year; however, matters of urgency take effect immediately.

For a graphic overview of California's legislative process, see the attached diagram at the end of this section.

Positions on Legislation

As a regulatory body, the Board can propose its own legislative proposals or take a position on a current piece of legislation.

At Board Meetings, staff may present current legislation that is of potential interest to the Board and/or which may directly impact the Board and the practice of optometry. When the Board attains research on legislation, it can take a position on the matter.

Possible positions include:

- **No Position:** The Board may decide that the bill is outside the Board's jurisdiction or that it has other reasons to not have any position on the bill. The Board would not generally testify on such a bill.
- **Neutral**: If a bill poses no problems or concerns to the Board, the Board may choose to adopt a neutral position.
- **Neutral if Amended:** The Board may take this position if there are minor problems with the bill but, providing they are amended, the intent of the legislation does not impede with Board processes.
- **Support:** This position may be taken if the Board supports the legislation and has no recommended changes.
- **Support if Amended:** This position may be taken if the Board has amendments and if accepted, the Board will support the legislation.
- **Oppose:** The Board may opt to oppose a bill if it negatively impacts consumers or is against the Board's own objectives.
- **Oppose Unless Amended:** The Board may take this position unless the objectionable language is removed. This is a more common and substantive stance than Neutral if Amended.

Board Members can access bill language, analyses, and vote history at http://leginfo.legislature.ca.gov/ and watch all legislative hearings online at www.calchannel.com.

THE LIFE CYCLE OF LEGISLATION

From Idea into Law

ASSEMBLY MEMBER

ASSEMBLY BILL PREPARED BY LEGISLATIVE COUNSEL

INTRODUCED BY MEMBER, NUMBERED, FIRST READING, PRINTED

RULES COMMITTEE ASSIGNS BILL TO COMMITTEE

Bill may not be heard by committee until 31st day after introduction

COMMITTEE HEARING: Policy or Appropriations CHAIRPERSON AND MEMBERS TESTIFY: BILL AUTHOR CITIZENS EXPERTS LOBBYISTS

HELD IN COMMITTEE

COMMITTEE RECOMENDATIONS PASS

SECOND ASSEMBLY READING

THIRD ASSEMBLY READING DEBATE VOTE

PASSAGE REFUSED

Proposed Amendments

Revised Third Reading Analysis

TO SENATE

FIRST SENATE READING

RULES ASSIGNS BILLS TO COMMITTEE

COMMITTEE HEARING: Policy or Appropriations CHAIRPERSON AND MEMBERS TESTIMONY BY: BILL AUTHOR CITIZENS EXPERTS LOBBYISTS

HELD IN COMMITTEE

COMMITTEE RECOMENDATIONS PASS

SECOND SENATE READING

THIRD SENATE READING DEBATE VOTE

PASSAGE REFUSED

Proposed Amendments

Revised Third Reading Analysis

PASSED

WITH SENATE AMENDMENTS

WITHOUT SENATE AMENDMENTS

RETURN TO ASSEMBLY FLOOR Concurrence in Senate Amendments

YES

NO

CONFERENCE COMMITTEE

3 Assembly Members 3 Senate Members

CONFERENCE REPORT

YES

ASSEMBLY and SENATE Adopt Conference Report

NO

*Follow same procedures as in the Assembly

SUGGESTIONS FOR NEEDED LEGISLATION FROM
Agencies, Citizens, Governor, Lobbyists

THE CALIFORNIA LEGISLATURE

ASSEMBLY RULES COMMITTEE

Although the procedure can become complicated, this chart shows the essential steps for passage of a bill.

Typical committee actions are used to simplify charting the course of legislation.

Some bills require hearings by more than one committee, in which case a committee may re–refer the bill to another committee. For example, bills with monetary implications must be re–referred to the proper fiscal committee in each House before they are sent to the second reading file and final action.

A bill may be amended at various times as it moves through the Houses. The bill must be reprinted each time an amendment is adopted by either house. All bill actions are printed in the DAILY FILES, JOURNALS and HISTORIES.

If a bill is amended in the opposite House, it is returned to the House of Origin for concurrence in amendments. If House of Origin does not concur, a Conference Committee Report must then be adopted by each House before the bill can be sent to the Governor.

STATE · CALIFORNIA · ASSEMBLY

LEGISLATORUM

EST JUSTAS LEGES CONDERE

LEGISLATURE HAS 60 DAYS (not including joint recesses) TO OVERRIDE VETO WITH 2/3 VOTE IN EACH HOUSE

VETO

** Assembly policy committee will do Governor's Veto analysis

BILL IS CHAPTERED BY SECRETARY OF STATE

Bill becomes law January 1st of the following year unless it contains an urgency clause (takes effect immediately) or specifies its own effective date.

SIGN

GOVERNOR

BECOMES LAW WITHOUT SIGNATURE

WITHOUT ASSEMBLY AMENDMENTS

RETURN TO SENATE FLOOR Concurrence in Assembly Amendments

SENATOR

SENATE BILL PREPARED BY LEGISLATIVE COUNSEL

INTRODUCED BY MEMBER, NUMBERED, FIRST READING, PRINTED

RULES COMMITTEE ASSIGNS BILL TO COMMITTEE

Bill may not be heard by committee until 31st day after introduction

COMMITTEE HEARING: Policy or Appropriations CHAIRPERSON AND MEMBERS TESTIFY: BILL AUTHOR CITIZENS EXPERTS LOBBYISTS

HELD IN COMMITTEE

COMMITTEE RECOMENDATIONS PASS

SECOND SENATE READING

THIRD SENATE READING DEBATE VOTE

PASSAGE REFUSED

FIRST ASSEMBLY READING

RULES ASSIGNS BILLS TO COMMITTEE

COMMITTEE HEARING: Policy or Appropriations CHAIRPERSON AND MEMBERS

HELD IN COMMITTEE

COMMITTEE RECOMENDATIONS PASS

SECOND

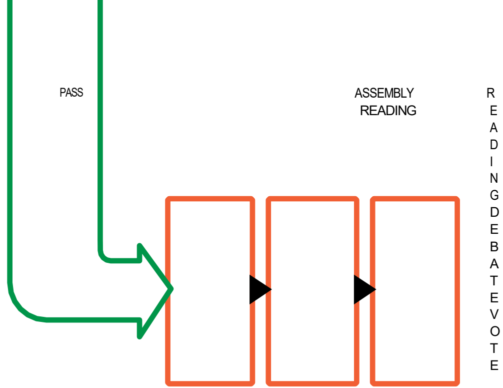
THIRD ASSEMBLY

PASSAGE REFUSED

PASSED

WITH ASSEMBLY AMENDMENTS

TESTIMONY BY: BILL AUTHOR CITIZENS EXPERTS LOBBYISTS



Proposed Amendments

Revised Third Reading Analysis

Proposed Amendments

Revised Third Reading Analysis

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:

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) Recognizing that abuse survivors often need to access health
4 care and medical treatment apart from police reporting and criminal
5 legal involvement, this bill replaces mandated police reporting by
6 medical professionals with offering connection to survivor services.
7 (b) Health care providers play a critical role in prevention,
8 identification, and response to violence. However, current law
9 requiring health professionals in California to file reports to law
10 enforcement when treating patients for all suspected
11 violence-related injuries can have a chilling effect of preventing
12 domestic and sexual violence survivors from seeking medical care,
13 decreasing patient autonomy and trust, and resulting in health
14 providers being reluctant to address domestic and sexual violence
15 with their patients.
16 (c) Studies have shown that medical mandatory reporting of
17 adult domestic and sexual violence may increase patient danger
18 and insecurity, whereas being able to openly discuss abuse without

1 fear of police reporting can produce greater health and safety
2 outcomes.
3 (d) Because of the complexity of interpersonal violence and
4 impact of social inequities on safety, people who have experienced
5 violence should be provided survivor-centered support and health
6 care that results in better outcomes for patient safety. Doing so
7 can improve the health and safety of patients already in care,
8 decrease potential barriers to care, and promote trust between
9 survivors and health providers.
10 (e) ~~Nothing in this act limits or overrides~~ *This act does not limit*
11 *or override* the ability of a health practitioner to make reports
12 permitted by subdivisions (c) or (j) of Section 164.512 of Title 45
13 of the Code of Federal Regulations, or at the patient's request.
14 Providers must still follow reporting requirements for child abuse,
15 pursuant to Section 11165 of the Penal Code, and elder and
16 vulnerable adult abuse, pursuant to Section 15600 of the Welfare
17 and Institutions Code. It is the intent of the Legislature to promote
18 partnership between health facilities and domestic and sexual
19 violence advocacy organizations, legal aid, county forensic
20 response teams, family justice centers, and other community-based
21 organizations that address social determinants of health in order
22 to better ensure the safety and wellness of their patients and provide
23 training for health practitioners. California has made strides to
24 enhance health practitioners' capacity to address and prevent
25 violence and trauma, including education for practitioners on how
26 to assess for and document abuse as referenced in subdivision (h)
27 of Section 2191 of, Section 2196.5 of, and Section 2091.2 of, the
28 Business and Professions Code, Section 13823.93 of the Penal
29 Code, and Section 1259.5 of the Health and Safety Code.
30 SEC. 2. Section 11160 of the Penal Code is amended to read:
31 11160. (a) A health practitioner, as defined in subdivision (a)
32 of Section 11162.5, employed by a health facility, clinic,
33 physician's office, local or state public health department, local
34 government agency, or a clinic or other type of facility operated
35 by a local or state public health department who, in the health
36 practitioner's professional capacity or within the scope of the health
37 practitioner's employment, provides medical services for a physical
38 condition to a patient whom the health practitioner knows or
39 reasonably suspects is a person described as follows, shall
40 immediately make a report in accordance with subdivision (b):

1 (1) A person suffering from a wound or other physical injury
2 inflicted by the person's own act or inflicted by another where the
3 injury is by means of a firearm.
4 (2) A person suffering from a wound or other physical injury
5 inflicted upon the person where the injury is the result of assaultive
6 or abusive conduct.
7 (b) A health practitioner, as defined in subdivision (a) of Section
8 11162.5, employed by a health facility, clinic, physician's office,
9 local or state public health department, local government agency,
10 or a clinic or other type of facility operated by a local or state
11 public health department shall make a report regarding persons
12 described in subdivision (a) to a local law enforcement agency as
13 follows:
14 (1) A report by telephone shall be made immediately or as soon
15 as practically possible.
16 (2) A written report shall be prepared on the standard form
17 developed in compliance with paragraph (4), and adopted by the
18 Office of Emergency Services, or on a form developed and adopted
19 by another state agency that otherwise fulfills the requirements of
20 the standard form. The completed form shall be sent to a local law
21 enforcement agency within two working days of receiving the
22 information regarding the person.
23 (3) A local law enforcement agency shall be notified and a
24 written report shall be prepared and sent pursuant to paragraphs
25 (1) and (2) even if the person who suffered the wound, other injury,
26 or assaultive or abusive conduct has expired, regardless of whether
27 or not the wound, other injury, or assaultive or abusive conduct
28 was a factor contributing to the death, and even if the evidence of
29 the conduct of the perpetrator of the wound, other injury, or
30 assaultive or abusive conduct was discovered during an autopsy.
31 (4) The report shall include, but shall not be limited to, the
32 following:
33 (A) The name of the injured person, if known.
34 (B) The injured person's whereabouts.
35 (C) The character and extent of the person's injuries.
36 (D) The identity of any person the injured person alleges
37 inflicted the wound, other injury, or assaultive or abusive conduct
38 upon the injured person.
39 (c) For the purposes of this section, "injury" does not include
40 any psychological or physical condition brought about solely

1 through the voluntary administration of a narcotic or restricted
2 dangerous drug.
3 (d) For the purposes of this section, “assaultive or abusive
4 conduct” includes any of the following offenses:
5 (1) Murder, in violation of Section 187.
6 (2) Manslaughter, in violation of Section 192 or 192.5.
7 (3) Mayhem, in violation of Section 203.
8 (4) Aggravated mayhem, in violation of Section 205.
9 (5) Torture, in violation of Section 206.
10 (6) Assault with intent to commit mayhem, rape, sodomy, or
11 oral copulation, in violation of Section 220.
12 (7) Administering controlled substances or anesthetic to aid in
13 commission of a felony, in violation of Section 222.
14 (8) Battery, in violation of Section 242.
15 (9) Sexual battery, in violation of Section 243.4.
16 (10) Incest, in violation of Section 285.
17 (11) Throwing any vitriol, corrosive acid, or caustic chemical
18 with intent to injure or disfigure, in violation of Section 244.
19 (12) Assault with a stun gun or taser, in violation of Section
20 244.5.
21 (13) Assault with a deadly weapon, firearm, assault weapon, or
22 machinegun, or by means likely to produce great bodily injury, in
23 violation of Section 245.
24 (14) Rape, in violation of Section 261 or former Section 262.
25 (15) Procuring a person to have sex with another person, in
26 violation of Section 266, 266a, 266b, or 266c.
27 (16) Child abuse or endangerment, in violation of Section 273a
28 or 273d.
29 (17) Abuse of spouse or cohabitant, in violation of Section
30 273.5.
31 (18) Sodomy, in violation of Section 286.
32 (19) Lewd and lascivious acts with a child, in violation of
33 Section 288.
34 (20) Oral copulation, in violation of Section 287 or former
35 Section 288a.
36 (21) Sexual penetration, in violation of Section 289.
37 (22) Elder abuse, in violation of Section 368.
38 (23) An attempt to commit any crime specified in paragraphs
39 (1) to (22), inclusive.

1 (e) When two or more persons who are required to report are
2 present and jointly have knowledge of a known or suspected
3 instance of violence that is required to be reported pursuant to this
4 section, and when there is an agreement among these persons to
5 report as a team, the team may select by mutual agreement a
6 member of the team to make a report by telephone and a single
7 written report, as required by subdivision (b). The written report
8 shall be signed by the selected member of the reporting team. Any
9 member who has knowledge that the member designated to report
10 has failed to do so shall thereafter make the report.
11 (f) The reporting duties under this section are individual, except
12 as provided in subdivision (e).
13 (g) A supervisor or administrator shall not impede or inhibit the
14 reporting duties required under this section and a person making
15 a report pursuant to this section shall not be subject to any sanction
16 for making the report. However, internal procedures to facilitate
17 reporting and apprise supervisors and administrators of reports
18 may be established, except that these procedures shall not be
19 inconsistent with this article. The internal procedures shall not
20 require an employee required to make a report under this article
21 to disclose the employee's identity to the employer.
22 (h) For the purposes of this section, it is the Legislature's intent
23 to avoid duplication of information.
24 (i) For purposes of this section only, "employed by a local
25 government agency" includes an employee of an entity under
26 contract with a local government agency to provide medical
27 services.
28 (j) This section shall remain in effect only until January 1, 2025,
29 and as of that date is repealed.
30 SEC. 3. Section 11160 is added to the Penal Code, to read:
31 11160. (a) A health practitioner, as defined in subdivision (a)
32 of Section 11162.5, employed by a health facility, clinic,
33 physician's office, local or state public health department, local
34 government agency, or a clinic or other type of facility operated
35 by a local or state public health department who, in the health
36 practitioner's professional capacity or within the scope of the health
37 practitioner's employment, provides medical services for a physical
38 condition to a patient whom the health practitioner knows or
39 reasonably suspects is a person suffering from any of the following

1 shall immediately make a report in accordance with subdivision
2 (b):
3 (1) A wound or other physical injury inflicted by the person's
4 own act or inflicted by another where the injury is by means of a
5 firearm.
6 (2) A wound or other physical injury resulting from child abuse,
7 pursuant to Section 11165.6.
8 (3) A wound or other physical injury resulting from abuse of
9 an elder or dependent adult, pursuant to Section 15610.07 of the
10 Welfare and Institutions Code.
11 (b) A health practitioner, as defined in subdivision (a) of Section
12 11162.5, employed by a health facility, clinic, physician's office,
13 local or state public health department, local government agency,
14 or a clinic or other type of facility operated by a local or state
15 public health department shall make a report regarding persons
16 described in subdivision (a) to a local law enforcement agency as
17 follows:
18 (1) A report by telephone shall be made immediately or as soon
19 as practically possible.
20 (2) A written report shall be prepared on the standard form
21 developed in compliance with paragraph (4), and adopted by the
22 Office of Emergency Services, or on a form developed and adopted
23 by another state agency that otherwise fulfills the requirements of
24 the standard form. The completed form shall be maintained in the
25 medical record and sent to a local law enforcement agency within
26 two working days of the patient receiving treatment.
27 (3) A local law enforcement agency shall be notified and a
28 written report shall be prepared and sent pursuant to paragraphs
29 (1) and (2) even if the person who suffered the wound or other
30 injury has expired, regardless of whether or not the wound or other
31 injury was a factor contributing to the death, and even if the
32 evidence of the conduct of the perpetrator of the wound or other
33 injury was discovered during an autopsy.
34 (4) The report shall include, but shall not be limited to, the
35 following:
36 (A) The name of the injured person, if known.
37 (B) The injured person's whereabouts.
38 (C) The character and extent of the person's injuries.
39 (D) The identity of any person the injured person alleges
40 inflicted the wound or other injury upon the injured person.

1 (c) If an adult seeking care for injuries related to domestic,
2 sexual, or any nonaccidental violent injury, requests a report be
3 sent to law enforcement, health practitioners shall adhere to the
4 reporting process outlined in paragraph (3) of subdivision (b). The
5 medical documentation of injuries related to domestic, sexual, or
6 any nonaccidental violent injury shall be conducted and made
7 available to the patient for use as outlined in the Health Insurance
8 Portability and Accountability Act.
9 (d) For the purposes of this section, "injury" does not include
10 any psychological or physical condition brought about solely
11 through the voluntary administration of a narcotic or restricted
12 dangerous drug.
13 (e) When two or more persons who are required to report are
14 present and jointly have knowledge of a known or suspected
15 instance of violence that is required to be reported pursuant to this
16 section, and when there is an agreement among these persons to
17 report as a team, the team may select by mutual agreement a
18 member of the team to make a report by telephone and a single
19 written report, as required by subdivision (b). The written report
20 shall be signed by the selected member of the reporting team. Any
21 member who has knowledge that the member designated to report
22 has failed to do so shall thereafter make the report.
23 (f) The reporting duties under this section are individual, except
24 as provided in subdivision (e).
25 (g) A supervisor or administrator shall not impede or inhibit the
26 reporting duties required under this section and a person making
27 a report pursuant to this section shall not be subject to any sanction
28 for making the report. However, internal procedures to facilitate
29 reporting and apprise supervisors and administrators of reports
30 may be established, except that these procedures shall not be
31 inconsistent with this article. The internal procedures shall not
32 require an employee required to make a report under this article
33 to disclose the employee's identity to the employer.
34 (h) (1) A health practitioner, as defined in subdivision (a) of
35 Section 11162.5, employed by a health facility, clinic, physician's
36 office, local or state public health department, local government
37 agency, or a clinic or other type of facility operated by a local or
38 state public health department who, in the health practitioner's
39 professional capacity or within the scope of the health practitioner's
40 employment, provides medical services to a patient whom the

1 health practitioner knows or reasonably suspects is experiencing
2 any form of domestic violence, as set forth in Section 124250 of
3 the Health and Safety Code, or sexual violence, as set forth in
4 Sections 243.4 and 261, shall, to the degree that it is medically
5 possible for the individual patient, provide brief counseling,
6 education, or other support, and offer a warm handoff or referral
7 to local and national domestic violence or sexual violence advocacy
8 services, as described in Sections 1035.2 and 1037.1 of the
9 Evidence Code, before the end of the patient visit. The health
10 practitioner shall have met the requirements of this subdivision
11 when the brief counseling, education, or other support is provided
12 and warm handoff or referral is offered by a member of the health
13 care team at the health facility.
14 (2) If the health practitioner is providing medical services to
15 the patient in the emergency department of a general acute care
16 hospital, they shall also offer assistance to the patient in accessing
17 a forensic evidentiary exam or reporting to law enforcement, if
18 the patient wants to pursue these options.
19 (i) A health practitioner may offer a warm handoff and referral
20 to other available victim services, including, but not limited to,
21 legal aid, community-based organizations, behavioral health, crime
22 victim compensation, forensic evidentiary exams, trauma recovery
23 centers, family justice centers, and law enforcement to patients
24 who are suspected to have suffered any nonaccidental injury.
25 (j) To the extent possible, health practitioners shall document
26 all nonaccidental violent injuries and incidents of abuse in the
27 medical record. Health practitioners shall follow privacy and
28 confidentiality protocols when documenting violence and abuse
29 to promote the safety of the patient. If documenting abuse in the
30 medical record increases danger for the patient, it may be marked
31 confidential.
32 (k) This section does not limit or override the ability of a health
33 care practitioner to make reports to law enforcement at the patient's
34 request, or as permitted by the federal Health Insurance Portability
35 and Accountability Act of 1996 in Section 164.512(c) of Title 45
36 of the Code of Federal Regulations, which permits disclosures
37 about victims of abuse, neglect, or domestic violence, if the
38 individual agrees, or pursuant to Section 164.512(j) of Title 45 of
39 the Code of Federal Regulations, which permits disclosures to

1 prevent or limit a serious and imminent threat to a person or the
2 public.
3 (*l*) For the purposes of this section, it is the Legislature's intent
4 to avoid duplication of information.
5 (m) For purposes of this section only, "employed by a local
6 government agency" includes an employee of an entity under
7 contract with a local government agency to provide medical
8 services.
9 (n) For purposes of this section, the following terms have the
10 following meanings:
11 (1) "Warm handoff" may include, but is not limited to, the health
12 practitioner establishing direct and live connection through a call
13 with a survivor advocate, in-person onsite survivor advocate,
14 in-person on-call survivor advocate, or some other form of
15 teleadvocacy. When a telephone call is not possible, the warm
16 handoff may be completed through an email. The patient may
17 decline the warm handoff.
18 (2) "Referral" may include, but is not limited to, the health
19 practitioner sharing information about how a patient can get in
20 touch with a local or national survivor advocacy organization,
21 information about how the survivor advocacy organization could
22 be helpful for the patient, what the patient could expect when
23 contacting the survivor advocacy organization, or the survivor
24 advocacy organization's contact information.
25 (o) A health practitioner shall not be civilly or criminally liable
26 for acting in compliance with this section and for any report that
27 is made in good faith and in compliance with this section and all
28 other applicable state and federal laws.
29 (p) This section shall become operative on January 1, 2025.
30 SEC. 4. Section 11161 of the Penal Code is amended to read:
31 11161. Notwithstanding Section 11160, the following shall
32 apply to every physician and surgeon who has under their charge
33 or care any person described in subdivision (a) of Section 11160:
34 (a) The physician and surgeon shall make a report in accordance
35 with subdivision (b) of Section 11160 to a local law enforcement
36 agency.
37 (b) It is recommended that any medical records of a person
38 about whom the physician and surgeon is required to report
39 pursuant to subdivision (a) include the following:

1 (1) Any comments by the injured person regarding past domestic
2 violence, as defined in Section 13700, or regarding the name of
3 any person suspected of inflicting the wound, other physical injury,
4 or assaultive or abusive conduct upon the person.
5 (2) A map of the injured person's body showing and identifying
6 injuries and bruises at the time of the health care.
7 (3) A copy of the law enforcement reporting form.
8 (c) It is recommended that the physician and surgeon refer the
9 person to local domestic violence services if the person is suffering
10 or suspected of suffering from domestic violence, as defined in
11 Section 13700.
12 (d) This section shall remain in effect only until January 1, 2025,
13 and as of that date is repealed.
14 SEC. 5. Section 11161 is added to the Penal Code, to read:
15 11161. Notwithstanding Section 11160, the following shall
16 apply to every health practitioner who has under their charge or
17 care any person described in subdivision (a) of Section 11160:
18 (a) The health practitioner or member of the care team shall
19 make a report in accordance with subdivision (b) of Section 11160
20 to a local law enforcement agency.
21 (b) It is recommended that any medical records of a person
22 about whom the health practitioner or member of the care team is
23 required to report pursuant to subdivision (a) include the following:
24 (1) Any comments by the injured person regarding past domestic
25 violence, as defined in Section 13700, or regarding the name of
26 any person suspected of inflicting the wound or other physical
27 injury upon the person.
28 (2) A map of the injured person's body showing and identifying
29 injuries and bruises at the time of the health care.
30 (3) A copy of the law enforcement reporting form.
31 (c) The health practitioner or member of the care team shall
32 offer a referral to local domestic violence services if the person is
33 suffering or suspected of suffering from domestic violence, as
34 defined in Section 13700.
35 (d) This section shall become operative on January 1, 2025.
36 SEC. 6. Section 11163.2 of the Penal Code is amended to read:
37 11163.2. (a) In any court proceeding or administrative hearing,
38 neither the physician-patient privilege nor the psychotherapist
39 privilege applies to the information required to be reported pursuant
40 to this article.

1 (b) The reports required by this article shall be kept confidential
2 by the health facility, clinic, or physician's office that submitted
3 the report, and by local law enforcement agencies, and shall only
4 be disclosed by local law enforcement agencies to those involved
5 in the investigation of the report or the enforcement of a criminal
6 law implicated by a report. In no case shall the person suspected
7 or accused of inflicting the wound, other injury, or assaultive or
8 abusive conduct upon the injured person or their attorney be
9 allowed access to the injured person's whereabouts. Nothing in
10 this subdivision is intended to conflict with Section 1054.1 or
11 1054.2.
12 (c) For the purposes of this article, reports of suspected child
13 abuse and information contained therein may be disclosed only to
14 persons or agencies with whom investigations of child abuse are
15 coordinated under the regulations promulgated under Section
16 11174.
17 (d) The Board of Prison Terms may subpoena reports that are
18 not unfounded and reports that concern only the current incidents
19 upon which parole revocation proceedings are pending against a
20 parolee.
21 (e) This section shall remain in effect only until January 1, 2025,
22 and as of that date is repealed.
23 SEC. 7. Section 11163.2 is added to the Penal Code, to read:
24 11163.2. (a) In any court proceeding or administrative hearing,
25 neither the physician-patient privilege nor the
26 psychotherapist-patient privilege applies to the information required
27 to be reported pursuant to this article.
28 (b) The reports required by this article shall be kept confidential
29 by the health facility, clinic, or physician's office that submitted
30 the report, and by local law enforcement agencies, and shall only
31 be disclosed by local law enforcement agencies to those involved
32 in the investigation of the report or the enforcement of a criminal
33 law implicated by a report. In no case shall the person suspected
34 or accused of inflicting the wound or other injury upon the injured
35 person, or the attorney of the suspect or accused, be allowed access
36 to the injured person's whereabouts. Nothing in this subdivision
37 is intended to conflict with Section 1054.1 or 1054.2.
38 (c) For the purposes of this article, reports of suspected child
39 abuse and information contained therein may be disclosed only to
40 persons or agencies with whom investigations of child abuse are

1 coordinated under the regulations promulgated under Section
2 11174.
3 (d) The Board of Prison Terms may subpoena reports that are
4 not unfounded and reports that concern only the current incidents
5 upon which parole revocation proceedings are pending against a
6 parolee.
7 (e) This section shall become operative on January 1, 2025.
8 SEC. 8. Section 11163.3 of the Penal Code is amended to read:
9 11163.3. (a) A county may establish an interagency domestic
10 violence death review team to assist local agencies in identifying
11 and reviewing domestic violence deaths and near deaths, including
12 homicides and suicides, and facilitating communication among
13 the various agencies involved in domestic violence cases.
14 Interagency domestic violence death review teams have been used
15 successfully to ensure that incidents of domestic violence and
16 abuse are recognized and that agency involvement is reviewed to
17 develop recommendations for policies and protocols for community
18 prevention and intervention initiatives to reduce and eradicate the
19 incidence of domestic violence.
20 (b) (1) For purposes of this section, "abuse" has the meaning
21 set forth in Section 6203 of the Family Code and "domestic
22 violence" has the meaning set forth in Section 6211 of the Family
23 Code.
24 (2) For purposes of this section, "near death" means the victim
25 suffered a life-threatening injury, as determined by a licensed
26 physician or licensed nurse, as a result of domestic violence.
27 (c) A county may develop a protocol that may be used as a
28 guideline to assist coroners and other persons who perform
29 autopsies on domestic violence victims in the identification of
30 domestic violence, in the determination of whether domestic
31 violence contributed to death or whether domestic violence had
32 occurred prior to death, but was not the actual cause of death, and
33 in the proper written reporting procedures for domestic violence,
34 including the designation of the cause and mode of death.
35 (d) County domestic violence death review teams shall be
36 comprised of, but not limited to, the following:
37 (1) Experts in the field of forensic pathology.
38 (2) Medical personnel with expertise in domestic violence abuse.
39 (3) Coroners and medical examiners.
40 (4) Criminologists.

1 (5) District attorneys and city attorneys.
2 (6) Representatives of domestic violence victim service
3 organizations, as defined in subdivision (b) of Section 1037.1 of
4 the Evidence Code.
5 (7) Law enforcement personnel.
6 (8) Representatives of local agencies that are involved with
7 domestic violence abuse reporting.
8 (9) County health department staff who deal with domestic
9 violence victims' health issues.
10 (10) Representatives of local child abuse agencies.
11 (11) Local professional associations of persons described in
12 paragraphs (1) to (10), inclusive.
13 (e) An oral or written communication or a document shared
14 within or produced by a domestic violence death review team
15 related to a domestic violence death review is confidential and not
16 subject to disclosure or discoverable by a third party. An oral or
17 written communication or a document provided by a third party
18 to a domestic violence death review team, or between a third party
19 and a domestic violence death review team, is confidential and not
20 subject to disclosure or discoverable by a third party. This includes
21 a statement provided by a survivor in a near-death case review.
22 Notwithstanding the foregoing, recommendations of a domestic
23 violence death review team upon the completion of a review may
24 be disclosed at the discretion of a majority of the members of the
25 domestic violence death review team.
26 (f) Each organization represented on a domestic violence death
27 review team may share with other members of the team information
28 in its possession concerning the victim who is the subject of the
29 review or any person who was in contact with the victim and any
30 other information deemed by the organization to be pertinent to
31 the review. Any information shared by an organization with other
32 members of a team is confidential. This provision shall permit the
33 disclosure to members of the team of any information deemed
34 confidential, privileged, or prohibited from disclosure by any other
35 statute.
36 (g) Written and oral information may be disclosed to a domestic
37 violence death review team established pursuant to this section.
38 The team may make a request in writing for the information sought
39 and any person with information of the kind described in paragraph

1 (2) may rely on the request in determining whether information
2 may be disclosed to the team.
3 (1) An individual or agency that has information governed by
4 this subdivision shall not be required to disclose information. The
5 intent of this subdivision is to allow the voluntary disclosure of
6 information by the individual or agency that has the information.
7 (2) The following information may be disclosed pursuant to this
8 subdivision:
9 (A) Notwithstanding Section 56.10 of the Civil Code, medical
10 information.
11 (B) Notwithstanding Section 5328 of the Welfare and
12 Institutions Code, mental health information.
13 (C) Notwithstanding Section 15633.5 of the Welfare and
14 Institutions Code, information from elder abuse reports and
15 investigations, except the identity of persons who have made
16 reports, which shall not be disclosed.
17 (D) Notwithstanding Section 11167.5 of the Penal Code,
18 information from child abuse reports and investigations, except
19 the identity of persons who have made reports, which shall not be
20 disclosed.
21 (E) State summary criminal history information, criminal
22 offender record information, and local summary criminal history
23 information, as defined in Sections 11075, 11105, and 13300 of
24 the Penal Code.
25 (F) Notwithstanding Section 11163.2 of the Penal Code,
26 information pertaining to reports by health practitioners of persons
27 suffering from physical injuries inflicted by means of a firearm or
28 of persons suffering physical injury where the injury is a result of
29 assaultive or abusive conduct, and information relating to whether
30 a physician referred the person to local domestic violence services
31 as recommended by Section 11161 of the Penal Code.
32 (G) Notwithstanding Section 827 of the Welfare and Institutions
33 Code, information in any juvenile court proceeding.
34 (H) Information maintained by the Family Court, including
35 information relating to the Family Conciliation Court Law pursuant
36 to Section 1818 of the Family Code, and Mediation of Custody
37 and Visitation Issues pursuant to Section 3177 of the Family Code.
38 (I) Information provided to probation officers in the course of
39 the performance of their duties, including, but not limited to, the

1 duty to prepare reports pursuant to Section 1203.10 of the Penal
2 Code, as well as the information on which these reports are based.
3 (J) Notwithstanding Section 10850 of the Welfare and
4 Institutions Code, records of in-home supportive services, unless
5 disclosure is prohibited by federal law.
6 (3) The disclosure of written and oral information authorized
7 under this subdivision shall apply notwithstanding Sections 2263,
8 2918, 4982, and 6068 of the Business and Professions Code, or
9 the lawyer-client privilege protected by Article 3 (commencing
10 with Section 950) of Chapter 4 of Division 8 of the Evidence Code,
11 the physician-patient privilege protected by Article 6 (commencing
12 with Section 990) of Chapter 4 of Division 8 of the Evidence Code,
13 the psychotherapist-patient privilege protected by Article 7
14 (commencing with Section 1010) of Chapter 4 of Division 8 of
15 the Evidence Code, the sexual assault counselor-victim privilege
16 protected by Article 8.5 (commencing with Section 1035) of
17 Chapter 4 of Division 8 of the Evidence Code, the domestic
18 violence counselor-victim privilege protected by Article 8.7
19 (commencing with Section 1037) of Chapter 4 of Division 8 of
20 the Evidence Code, and the human trafficking caseworker-victim
21 privilege protected by Article 8.8 (commencing with Section 1038)
22 of Chapter 4 of Division 8 of the Evidence Code.
23 (4) In near-death cases, representatives of domestic violence
24 victim service organizations, as defined in subdivision (b) of
25 Section 1037.1 of the Evidence Code, shall obtain an individual's
26 informed consent in accordance with all applicable state and federal
27 confidentiality laws, before disclosing confidential information
28 about that individual to another team member as specified in this
29 section. In death review cases, representatives of domestic violence
30 victim service organizations shall only provide client-specific
31 information in accordance with both state and federal
32 confidentiality requirements.
33 (5) Near-death case reviews shall only occur after any
34 prosecution has concluded.
35 (6) Near-death survivors shall not be compelled to participate
36 in death review team investigations; their participation is voluntary.
37 In cases of death, the victim's family members may be invited to
38 participate, however they shall not be compelled to do so; their
39 participation is voluntary. Members of the death review teams

1 shall be prepared to provide referrals for services to address the
2 unmet needs of survivors and their families when appropriate.
3 (h) This section shall remain in effect only until January 1, 2025,
4 and as of that date is repealed.
5 SEC. 9. Section 11163.3 is added to the Penal Code, to read:
6 11163.3. (a) A county may establish an interagency domestic
7 violence death review team to assist local agencies in identifying
8 and reviewing domestic violence deaths and near deaths, including
9 homicides and suicides, and facilitating communication among
10 the various agencies involved in domestic violence cases.
11 Interagency domestic violence death review teams have been used
12 successfully to ensure that incidents of domestic violence and
13 abuse are recognized and that agency involvement is reviewed to
14 develop recommendations for policies and protocols for community
15 prevention and intervention initiatives to reduce and eradicate the
16 incidence of domestic violence.
17 (b) (1) For purposes of this section, "abuse" has the meaning
18 set forth in Section 6203 of the Family Code and "domestic
19 violence" has the meaning set forth in Section 6211 of the Family
20 Code.
21 (2) For purposes of this section, "near death" means the victim
22 suffered a life-threatening injury, as determined by a licensed
23 physician or licensed nurse, as a result of domestic violence.
24 (c) A county may develop a protocol that may be used as a
25 guideline to assist coroners and other persons who perform
26 autopsies on domestic violence victims in the identification of
27 domestic violence, in the determination of whether domestic
28 violence contributed to death or whether domestic violence had
29 occurred prior to death, but was not the actual cause of death, and
30 in the proper written reporting procedures for domestic violence,
31 including the designation of the cause and mode of death.
32 (d) County domestic violence death review teams shall be
33 comprised of, but not limited to, the following:
34 (1) Experts in the field of forensic pathology.
35 (2) Medical personnel with expertise in domestic violence abuse.
36 (3) Coroners and medical examiners.
37 (4) Criminologists.
38 (5) District attorneys and city attorneys.

1 (6) Representatives of domestic violence victim service
2 organizations, as defined in subdivision (b) of Section 1037.1 of
3 the Evidence Code.
4 (7) Law enforcement personnel.
5 (8) Representatives of local agencies that are involved with
6 domestic violence abuse reporting.
7 (9) County health department staff who deal with domestic
8 violence victims' health issues.
9 (10) Representatives of local child abuse agencies.
10 (11) Local professional associations of persons described in
11 paragraphs (1) to (10), inclusive.
12 (e) An oral or written communication or a document shared
13 within or produced by a domestic violence death review team
14 related to a domestic violence death review is confidential and not
15 subject to disclosure or discoverable by a third party. An oral or
16 written communication or a document provided by a third party
17 to a domestic violence death review team, or between a third party
18 and a domestic violence death review team, is confidential and not
19 subject to disclosure or discoverable by a third party. This includes
20 a statement provided by a survivor in a near-death case review.
21 Notwithstanding the foregoing, recommendations of a domestic
22 violence death review team upon the completion of a review may
23 be disclosed at the discretion of a majority of the members of the
24 domestic violence death review team.
25 (f) Each organization represented on a domestic violence death
26 review team may share with other members of the team information
27 in its possession concerning the victim who is the subject of the
28 review or any person who was in contact with the victim and any
29 other information deemed by the organization to be pertinent to
30 the review. Any information shared by an organization with other
31 members of a team is confidential. This provision shall permit the
32 disclosure to members of the team of any information deemed
33 confidential, privileged, or prohibited from disclosure by any other
34 statute.
35 (g) Written and oral information may be disclosed to a domestic
36 violence death review team established pursuant to this section.
37 The team may make a request in writing for the information sought
38 and any person with information of the kind described in paragraph
39 (2) may rely on the request in determining whether information
40 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.

1 (3) The disclosure of written and oral information authorized
2 under this subdivision shall apply notwithstanding Sections 2263,
3 2918, 4982, and 6068 of the Business and Professions Code, or
4 the lawyer-client privilege protected by Article 3 (commencing
5 with Section 950) of Chapter 4 of Division 8 of the Evidence Code,
6 the physician-patient privilege protected by Article 6 (commencing
7 with Section 990) of Chapter 4 of Division 8 of the Evidence Code,
8 the psychotherapist-patient privilege protected by Article 7
9 (commencing with Section 1010) of Chapter 4 of Division 8 of
10 the Evidence Code, the sexual assault counselor-victim privilege
11 protected by Article 8.5 (commencing with Section 1035) of
12 Chapter 4 of Division 8 of the Evidence Code, the domestic
13 violence counselor-victim privilege protected by Article 8.7
14 (commencing with Section 1037) of Chapter 4 of Division 8 of
15 the Evidence Code, and the human trafficking caseworker-victim
16 privilege protected by Article 8.8 (commencing with Section 1038)
17 of Chapter 4 of Division 8 of the Evidence Code.
18 (4) In near-death cases, representatives of domestic violence
19 victim service organizations, as defined in subdivision (b) of
20 Section 1037.1 of the Evidence Code, shall obtain an individual's
21 informed consent in accordance with all applicable state and federal
22 confidentiality laws, before disclosing confidential information
23 about that individual to another team member as specified in this
24 section. In death review cases, representatives of domestic violence
25 victim service organizations shall only provide client-specific
26 information in accordance with both state and federal
27 confidentiality requirements.
28 (5) Near-death case reviews shall only occur after any
29 prosecution has concluded.
30 (6) Near-death survivors shall not be compelled to participate
31 in death review team investigations; their participation is voluntary.
32 In cases of death, the victim's family members may be invited to
33 participate, however they shall not be compelled to do so; their
34 participation is voluntary. Members of the death review teams
35 shall be prepared to provide referrals for services to address the
36 unmet needs of survivors and their families when appropriate.
37 (h) This section shall become operative on January 1, 2025.
38 SEC. 10. No reimbursement is required by this act pursuant to
39 Section 6 of Article XIII B of the California Constitution because
40 the only costs that may be incurred by a local agency or school

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

O

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

Status: Died.

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:
The bill failed passage in the Assembly Appropriations Committee and is dead for 2024.

FISCAL:
The Board estimates net costs of this bill as follows:

- $515,000 in fiscal year (FY) 2025-26.
- $507,000 in FY 2026-27.
- $403,400 in FY 2027-28.
- $201,400 in FY 2028-29.
- $107,800 in FY 2029-30.
- $201,400 in FY 2030-31.

- $4,200 in FY 2031-32 and ongoing (State Optometry Fund, Professions and Vocations Fund).

These costs are based on the need for up to two additional staff to implement and operate the provisions of this bill, at a cost of $323,000 in fiscal year (FY) 2025-26 and $315,000 in FY 2026-27 and ongoing. The Board estimates additional annual costs of $192,000 for three years for a limited-term medical consultant to assist with development of the regulatory program and to approve courses and training programs. The Board also anticipates increased revenue with the new certification fee, which it estimates would need to be at least $400 to recover most costs to regulate the new certification. The Department of Consumer Affairs estimates an additional $40,000 in one-time, absorbable information technology costs.

BOARD POSITION:
Support if amended to address implementation concerns.

Action Requested:

None at this time.

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

Date of Hearing: January 18, 2024

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Chris Holden, Chair
AB 1570 (Low) – As Amended January 3, 2024

Policy Committee: Business and Professions Vote: 11 - 3

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill expands the scope of practice for an optometrist to also perform specified procedures after meeting specified education and training requirements.

Specifically, this bill:

1) Adds neuromuscular blockers to the listed classes of agents that are excluded from the practice of optometry absent an explicit U.S. Food and Drug Administration-approved indication for treatment of a condition or disease authorized by statute.

2) Authorizes an optometrist certified to treat glaucoma to become additionally certified to perform the following advanced procedures on a patient 18 years of age or older: laser trabeculoplasty; laser peripheral iridotomy for the prophylactic treatment of a clinically significant narrow drainage angle of the anterior chamber of the eye; laser posterior capsulotomy after cataract surgery; excision or drainage of nonrecurrent lesions of the adnexa the optometrist considers to be noncancerous, as specified, and wound closure and local anesthesia for such a procedure; injections for the treatment of chalazia; and corneal crosslinking or the use of medication and ultraviolet light to make the tissues of the cornea stronger.

3) Requires an optometrist seeking to become certified to perform advanced procedures listed in item 2, above, to complete specified training and pass a specified examination within three years prior to beginning a Board-approved training program. Specifies numbers of each type of advanced procedure the optometrist must complete in training, and conditions for the training requirements.

4) Requires the program course administrator to certify an optometrist is competent to perform advanced procedures using a form approved by the California State Board of Optometry (Board).

5) Requires an optometrist to make a timely referral of a patient and all related records to an ophthalmologist or a qualified center to provide urgent or emergent care, after stabilizing the patient to the degree possible if the optometrist: (a) makes an intraoperative determination that a procedure being performed does not meet the statutory standard, or (b) receives a pathology report indicating a lesion might be malignant.

6) Requires an optometrist to monitor and report specified information to the Board, including the number and types of procedures, the diagnosis of the patient, and adverse treatment outcomes requiring a referral to or consultation with another health care provider.

7) Requires the Board to review adverse treatment outcome reports in a timely manner and request additional information as necessary, and to provide a report on the data.

FISCAL EFFECT:

The Board estimates net costs of this bill as follows:

- $515,000 in fiscal year (FY) 2025-26.
- $507,000 in FY 2026-27.
- $403,400 in FY 2027-28.
- $201,400 in FY 2028-29.
- $107,800 in FY 2029-30.
- $201,400 in FY 2030-31.
- $4,200 in FY 2031-32 and ongoing (State Optometry Fund, Professions and Vocations Fund).

These costs are based on the need for up to two additional staff to implement and operate the provisions of this bill, at a cost of $323,000 in fiscal year (FY) 2025-26 and $315,000 in FY 2026-27 and ongoing. The Board estimates additional annual costs of $192,000 for three years for a limited-term medical consultant to assist with development of the regulatory program and to approve courses and training programs.

The Board also anticipates increased revenue with the new certification fee, which it estimates would need to be at least $400 to recover most costs to regulate the new certification.

The Department of Consumer Affairs estimates an additional $40,000 in one-time, absorbable information technology costs.

COMMENTS:

1) **Purpose.** This bill is sponsored by the California Optometric Association. According to the author:

> 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.

2) **Scope of Practice: Optometry and Ophthalmology.** Optometrists are often considered mid-level practitioners with a narrow focus on diagnosing and treating specific eye conditions, while ophthalmologists are physicians and surgeons working within a specialty that emphasizes conditions of the eye. Ophthalmologists may engage in virtually any activity

within the practice of optometry, while also being authorized to perform a greater number of treatments and procedures than optometrists. Due in part to a shortage of ophthalmologists in some areas, legislation enacted in recent years has allowed optometrists to treat glaucoma, use therapeutic pharmaceutical agents, and employ the use of new drugs and technologies to treat certain conditions.

3) **Prior Legislation.**

   a) AB 2236 (Low), of the 2021-22 Legislative Session, was similar to this proposal but included less stringent training requirements. AB 2236 was vetoed by the Governor, who stated:

      > I am not convinced that the education and training required is sufficient to prepare optometrists to perform the surgical procedures identified. This bill would allow optometrists to perform advanced surgical procedures with less than one year of training. In comparison, physicians who perform these procedures must complete at least a three year residency program.

   b) Other bills, including AB 407 (Salas), Chapter 652, Statutes of 2021, AB 443 (Salas), Chapter 549, Statutes of 2017, and SB 1406 (Correa), Chapter 352, Statutes of 2008, have expanded and revised the scope of practice for qualified optometrists to diagnose and treat specified disorders of the visual system, and authorized optometrists to administer specific immunizations and treat glaucoma, among other changes.

4) **Opposition.** The California Medical Association writes "This bill would expand the scope of practice for optometrists to perform advanced surgical and laser procedures with minimal training…[and] would put patients at harm…" The sponsor of this bill, however, asserts recent amendments address the opposition's concerns.

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081

california legislature—2023-24 regular session

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:

1 SECTION 1. Section 3041 of the Business and Professions
2 Code is amended to read:
3 3041. (a) The practice of optometry includes the diagnosis,
4 prevention, treatment, and management of disorders and
5 dysfunctions of the visual system, as authorized by this chapter,
6 as well as the provision of habilitative or rehabilitative optometric
7 services, and is the doing of any or all of the following:
8 (1) The examination of the human eyes and their adnexa,
9 including through the use of all topical and oral diagnostic
10 pharmaceutical agents that are not controlled substances, and the
11 analysis of the human vision system, either subjectively or
12 objectively.
13 (2) The determination of the powers or range of human vision
14 and the accommodative and refractive states of the human eyes,
15 including the scope of their functions and general condition.
16 (3) The prescribing, using, or directing the use of any optical
17 device in connection with ocular exercises, visual training, vision
18 training, or orthoptics.
19 (4) The prescribing, fitting, or adaptation of contact and
20 spectacle lenses to, the human eyes, including lenses that may be

1 classified as drugs or devices by any law of the United States or
2 of this state, and diagnostic or therapeutic contact lenses that
3 incorporate a medication or therapy the optometrist is certified to
4 prescribe or provide.
5 (5) For an optometrist certified pursuant to Section 3041.3,
6 diagnosing and preventing conditions and diseases of the human
7 eyes and their adnexa, and treating nonmalignant conditions and
8 diseases of the anterior segment of the human eyes and their
9 adnexa, including ametropia and presbyopia:
10 (A) Using or prescribing, including for rational off-label
11 purposes, topical and oral prescription and nonprescription
12 therapeutic pharmaceutical agents that are not controlled substances
13 and are not antiglaucoma agents or limited or excluded by
14 subdivision (b). For purposes of this section, "controlled substance"
15 has the same meaning as used in the California Uniform Controlled
16 Substances Act (Division 10 (commencing with Section 11000)
17 of the Health and Safety Code) and the United States Uniform
18 Controlled Substances Act (21 U.S.C. Sec. 801 et seq.).
19 (B) Prescribing the oral analgesic controlled substance codeine
20 with compounds, hydrocodone with compounds, and tramadol as
21 listed in the California Uniform Controlled Substances Act
22 (Division 10 (commencing with Section 11000) of the Health and
23 Safety Code) and the United States Uniform Controlled Substances
24 Act (21 U.S.C. Sec. 801 et seq.), limited to three days, with referral
25 to an ophthalmologist if the pain persists.
26 (C) If also certified under subdivision (c), using or prescribing
27 topical and oral antiglaucoma agents for the medical treatment of
28 all primary open-angle, exfoliation, pigmentary, and
29 steroid-induced glaucomas in persons 18 years of age or over. In
30 the case of steroid-induced glaucoma, the prescriber of the steroid
31 medication shall be promptly notified if the prescriber did not refer
32 the patient to the optometrist for treatment.
33 (D) If also certified under subdivision (d), independent initiation
34 and administration of immunizations for influenza, herpes zoster
35 virus, pneumococcus, and SARS-CoV-2 in compliance with
36 individual Advisory Committee on Immunization Practices (ACIP)
37 vaccine recommendations published by the federal Centers for
38 Disease Control and Prevention (CDC) in persons 18 years of age
39 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

1 training to qualify to use each noninvasive medical device or
2 technology approved by the board pursuant to this paragraph.
3 (b) Exceptions or limitations to the provisions of subdivision
4 (a) are as follows:
5 (1) Treatment of the following is excluded from the practice of
6 optometry in a patient under 18 years of age, unless explicitly
7 allowed otherwise:
8 (A) Anterior segment inflammation, which shall not exclude
9 treatment of:
10 (i) The conjunctiva.
11 (ii) Nonmalignant ocular surface disease, including dry eye
12 syndrome.
13 (iii) Contact lens-related inflammation of the cornea.
14 (iv) An infection of the cornea.
15 (B) Conditions or diseases of the sclera.
16 (2) Use of any oral prescription steroid anti-inflammatory
17 medication for a patient under 18 years of age shall be done
18 pursuant to a documented, timely consultation with an appropriate
19 physician and surgeon.
20 (3) Use of any nonantibiotic oral prescription medication for a
21 patient under five years of age shall be done pursuant to a
22 documented, prior consultation with an appropriate physician and
23 surgeon.
24 (4) The following classes of agents are excluded from the
25 practice of optometry unless they have an explicit United States
26 Food and Drug Administration-approved indication for treatment
27 of a condition or disease authorized under this section:
28 (A) Antiamoebics.
29 (B) Antineoplastics.
30 (C) Coagulation modulators.
31 (D) Hormone modulators.
32 (E) Immunomodulators.
33 *(F) Neuromuscular blockers.*
34 (5) The following are excluded from authorization under
35 subparagraph (G) of paragraph (5) of subdivision (a):
36 (A) A laboratory test or imaging study.
37 (B) Any noninvasive device or technology that constitutes
38 surgery under paragraph (6).
39 (6) Performing surgery is excluded from the practice of
40 optometry. “Surgery” means any act in which human tissue is cut,

1 altered, or otherwise infiltrated by any means. It does not mean an
2 act that solely involves the administration or prescribing of a topical
3 or oral therapeutic pharmaceutical.
4 (7) (A) Treatment with topical and oral medications authorized
5 in subdivision (a) related to an ocular surgery shall be comanaged
6 with the ophthalmologist that performed the surgery, or another
7 ophthalmologist designated by that surgeon, during the customary
8 preoperative and postoperative period for the procedure. For
9 purposes of this subparagraph, this may involve treatment of ocular
10 inflammation in a patient under 18 years of age.
11 (B) Where published, the postoperative period shall be the
12 "global" period established by the federal Centers for Medicare
13 and Medicaid Services, or, if not published, a reasonable period
14 not to exceed 90 days.
15 (C) Such comanaged treatment may include addressing
16 agreed-upon complications of the surgical procedure occurring in
17 any ocular or adnexal structure with topical and oral medications
18 authorized in subdivision (a). For patients under 18 years of age,
19 this subparagraph shall not apply unless the patient's primary care
20 provider agrees to allowing comanagement of complications.
21 (c) An optometrist certified pursuant to Section 3041.3 shall be
22 certified to medically treat authorized glaucomas under this chapter
23 after meeting the following requirements:
24 (1) For licensees who graduated from an accredited school of
25 optometry on or after May 1, 2008, submission of proof of
26 graduation from that institution.
27 (2) For licensees who were certified to treat glaucoma under
28 this section before January 1, 2009, submission of proof of
29 completion of that certification program.
30 (3) For licensees who completed a didactic course of not less
31 than 24 hours in the diagnosis, pharmacological, and other
32 treatment and management of glaucoma, submission of proof of
33 satisfactory completion of the case management requirements for
34 certification established by the board.
35 (4) For licensees who graduated from an accredited school of
36 optometry on or before May 1, 2008, and who are not described
37 in paragraph (2) or (3), submission of proof of satisfactory
38 completion of the requirements for certification established by the
39 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.

1 (5) "Prevention" means use or prescription of an agent or
2 noninvasive device or technology for the purpose of inhibiting the
3 development of an authorized condition or disease.
4 (6) "Treatment" means use of or prescription of an agent or
5 noninvasive device or technology to alter the course of an
6 authorized condition or disease once it is present.
7 (h) In an emergency, an optometrist shall stabilize, if possible,
8 and immediately refer any patient who has an acute attack of angle
9 closure to an ophthalmologist.
10 SEC. 2. Section 3041.4 is added to the Business and Professions
11 Code, to read:
12 3041.4. (a) An optometrist certified to treat glaucoma pursuant
13 to subdivision (c) of Section 3041 shall be certified to perform the
14 following set of advanced procedures after meeting the
15 requirements in subdivision (b) after graduating from an accredited
16 school of optometry:
17 (1) Laser trabeculoplasty.
18 (2) Laser peripheral iridotomy for the prophylactic treatment
19 of a clinically significant narrow drainage angle of the anterior
20 chamber of the eye.
21 (3) Laser posterior capsulotomy after cataract surgery.
22 (4) Excision or drainage of nonrecurrent lesions of the adnexa
23 evaluated consistent with the standard of care by the optometrist
24 to be noncancerous, not involving the eyelid margin, lacrimal
25 supply, or drainage systems, no deeper than the orbicularis muscle,
26 excepting chalazia, and smaller than five millimeters in diameter.
27 Tissue excised that is not fully necrotic shall be submitted for
28 surgical pathological analysis.
29 (5) Closure of a wound resulting from a procedure described in
30 paragraph (4).
31 (6) Injections for the treatment of chalazia and to administer
32 local anesthesia required to perform procedures delineated in
33 paragraph (4).
34 (7) Corneal crosslinking procedure, or the use of medication
35 and ultraviolet light to make the tissues of the cornea stronger.
36 (b) An optometrist shall satisfy the requirements specified in
37 paragraphs (1) and (2) to perform the advanced procedures
38 specified in subdivision (a).
39 (1) Within two years prior to beginning the requirements in
40 paragraph (2), an optometrist shall satisfy both of the following:

1 (A) Complete a California State Board of Optometry-approved
2 course of at least 32 hours that is designed to provide education
3 on the advanced procedures delineated in subdivision (a), including,
4 but not limited to, medical decisionmaking that includes cases that
5 would be poor surgical candidates, an overview and case
6 presentations of known complications, practical experience
7 performing the procedures, including a detailed assessment of the
8 optometrist's technique, and a written examination for which the
9 optometrist achieves a passing score.
10 (B) Pass both sections of the Laser and Surgical Procedures
11 Examination of the National Board of Examiners in Optometry,
12 or, in the event this examination is no longer offered, its equivalent,
13 as determined by the California State Board of Optometry. At the
14 California State Board of Optometry's discretion, the requirement
15 to pass the Laser and Surgical Procedures Examination may be
16 waived if an optometrist has successfully passed both sections of
17 the examination previously.
18 (2) Within three years, complete a California State Board of
19 Optometry-approved training program conducted in California,
20 including the performance of all required procedures that shall
21 involve sufficient direct experience with live human patients to
22 permit certification of competency, by an accredited California
23 school of optometry that shall contain the following:
24 (A) Hands-on instruction on no less than the following number
25 of simulated eyes before performing the related procedure on live
26 human patients:
27 (i) Five for each laser procedure set forth in clauses (i), (ii), and
28 (iii) of subparagraph (B).
29 (ii) Five to learn the skills to perform excision and drainage
30 procedures and injections authorized by this section.
31 (iii) Five to learn the skills related to corneal crosslinking.
32 (B) The performance of at least 43 complete surgical procedures
33 on live human patients, as follows:
34 (i) Eight laser trabeculoplasties.
35 (ii) Eight laser posterior capsulotomies.
36 (iii) Five laser peripheral iridotomies.
37 (iv) Five chalazion excisions.
38 (v) Four chalazion intralesional injections.
39 (vi) Seven excisions of an authorized lesion of greater than or
40 equal to two millimeters in size.

1 (vii) Five excisions or drainages of other authorized lesions.
2 (viii) One surgical corneal crosslinking involving removal of
3 epithelium.
4 (C) (i) If necessary to certify the competence of the optometrist,
5 the program shall require sufficient additional experience to that
6 specified in subparagraph (B) performing complete procedures on
7 live human patients.
8 (ii) One time per optometrist seeking initial certification under
9 this section, a procedure required by clause (i) to (vii), inclusive,
10 of subparagraph (B) may be substituted for a different procedure
11 required by clause (i) to (vii), inclusive, of subparagraph (B) to
12 achieve the total number of complete surgical procedures required
13 by subparagraph (B) if the procedures impart similar skills. The
14 course administrator shall determine if the procedures impart
15 similar skills.
16 (D) The training required by this section shall include at least
17 a certain percent of the required procedures in subparagraph (B)
18 performed in a cohort model where, for each patient and under the
19 direct in-person supervision of a qualified educator, each member
20 of the cohort independently assesses the patient, develops a
21 treatment plan, evaluates the clinical outcome posttreatment,
22 develops a plan to address any adverse or unintended clinical
23 outcomes, and discusses and defends medical decisionmaking.
24 The California State Board of Optometry-approved training
25 program shall be responsible for determining the percentage of
26 the required procedures in subparagraph (B).
27 (E) Any procedures not completed under the terms of
28 subparagraph (D) may be completed under a preceptorship model
29 where, for each patient and under the direct in-person supervision
30 of a qualified educator, the optometrist independently assesses the
31 patient, develops a treatment plan, evaluates the clinical outcome
32 posttreatment, develops a plan to address any adverse or unintended
33 clinical outcomes, and discusses and defends medical
34 decisionmaking.
35 (F) The qualified educator shall certify the competent
36 performance of procedures completed pursuant to subparagraphs
37 (D) and (E) on a form approved by the California State Board of
38 Optometry.
39 (G) Upon the optometrist's completion of all certification
40 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

1 optometrist to perform that procedure until, with regard to that
2 procedure, the optometrist performs at least the number of the
3 specific advanced procedures required to be performed in
4 subparagraph (B) of paragraph (2) of subdivision (b), as applicable,
5 under the supervision of a qualified educator through either the
6 cohort or preceptorship model outlined in subparagraphs (D) and
7 (E) of paragraph (2) of subdivision (b), subject to subparagraph
8 (F) of paragraph (2) of subdivision (b), and the qualified educator
9 certifies that the optometrist is competent to perform the specific
10 advanced procedures. The qualified educator may require the
11 optometrist to perform additional procedures if necessary to certify
12 the competence of the optometrist. The optometrist shall provide
13 the certification to the California State Board of Optometry.
14 (g) The California State Board of Optometry shall review
15 adverse treatment outcome reports required under subdivision (e)
16 in a timely manner, requesting additional information as necessary
17 to make decisions regarding the need to impose additional training,
18 or to restrict or revoke certifications based on its patient safety
19 authority. The California State Board of Optometry shall compile
20 a report summarizing the data collected pursuant to subdivision
21 (e), including, but not limited to, percentage of adverse outcome
22 distributions by unidentified licensee and California State Board
23 of Optometry interventions, and shall make the report available
24 on its internet website.
25 (h) The California State Board of Optometry may adopt
26 regulations to implement this section.
27 (i) The California State Board of Optometry, by regulation, shall
28 set the fee for issuance and renewal of a certificate authorizing the
29 use of advanced procedures at an amount no higher than the
30 reasonable cost of regulating optometrists certified to perform
31 advanced procedures pursuant to this section.
32 (j) For the purposes of this section, the following definitions
33 apply:
34 (1) “Complete procedure” means all reasonably included steps
35 to perform a surgical procedure, including, but not limited to,
36 preoperative care, informed consent, all steps of the actual
37 procedure, required reporting and review of any specimen
38 submitted for pathologic review, and postoperative care. Multiple
39 surgical procedures performed on a patient during a surgical session
40 shall be considered a single surgical procedure.

1 (2) “Qualified educator” means a person nominated by an
2 accredited California school of optometry as a person who is
3 believed to be a suitable instructor, is subject to the regulatory
4 authority of that person’s licensing board in carrying out required
5 responsibilities under this section, and is either of the following:
6 (A) A California-licensed optometrist in good standing certified
7 to perform advanced procedures approved by the California State
8 Board of Optometry who has been continuously certified for three
9 years and has performed at least 10 of the specific advanced
10 procedures for which they will serve as a qualified educator during
11 the preceding two years.
12 (B) A California-licensed physician and surgeon who is
13 board-certified in ophthalmology, in good standing with the
14 Medical Board of California, and in active surgical practice an
15 average of at least 10 hours per week.
16 SEC. 3. No reimbursement is required by this act pursuant to
17 Section 6 of Article XIII B of the California Constitution because
18 the only costs that may be incurred by a local agency or school
19 district will be incurred because this act creates a new crime or
20 infraction, eliminates a crime or infraction, or changes the penalty
21 for a crime or infraction, within the meaning of Section 17556 of
22 the Government Code, or changes the definition of a crime within
23 the meaning of Section 6 of Article XIII B of the California
24 Constitution.

O

C. AB 1991 (Bonta) License and registrant records

Status: Amended 3/11/2024 / Referred to Committee on Business and Professions

AUTHOR REASON FOR THE BILL

Unknown currently, but likely to increase data quality to better inform health workforce policy.

DESCRIPTION OF CURRENT LEGISLATION

This bill would require healing arts boards, including CSBO, to collect workforce data from their respective licensees or registrants, and would require that data to be required at the time of electronic license or registration renewal, as specified. The bill would require a licensee or registrant to provide the specified workforce data as a condition for license or registration renewal and would delete the provision that specifies that a licensee or registrant shall not be subject to discipline for not providing that information. Under current law, healing arts boards must ask licensees to supply this data, but licensees are not required to provide it.

BACKGROUND

All health professional licensing boards in California are required to collect core data about the health workforce they oversee and provide this data to the Department of Health Care Access and Innovation (HCAI) for analysis. Similar data is not collected for nonhealing arts programs within DCA. Presently, on renewal applications, CSBO must ask for the following information, which is generally done via survey:
(1) Anticipated year of retirement.
(2) Area of practice or specialty.
(3) City, county, and ZIP Code of practice.
(4) Date of birth.
(5) Educational background and the highest level attained at time of licensure or registration.
(6) Gender or gender identity.
(7) Hours spent in direct patient care, including telehealth hours as a subcategory, training, research, and administration.
(8) Languages spoken.
(9) National Provider Identifier.
(10) Race or ethnicity.
(11) Type of employer or classification of primary practice site among the types of practice sites specified by the board, including, but not limited to, clinic, hospital, managed care organization, or private practice.
(12) Work hours.
(13) Sexual orientation.
(14) Disability status.

Renewing licensees are not required to provide this information and may instead “decline to answer” any or all of it.

HCAI publishes the workforce data in various data sets and dashboards, which can be accessed here: HCAI Health Workforce Data.

ANALYSIS

HCAI presently publishes numerous health workforce data, which it collects from boards within DCA. This data is optional to provide. Renewing licensees cannot be disciplined for not providing it. The bill likely originates in an attempt to acquire more data to better inform the present and future work force needs in California. Occasionally, some licensees make complaint about being asked personal demographic information, such as

race, gender, or sexual orientation. Moving from optional to mandatory may increase the frequency of these complaints. However, high quality data regarding the health workforce data in California serves to inform policy makers and can benefit future planning efforts.

FISCAL

Unknown, but possibly some impact to change IT and business processes to mandate collection of this information on applications. Board staff will work with DCA to determine any fiscal impacts.

COMMITTEE RECOMMENDATION

Neutral.

Attachment 1: Bill text

AMENDED IN ASSEMBLY MARCH 11, 2024

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL **No. 1991**

Introduced by Assembly Member Bonta

January 30, 2024

An act to amend ~~Section 127885 of the Health and Safety Code, relating to public health.~~ *Section 502 of the Business and Professions Code, relating to healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1991, as amended, Bonta. ~~Health Professions Career Opportunity Program.~~ *Licensee and registrant records.*

Existing law establishes uniform requirements for the reporting and collection of workforce data from health care-related licensing boards. Existing law requires certain boards that regulate healing arts licensees or registrants to request specified workforce data from their respective licensees and registrants and requires the data to be requested at the time of electronic license or registration renewal, as specified. Existing law provides that a licensee or registrant is not required to provide the specified workforce data as a condition for license or registration renewal, and that those individuals who do not provide that data are not subject to discipline.

This bill would, instead, require certain boards that regulate healing arts licensees or registrants to collect workforce data from their respective licensees or registrants, and would require that data to be required at the time of electronic license or registration renewal, as specified. The bill would, instead, require a licensee or registrant to provide the specified workforce data as a condition for license or registration renewal and would delete the provision that specifies that

a licensee or registrant shall not be subject to discipline for not providing that information.

~~Existing law establishes the Department of Health Care Access and Information and requires the department to maintain a Health Professions Career Opportunity Program to, among other things, implement programs at colleges and universities selected by the department and include in those programs pipeline programs that provide comprehensive academic enrichment, career development, mentorship, and advising in order to support students from underrepresented regions and backgrounds to pursue health careers.~~

~~This bill would make technical, nonsubstantive changes to this provision.~~

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

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

SECTION 1. Section 502 of the Business and Professions Code is amended to read:

502. (a) Notwithstanding any other law, both of the following apply:

(1) The Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the Physician Assistant Board, and the Respiratory Care Board of California shall collect workforce data from their respective licensees and registrants as specified in subdivision (b) for future workforce planning at least biennially. The data shall be collected at the time of electronic license or registration renewal for those boards that utilize electronic renewals for licensees or registrants.

(2) All other boards that are not listed in paragraph (1) that regulate healing arts licensees or registrants under this division shall ~~request~~ *collect* workforce data from their respective licensees and registrants as specified in subdivision (b) for future workforce planning at least biennially. The data shall be ~~requested~~ *required* at the time of electronic license or registration renewal for those boards that utilize electronic renewals for licensees or registrants.

(b) In conformance with specifications under subdivision (d), the workforce data collected or ~~requested~~ *required* by each board about its licensees and registrants shall include, at a minimum, all of the following information:

(1) Anticipated year of retirement.
(2) Area of practice or specialty.
(3) City, county, and ZIP Code of practice.
(4) Date of birth.
(5) Educational background and the highest level attained at time of licensure or registration.
(6) Gender or gender identity.
(7) Hours spent in direct patient care, including telehealth hours as a subcategory, training, research, and administration.
(8) Languages spoken.
(9) National Provider Identifier.
(10) Race or ethnicity.
(11) Type of employer or classification of primary practice site among the types of practice sites specified by the board, including, but not limited to, clinic, hospital, managed care organization, or private practice.
(12) Work hours.
(13) Sexual orientation.
(14) Disability status.

(c) Each board shall maintain the confidentiality of the information it receives from licensees and registrants under this section and shall only release information in an aggregate form that cannot be used to identify an individual other than as specified in subdivision (e).

(d) The Department of Consumer Affairs, in consultation with the Department of Health Care Access and Information, shall specify for each board subject to this section the specific information and data that will be collected or requested pursuant to subdivision (b). The Department of Consumer Affairs' identification and specification of this information and data shall be exempt until June 30, 2023, from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) Each board, or the Department of Consumer Affairs on its behalf, shall, beginning on July 1, 2022, and quarterly thereafter, provide the individual licensee and registrant data it collects pursuant to this section to the Department of Health Care Access and Information in a manner directed by the Department of Health Care Access and Information, including license or registration

number and associated license or registration information. The Department of Health Care Access and Information shall maintain the confidentiality of the licensee and registrant information it receives and shall only release information in an aggregate form that cannot be used to identify an individual.

(f) A licensee or registrant shall ~~not~~ be required to provide the information listed in subdivision (b) as a condition for license or registration ~~renewal, and licensees or registrants shall not be subject to discipline for not providing the information listed in subdivision (b).~~ *renewal.*

(g) This section does not alter or affect mandatory reporting requirements for licensees or registrants established pursuant to this division, including, but not limited to, Sections 1715.5, 1902.2, 2425.3, and 2455.2.

~~SECTION 1. Section 127885 of the Health and Safety Code is amended to read:~~

~~127885. (a) The department shall maintain a Health Professions Career Opportunity Program that shall include, but not be limited to, all of the following:~~

~~(1) Implementing programs at colleges and universities selected by the department, which may include public and private institutions.~~

~~(A) In selecting campuses for the programs, the department shall give priority to campuses in medically underserved areas or with students from groups underrepresented in medicine, a demonstrated commitment to diversity and associated institutional change, a track record of providing tailored student support, and strong health professions school partnerships.~~

~~(B) The department may enter into contracts, to meet the requirements of this article, with nonprofit entities headquartered in California that have previous experience with administering statewide workforce programs aimed at building a diverse provider workforce.~~

~~(C) The programs shall include one or both of the following:~~

~~(i) Pipeline programs that provide comprehensive academic enrichment, career development, mentorship, and advising in order to support students from underrepresented regions and backgrounds to pursue health careers. This may include internships and fellowships to enable students to compete for admission to graduate~~

~~health professions schools or employment in the health field, including, but not limited to, both of the following:~~

~~(I) Paid summer internships for students interning in community health centers, in public health departments, in public behavioral health settings, with geriatric providers, and with community-based initiatives that promote health equity.~~

~~(II) One-year postundergraduate fellowships for in-depth, pregraduate school experience in primary care and prevention, behavioral health, and geriatric health.~~

~~(ii) Annual postbaccalaureate reapplicant slots and the provision of student scholarships for reapplicant postbaccalaureate students to cover program tuition.~~

~~(2) Producing and disseminating a series of publications aimed at informing and motivating minority and disadvantaged students to pursue health professional careers.~~

~~(3) Conducting a conference series aimed at informing students of opportunities in health professional training and mechanisms of successfully preparing to enter the training.~~

~~(4) Providing support and technical assistance to health professional schools and colleges as well as to student and community organizations active in health professional development of underrepresented groups in medicine.~~

~~(5) Conducting relevant health workforce information and data analysis regarding underrepresented groups in medicine.~~

~~(6) Providing necessary consultation, recruitment, and counseling through other means.~~

~~(7) Supporting and encouraging health professionals in training who are from underrepresented groups to practice in health professional shortage areas of California.~~

~~(b) This section shall be implemented only to the extent that funds are appropriated for its purposes in the annual Budget Act or other statute.~~

O

D. AB 2327 (Wendy Carrillo) Optometry: mobile optometric offices: regulations

Status: Introduced 2/12/2024 / Referred to Committee on Business and Professions

AUTHOR REASON FOR THE BILL
According to the author: "Los Angeles Unified School District is the birthplace of Vision to Learn. Before the 2020 law, non-profit mobile optometric offices could only operate if they were affiliated with a school of optometry. This limitation constrained non-profit vision care providers like Vision to Learn from legally serving populations that needed optometric care but were not receiving it. While many optometrists take MediCal and do their best to reach out to low-income patients, they can't replicate the model used by non-profits who will bring a mobile clinic to a school, church, or other community facility. AB 2327 allows non-profit mobile optometric offices to continue to provide vital optometric services to ensure low- income students have the best chance possible to succeed in school and in life."

DESCRIPTION OF CURRENT LEGISLATION
This bill would require CSBO to adopt regulations establishing a registry for the owners and operators of mobile optometric offices by January 1, 2026. The bill would prohibit the board from bringing an enforcement action against a mobile optometric provider before January 1, 2026. The bill would extend the repeal date of the provisions related to the permitting and regulation of mobile optometric clinics to July 1, 2035.

BACKGROUND
The Mobile Optometric Office (MOO) program was established by Assembly Bill (AB) 896 (Low, Chapter 121, Statutes of 2020), which due to an urgency clause, became effective upon signing on September 24, 2020, and created BPC Section 3070.2. The following year, AB 1534 (Committee on Business and Professions, Chapter 630, Statutes of 2021), made further changes to BPC section 3070.2. Among other things, Section 3070.2 allows for specified nonprofits and charitable organizations to provide optometric services to patients regardless of the patient's ability to pay through mobile optometric offices under a new registration program within the Board.

Existing law requires the Board to adopt regulations establishing a registry for the owners and operators of mobile optometric offices, and to set a registration fee at an amount not to exceed the reasonable regulatory costs of administration by January 1, 2023. The Board did not meet that deadline; however, the proposed regulations were noticed on 2-23-24 for a 45-day public comment period which will end on 4-9-24.

ANALYSIS
The bill is necessary to extend the sunset date of the MOO program, which would otherwise expire on July 1, 2025. Extending the sunset date out 10 years may allow for sufficient time for the program to exist, once the regulations are final, to determine the overall utility of the program. The bills which created the MOO program, AB 896, and AB 1534, legally authorize six different categories of exemption to the MOO regulation requirement, authorizing entities such as specialized vision health care service plans, approved optometric schools, and nonprofits and charities using the services of licensees engaged in the temporary practice of optometry, among others, to legally operate and provide mobile optometric services without first holding a MOO registration with CSBO. This in fact may be the real impact of the original, authorizing legislation: prior to the enactment of AB 896 and AB 1534, mobile optometric facilities could only function as a part of a school teaching program as approved by the Board. While the law authorizes several different categories of exemption, the entire law sunsets on July 1, 2025, which if

that happens could mean that existing law found at Title 16, Division 15, California Code of Regulations section 15007.1 would then apply, and it states at subdivision (e): "Mobile optometric facilities may only function as a part of a school teaching program as approved by the Board."

FISCAL
Unknown, but likely minimal.

COMMITTEE RECOMMENDATION
Support. Extending the MOO program out 10 years allows for sufficient time for the program to exist, providing clarity to providers operating MOOs.

Attachment 1: Bill text

Attachment 2: Assembly Business and Professions Committee Analysis

ASSEMBLY BILL No. 2327

Introduced by Assembly Member Wendy Carrillo

February 12, 2024

An act to amend Section 3070.2 of the Business and Professions Code, relating to healing arts.

legislative counsel's digest

AB 2327, as introduced, Wendy Carrillo. Optometry: mobile optometric offices: regulations.

Existing law, the Optometry Practice Act, establishes the State Board of Optometry within the Department of Consumer Affairs and sets forth the powers and duties of the board relating to the licensure and regulation of the practice of optometry. Existing law requires the board, by January 1, 2023, to adopt regulations establishing a registry for the owners and operators of mobile optometric offices, as specified. Existing law prohibits the board, before January 1, 2023, from bringing an enforcement action against an owner and operator of a mobile optometric office based solely on its affiliation status with an approved optometry school in California for remotely providing optometric service. Existing law makes these and other provisions related to the permitting and regulation of mobile optometric offices effective only until July 1, 2025, and repeals them as of that date.

This bill would require the board to adopt the above-described regulations by January 1, 2026. The bill would prohibit the board from bringing the above-described enforcement action before January 1, 2026. The bill would extend the repeal date of the provisions related to the permitting and regulation of mobile optometric clinics to July 1, 2035.

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

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

1 SECTION 1. Section 3070.2 of the Business and Professions
2 Code is amended to read:
3 3070.2. (a) As used in this section, "mobile optometric office"
4 means a trailer, van, or other means of transportation in which the
5 practice of optometry, as defined in Section 3041, is performed
6 and which is not affiliated with an approved optometry school in
7 California.
8 (b) This section shall not apply to any of the following:
9 (1) Optometric services provided remotely by an approved
10 optometry school in California that meets the requirements of
11 Section 1507 of Title 16 of the California Code of Regulations.
12 (2) A licensee engaged in the practice of optometry at a facility
13 defined in paragraph (1), (2), or (3) of subdivision (a) of Section
14 3070.1.
15 (3) A federally qualified health center, as defined in Section
16 1396d(*l*)(2)(B) of Title 42 of the United States Code.
17 (4) A nonprofit or charitable organization exempt from taxation
18 pursuant to Section 501(c)(3), 501(c)(4), or 501(c)(6) of the Internal
19 Revenue Code (26 U.S.C. Sec. 501(c)(3), 501(c)(4), or 501(c)(6)),
20 which utilizes the volunteer services of licensees engaging in the
21 temporary practice of optometry pursuant to subdivision (b) of
22 Section 3070.
23 (5) A free clinic, as defined in subparagraph (B) of paragraph
24 (1) of subdivision (a) of Section 1204 of the Health and Safety
25 Code, which is operated by a clinic corporation, as defined in
26 paragraph (3) of subdivision (b) of Section 1200 of the Health and
27 Safety Code.
28 (6) A specialized vision health care service plan, as defined in
29 subdivision (f) of Section 1345 of the Health and Safety Code,
30 formed and existing pursuant to the provisions of the Nonprofit
31 Corporation Law (Division 2 (commencing with Section 5000) of
32 Title 1 of the Corporations Code).
33 (c) The ownership and operation of a mobile optometric office
34 shall be limited to a nonprofit or charitable organization that is
35 exempt from taxation pursuant to Section 501(c)(3) or 501(c)(4)

1 of the United States Internal Revenue Code that provides
2 optometric services to patients regardless of the patient's ability
3 to pay.
4 (1) The owner and operator of a mobile optometric office shall
5 register with the board. The owner and operator of a mobile
6 optometric office and the optometrist providing services shall not
7 accept payment for services other than those provided through the
8 Medi-Cal program or through any of the state's programs under
9 the Children's Health Insurance Program (CHIP) under Title XIX
10 (42 U.S.C. Sec. 1396 et seq.), or Title XXI (42 U.S.C. Sec. 1397aa
11 et seq.), of the Social Security Act.
12 (2) The medical operations of the mobile optometric office shall
13 be directed by a licensed optometrist and in every phase shall be
14 under the exclusive control of the licensed optometrist, including
15 the selection and supervision of optometric staff, the scheduling
16 of patients, the amount of time the optometrist or optician spends
17 with patients, the fees charged for optometric products and services,
18 the examination procedures, the treatment provided to patients,
19 and the followup care pursuant to this section.
20 (3) The owner and operator of a mobile optometric office shall
21 not operate more than 12 mobile optometric offices within the first
22 renewal period of two years, but may operate more than 12 offices
23 after the first renewal period is complete.
24 (d) An owner and operator who has obtained approval from the
25 board pursuant to paragraph (1) of subdivision (c) and wishes to
26 operate a mobile optometric office shall apply for a permit from
27 the board before beginning operation of each mobile optometric
28 office. The application shall be made on a board-prescribed form
29 that requests any information the board deems appropriate to
30 register a mobile optometric office pursuant to this section. The
31 form shall be accompanied by a nonrefundable fee of four hundred
32 seventy-two dollars ($472). The board may increase the fee, as
33 necessary to cover the reasonable regulatory costs of
34 administration, to not more than six hundred dollars ($600).
35 (1) Upon approval of the permit, the board shall issue a unique
36 identifying number for each mobile optometric office that shall be
37 used in all reporting by the owner and operator to the board.
38 (2) Upon approval, the permit shall be valid until the next
39 renewal date of the owner and operator registration.

1 (3) Mobile optometric office permits are specific to the vehicle
2 registered with the board. Permits are not transferrable.
3 (4) An owner and operator may apply for renewal of the mobile
4 optometric office permit by attesting to compliance with the
5 requirements of this section and payment of the biennial renewal
6 fee prescribed by the board.
7 (e) The owner and operator of the mobile optometric office
8 registering with the board pursuant to subdivision (c) shall provide
9 the following information to the board:
10 (1) The description of services to be rendered within the mobile
11 optometric office.
12 (2) The names and optometry license numbers of optometrists,
13 registration numbers of opticians, and names of any other persons
14 who are providing patient care, as described in Section 2544.
15 (3) The dates of operation and cities or counties served.
16 (4) A description of how followup care will be provided.
17 (5) A catalog of complaints, if any.
18 (6) Articles of incorporation or acknowledgment of intent to
19 operate and employer identification number demonstrating the
20 owner and operator is a nonprofit or charitable organization that
21 is exempt from taxation pursuant to Section 501(c)(3) or 501(c)(4)
22 of the Internal Revenue Code.
23 (7) Any other information the board deems appropriate to
24 safeguard the public from substandard optometric care, fraud, or
25 other violation of this chapter.
26 (f) The owner and operator of the mobile optometric office, on
27 a form prescribed by the board, shall file a quarterly report
28 containing the following information:
29 (1) A list of all visits made by each mobile optometric office,
30 including dates of operation, address, care provided, and names
31 and license numbers of optometrists and opticians who provided
32 care.
33 (2) A summary of all complaints received by each mobile
34 optometric office, the disposition of those complaints, and referral
35 information.
36 (3) An updated and current list of licensed optometrists,
37 registered opticians, and any other persons who have provided
38 care within each mobile optometric office since the last reporting
39 period.

(4) An updated and current list of licensed optometrists who are available for followup care as a result of a complaint on a volunteer basis or who accept Medi-Cal payments.

(5) Any other information the board deems appropriate to safeguard the public from substandard optometric care, fraud, or other violation of this chapter.

(g) The owner and operator of the mobile optometric office shall notify the board of any change to the information provided to the board pursuant to subdivision (d) within 14 days.

(h) (1) The owner and operator of the mobile optometric office shall provide each patient and, if applicable, the patient's caregiver or guardian, a consumer notice prescribed by the board that includes the following:

(A) The name, license number, and contact information for the optometrist.

(B) Optometrists providing services at a mobile optometric office are regulated by the board and the contact information for filing a complaint with the board.

(C) Information on how to obtain a copy of the patient's medical information.

(D) Information on followup care available for the patient, including a list of available Medi-Cal or volunteer optometrists. This list shall be updated every six months and is subject to the inspection by the board.

(E) Any other information the board deems appropriate to safeguard the public from substandard optometric care, fraud, or other violation of this chapter.

(2) The optometrist shall maintain a copy of the consumer notice described in paragraph (1) in the patient's medical record.

(3) Upon request by the patient's caregiver or guardian, a copy of the prescription made for the patient shall be provided.

(i) Any person who is employed by the owner and operator of the mobile optometric office to drive or transport the vehicle shall possess a valid driver's license.

(j) By January 1, ~~2023,~~ *2026,* the board shall adopt regulations establishing a registry for the owners and operators of mobile optometric offices and shall set a registration fee at an amount not to exceed the reasonable regulatory costs of administration.

(k) The board may adopt regulations to conduct quality assurance reviews for the owner and operator of a mobile

1 optometric office and optometrists engaging in the practice of
2 optometry at a mobile optometric office.
3 (*l*) The board shall not bring an enforcement action against an
4 owner and operator of a mobile optometric office based solely on
5 its affiliation status with an approved optometry school in
6 California for remotely providing optometric service before January
7 1, ~~2023.~~ *2026.*
8 (m) The owner and operator of a mobile optometric office shall
9 maintain records in the following manner, which shall be made
10 available to the board upon request for inspection:
11 (1) Records are maintained and made available to the patient
12 in such a way that the type and extent of services provided to the
13 patient are conspicuously disclosed. The disclosure of records shall
14 be made at or near the time services are rendered and shall be
15 maintained at the primary business office specified.
16 (2) The owner and operator of a mobile optometric office
17 complies with all federal and state laws and regulations regarding
18 the maintenance and protection of medical records, including, but
19 not limited to, the federal Health Insurance Portability and
20 Accountability Act of 1996 (42 U.S.C. Sec. 300gg).
21 (3) Pursuant to Section 3007, the owner and operator of the
22 mobile optometric office keeps all necessary records for a
23 minimum of seven years from the date of service in order to
24 disclose fully the extent of services furnished to a patient. Any
25 information included on a printed copy of an original document
26 to a patient shall be certified by the owner and operator of the
27 mobile optometric office as being true, accurate, and complete.
28 (4) If a prescription is issued to a patient, records shall be
29 maintained for each prescription as part of the patient's chart,
30 including all of the following information about the optometrist:
31 (A) Name.
32 (B) Optometrist license number.
33 (C) The place of practice and the primary business office.
34 (D) Description of the goods and services for which the patient
35 is charged and the amount charged. If no charge was made to the
36 patient, a description of the goods and services provided.
37 (5) The owners and operators of the mobile optometric offices
38 shall maintain accurate records of the mobile optometric offices,
39 including vehicle registration numbers and the year, make, and
40 model of each trailer or van.

1 (n) Any licensed optometrist who provides patient care in
2 conjunction with a mobile optometric office shall obtain a
3 statement of licensure pursuant to subdivision (a) of Section 3070
4 with the mobile optometric office's address as registered with the
5 board. If the licensee is not practicing optometry at a location other
6 than with the owner and operator of the mobile optometric office,
7 then the licensee shall list as their primary address of record the
8 owner and operator of the mobile optometric office's address as
9 registered with the board.
10 (o) All examinations performed at the mobile optometric office
11 shall be performed by a licensed optometrist who is certified to
12 use therapeutic pharmaceutical agents pursuant to Section 3041.3.
13 (p) This section does not apply to optometry services defined
14 in Section 3070.1.
15 (q) This section shall remain in effect only until July 1, ~~2025,~~
16 *2035,* and as of that date is repealed.

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Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 2327 (Wendy Carrillo) – As Introduced February 12, 2024

SUBJECT: Optometry: mobile optometric offices: regulations.

SUMMARY: Extends the sunset date for a registration program within the California State Board of Optometry (CBO) that allows for nonprofits and charitable organizations to provide optometric services to patients regardless of the patient's ability to pay through mobile optometric offices.

EXISTING LAW:

1) Establishes the Optometry Practice Act to provide for the regulation and oversight of optometry. (Business and Professions Code (BPC) §§ 3000 *et seq.*)

2) Establishes the CBO within the Department of Consumer Affairs (DCA) for the licensure and regulation of optometrists, registered dispensing opticians, contact lens dispensers, spectacle lens dispensers, and nonresident contact lens dispensers. (BPC § 3010.5)

3) Makes it unlawful for a person to engage in or advertise the practice of optometry without having first obtained an optometrist license from the CBO. (BPC § 3040)

4) 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)

5) Requires optometrists to notify the CBO in writing of the address where they intend to engage in the practice of optometry and of any changes to their place of practice, except for limited cases where they engage in temporary practice. (BPC § 3070)

6) Requires optometrists to post in each location where they practice optometry, in an area that is likely to be seen by all patients who use the office, their current license or other evidence of current license status issued by the CBO. (BPC § 3075)

7) Defines "office" as any office or other place for the practice of optometry, including but not limited to vans, trailers, or other mobile equipment, and limits optometrists to a maximum of 11 offices. (BPC § 3077)

8) Requires the CBO to adopt regulations by January 1, 2023 establishing a registry for mobile optometric office owned and operated by nonprofit or charitable organizations, which are required to report specified information to the CBO and provide patients with information on their care and the availability of followup care; provides that the statute establishing this registration program shall remain in effect only until July 1, 2025. (BPC § 3070.2)

THIS BILL:

1) Extends the sunset date for the CBO's mobile optometric office registry to July 1, 2035.

2) Extends the date by which the CBO is required to adopt regulations for the registry to no later than January 1, 2026, and correspondingly extends safe harbor language prohibiting the CBO from taking action against an owner and operator of a mobile optometric office prior to that date.

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

COMMENTS:

Purpose. This bill is sponsored by **Vision To Learn**. According to the author:

> "Los Angeles Unified School District is the birthplace of Vision to Learn. Previous to the 2020 law, non-profit mobile optometric offices could only operate if they were affiliated with a school of optometry. This limitation constrained non-profit vision care providers like Vision to Learn from legally serving populations that needed optometric care but were not receiving it. While many optometrists take MediCal and do their best to reach out to low-income patients, they can't replicate the model used by non-profits who will bring a mobile clinic to a school, church or other community facility. AB 2327 allows non-profit mobile optometric offices to continue to provide vital optometric services to ensure low- income students have the best chance possible to succeed in school and in life."

Background.

Practice of Optometry. California first formally regulated optometrists in 1903 when the Legislature defined the practice of optometry and established the California State Board of Examiners in Optometry. In 1913, the Legislature replaced the act with a new Optometry Law, which created a State Board of Optometry with expanded authority over optometrists, opticians, and schools of optometry. Much of the language enacted in this 1913 legislation survives in the Optometry Practice Act today. Education requirements for optometrists were subsequently enacted in 1923.

As of 2021, the current CBO is responsible for overseeing approximately 31,937 optometrists, opticians, and optical businesses. The CBO is also responsible for issuing certifications for optometrists to use Diagnostic Pharmaceutical Agents (DPA); Therapeutic Pharmaceutical Agents (TPA); TPA with Lacrimal Irrigation and Dilation (TPL); and TPA with Glaucoma Certification (TPG); and TPA with Lacrimal Irrigation and Dilation and Glaucoma Certification (TLG). The CBO additionally issues statements of licensure and fictitious name permits.

Under the Optometry Practice Act, the practice of optometry "includes the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of habilitative or rehabilitative optometric services." Statute establishes the scope of practice for optometrists by enumerating the examinations, procedures, and treatments that an optometrist may perform. No person may engage in the practice of optometry or advertise themselves as an optometrist in California without a valid license from the CBO.

Mobile Optometric Offices. Existing law allows for healing arts licensees to deliver services through mobile health care units to the extent authorized by written policies established by the governing body of the licensee. Previously, CBO regulations allowed for the provision of optometry services through registered "extended optometric clinical facilities." This registration program was restricted to clinical facilities employed by an approved school of optometry where optometry services were rendered outside or beyond the walls, boundaries, or precincts of the primary campus of the school. Mobile optometric facilities were only allowed to function as a part of a school teaching program, as approved by the CBO.

While the extended optometric clinical facility program was historically used to provide mobile optometry services to low-access communities, optometrists seeking to provide those services were limited to the extent that they were required to be affiliated with a school of optometry. This limitation created challenges for charitable organizations and nonprofits dedicated to providing care through mobile clinics as a way to address the widely recognized need for expanded access to optometric care for patients who are uninsured and unable to pay out of pocket. One reputable nonprofit, Vision to Learn, had provided more than 186,500 eye exams and more than 148,500 pairs of glasses to students and other Californians, regardless of income, between when it was established in 2012 and 2020.

While Vision To Learn and similar programs have been broadly celebrated as successful, there were concerns that their operation was technically unsupported by statute or board regulation to the extent that the provision of services was technically unaffiliated with a school of optometry. This lack of clarity led to concerns relating to the possibility of enforcement action by the CBO against nonprofit optometry service providers. To resolve this lack of certainty and provide nonprofits like Vision To Learn with statutory reassurance, the Legislature enacted Assembly Bill 896 (Low) in 2020. This bill sought to satisfy any apprehension by creating a new registration program to formalize the presence of mobile optometric offices operated by nonprofits and charitable organizations.

Under the provisions of AB 896, organizations are required to submit information to the CBO regarding services provided and any complaints received by the organization. Further, all medical operations of a mobile optometric office must be directed by a licensed optometrist. Finally, the bill created a safe harbor for charitable organizations and nonprofits currently providing services while the CBO promulgated regulations to implement the new registration program.

AB 896 required the CBO to adopt its regulations establishing a registry for the owners and operators of mobile optometric offices prior to January 2023; however, the CBO did not submit its notice of proposed regulatory action until December 2023, and those regulations are still pending. Meanwhile, the safe harbor provision intended to protect nonprofits from enforcement action prior to the adoption of regulations has expired. In addition, AB 896 contained a sunset clause subjecting the entire law to repeal on July 1, 2025 unless extended by the Legislature.

This bill would extend each of these three dates. First, the bill would extend the sunset on the mobile optometric offices law until July 1, 2035. Next, it would extend the deadline by which the CBO is required to adopt regulations until January 1, 2026. Finally, it would extend the safe harbor language to that same January 1, 2026 timeline. These changes will allow nonprofits like Vision To Learn to continue operating with peace of mind despite the CBO's delays in adopting their regulations to fully implement the program.

Prior Related Legislation.

AB 896 (Low, Chapter 121, Statutes of 2020) expressly allowed for nonprofits and charitable organizations to provide optometric services to patients regardless of the patient's ability to pay through mobile optometric offices under a new registration program within CBO.

ARGUMENTS IN SUPPORT:

Vision To Learn, the sponsor of this bill, writes: "One in five kids in public schools lack the glasses they need to see the board, read a book, or participate in class; and in low-income communities up to 95% of kids who need glasses do not have them." Vision to Learn argues that "passage of AB 2327 will give the Board the time it needs to promulgate regulations for Mobile Optometry clinics and will allow Vision To Learn and other non-profits to continue to serve California's vulnerable student populations and give them the tools they need to succeed in school."

ARGUMENTS IN OPPOSITION:

None on file.

IMPLEMENTATION ISSUES:

This bill extends both the CBO's deadline to adopt regulations and language providing safe harbor to mobile optometric clinics to January 1, 2026. These dates were previously aligned to ensure that the CBO would not take enforcement action against a nonprofit for failing to comply with regulations that had not yet been adopted. However, given that the CBO is in the final stages of the rulemaking process, there is cause for optimism that regulations will be adopted well in advance of 2026, and that safe harbor will not be needed for that extended an amount of time. The author may wish to consider providing that the safe harbor provision is valid either until January 1, 2026, or until the CBO's regulations are adopted, whichever is earlier.

AMENDMENTS:

To provide that the safe harbor language is valid until the earlier of either January 1, 2026, or until the CBO's regulations are adopted, amend subdivision (l) as follows:

> *(l) The board shall not bring an enforcement action against an owner and operator of a mobile optometric office based solely on its affiliation status with an approved optometry school in California for remotely providing optometric service prior to the adoption of the board's final regulations pursuant to subdivision (j), or before January 1, 2026, whichever occurs first.*

REGISTERED SUPPORT:

Vision To Learn *(Sponsor)*

REGISTERED OPPOSITION:

None on file.

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

E. AB 3137 (Flora) Department of Consumer Affairs

Status: Introduced 2/16/2024 / Referred to Committee on Business and Professions

AUTHOR REASON FOR THE BILL
Unknown. Spot bill, or a bill with no substantive impact, at this time.

DESCRIPTION OF CURRENT LEGISLATION
N/A

BACKGROUND
N/A

ANALYSIS
N/A

FISCAL
N/A

COMMITTEE RECOMMENDATION
Continue to watch.

Attachment 1: Bill text

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 3137

Introduced by Assembly Member Flora

February 16, 2024

An act to amend Section 101 of the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 3137, as introduced, Flora. Department of Consumer Affairs.

Existing law establishes in the Business, Consumer Services, and Housing Agency the Department of Consumer Affairs. Under existing law, the department is composed of various boards, bureaus, committees, and commissions.

This bill would make a nonsubstantive change to the latter provision and correct the name of a state entity.

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

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

1 SECTION 1. Section 101 of the Business and Professions Code
2 is amended to read:
3 101. The department is ~~comprised~~ *composed* of the following:
4 (a) The Dental Board of California.
5 (b) The Medical Board of California.
6 (c) The California State Board of Optometry.
7 (d) The California State Board of Pharmacy.
8 (e) The Veterinary Medical Board.
9 (f) The California Board of Accountancy.

1 (g) The California Architects Board.
2 (h) The State Board of Barbering and Cosmetology.
3 (i) The Board for Professional Engineers, Land Surveyors, and
4 Geologists.
5 (j) The Contractors State License Board.
6 (k) The Bureau for Private Postsecondary Education.
7 (*l*) The Bureau of Household Goods and Services.
8 (m) The Board of Registered Nursing.
9 (n) The Board of Behavioral Sciences.
10 (o) The State Athletic Commission.
11 (p) The Cemetery and Funeral Bureau.
12 (q) The Bureau of Security and Investigative Services.
13 (r) The Court Reporters Board of California.
14 (s) The Board of Vocational Nursing and Psychiatric
15 ~~Technicians.~~ *Technicians of the State of California.*
16 (t) The Landscape Architects Technical Committee.
17 (u) The Division of Investigation.
18 (v) The Bureau of Automotive Repair.
19 (w) The Respiratory Care Board of California.
20 (x) The Acupuncture Board.
21 (y) The Board of Psychology.
22 (z) The Podiatric Medical Board of California.
23 (aa) The Physical Therapy Board of California.
24 (ab) The Arbitration Review Program.
25 (ac) The Physician Assistant Board.
26 (ad) The Speech-Language Pathology and Audiology and
27 Hearing Aid Dispensers Board.
28 (ae) The California Board of Occupational Therapy.
29 (af) The Osteopathic Medical Board of California.
30 (ag) The California Board of Naturopathic Medicine.
31 (ah) The Dental Hygiene Board of California.
32 (ai) The Professional Fiduciaries Bureau.
33 (aj) The State Board of Chiropractic Examiners.
34 (ak) The Bureau of Real Estate Appraisers.
35 (a*l*) The Structural Pest Control Board.
36 (am) Any other boards, offices, or officers subject to its
37 jurisdiction by law.

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F. 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:

1 SECTION 1. This act shall be known, and may be cited, as the
2 Better Access to Better Vision Act.
3 SEC. 2. Section 2807 of the Penal Code is amended to read:
4 2807. (a) The authority is hereby authorized and empowered
5 to operate industrial, agricultural, and service enterprises ~~which~~
6 *that* will provide products and services needed by the state, or any
7 political subdivision thereof, or by the federal government, or any
8 department, agency, or corporation thereof, or for any other public
9 use. Products may be purchased by state agencies to be offered
10 for sale to inmates of the department and to any other person under
11 the care of the state who resides in state-operated institutional
12 facilities. Fresh meat may be purchased by food service operations
13 in state-owned facilities and sold for onsite consumption.
14 (b) All things authorized to be produced under subdivision (a)
15 shall be purchased by the state, or any agency thereof, and may
16 be purchased by any county, city, district, or political subdivision,
17 or any agency thereof, or by any state agency to offer for sale to
18 persons residing in state-operated institutions, at the prices fixed
19 by the authority. State agencies shall make maximum utilization
20 of these products, and shall consult with the staff of the authority
21 to develop new products and adapt existing products to meet their
22 needs.
23 (c) All products and services provided by the authority may be
24 offered for sale to a nonprofit organization, provided that all of
25 the following conditions are met:
26 (1) The nonprofit organization is located in California and is
27 exempt from taxation under Section 501(c)(3) of Title 26 of the
28 United States Code.

1 (2) The nonprofit organization has entered into a memorandum
2 of understanding with a local ~~educational~~ *education* agency. As
3 used in this section, "local ~~educational~~ *education* agency" means
4 a school district, county office of education, state special school,
5 or charter school.
6 (3) The products and services are provided to public school
7 students at no cost to the students or their families.
8 (d) Notwithstanding subdivision (b), the Department of Forestry
9 and Fire Protection may purchase personal protective equipment
10 from the authority or private entities, based on the Department of
11 Forestry and Fire Protection's needs and assessment of quality and
12 value.
13 *(e) Notwithstanding subdivision (b), a provider participating*
14 *in the Medi-Cal program may obtain eyeglasses from the authority*
15 *or private entities, based on the provider's needs and assessment*
16 *of quality and value.*
17 SEC. 3. Section 14131.08 is added to the Welfare and
18 Institutions Code, to read:
19 14131.08. For purposes of Medi-Cal reimbursement for covered
20 optometric services pursuant to Section 14132 or 14131.10 or any
21 other law, a provider may obtain eyeglasses from a private entity,
22 as an alternative to a purchase of eyeglasses from the Prison
23 Industry Authority pursuant to Section 2807 of the Penal Code.
24 This section shall be implemented only to the extent that federal
25 financial participation is available.

G. SB 1310 (Grove) Serious felonies

Status: Introduced 2/15/2024 / Referred to Committee on Rules

AUTHOR REASON FOR THE BILL

Unknown but likely to shore up gaps in existing law that define "serious felonies." In 2023, Senator Grove introduced, and Governor Newsom signed into law SB 14 (Serious felonies: human trafficking which added human trafficking of minors to the list of serious felonies found in law and made the crime subject to California's Three Strikes Law.

DESCRIPTION OF CURRENT LEGISLATION

SB 1310 is presently a spot bill and makes no substantive changes. It is not known which crime or crimes the author proposes to add to the list of serious felonies found in law.

BACKGROUND

Penal Code Section 1192.7(c) provides a definition of "serious felony" which includes 43 different crimes, including, murder, manslaughter, rape, kidnapping, and arson, among other crimes. All applicants for licensure as optometrist or optician must undergo a state and federal fingerprint background check to determine suitability for licensure. The Board may only deny a license if the applicant has been convicted of a crime within the preceding seven years from the date of application that is substantially related to the qualifications, functions, or duties of the business or profession for which the application is made, regardless of whether the applicant was incarcerated for that conviction, or the applicant has been convicted of a crime that is substantially related to the qualifications, functions, or duties of the business or profession for which the application is made and for which the applicant is presently incarcerated or for which the applicant was released from incarceration within the preceding seven years from the date of application. There are two exceptions to the seven-year limitation. Convictions for these types of crimes can lead to a denial regardless of age. They are as follows:

- A serious felony conviction. (See Penal Code Section 1192.7)
- A crime for which registration as a sex offender is required pursuant to Penal Code Section 290(d)(2) or (3)

The Board publishes an FAQ on its website regarding this: CSBO Conviction or Past Disciplinary Action FAQ.

ANALYSIS

At this time, it is not known which crime or crimes are proposed to be added to the list found at Penal Code Section 1192.7(c). No conviction or past disciplinary action automatically precludes anyone from receiving a license to practice optometry or opticianry. Board staff investigates every application with a criminal conviction or past disciplinary action. Whenever the Board considers suspending, revoking, or denying, or taking disciplinary action against a license or registration due to a conviction, professional misconduct, or act, it must first determine that the conviction, professional misconduct, or act is substantially related to the qualifications, functions, or duties of the licensed profession.

A conviction or formal disciplinary action is "substantially related" to a profession if to a substantial degree, it evidences present or potential unfitness of the license holder to perform the functions authorized by the license in a manner that is consistent with public

health, safety or welfare. The Board must consider all the following in making its determination:

- The nature and gravity of the offense.
- The number of years that have elapsed since the date of the offense; and
- The nature and duties of the profession. These criteria can be found in California Code of Regulations Title 16, section 1517 for Optometry and section 1399.270 for Opticianry. If the Board determines that a crime, professional misconduct, or act is substantially related, it is then required to consider evidence of rehabilitation.

The Board must always consider evidence of rehabilitation before denying, suspending, or revoking a license. Criteria the Board must consider when evaluating rehabilitation is outlined in Business and Professions Code Section 482, and also California Code of Regulations Title 16, sections 1516, 1399.271 and 1399.272.

Each person's case is unique and depends on a variety of factors, including, but not limited to, the nature and gravity of any act, professional misconduct, or conviction, evidence of any subsequent acts, professional misconduct, or conviction and the time period that has elapsed since their occurrence. For these reasons, it could be limiting or misleading to provide a checklist of exactly what is expected to demonstrate rehabilitation. Instead, each applicant should reflect on what they have done personally to move forward, make amends, and improve themselves and their community. Common examples of the types of rehabilitation the Board have seen include the following:

- Letters of recommendation (from a supervisor, volunteer organization, pastor, colleague, etc.)
- Evidence of community service
- Evidence of participation in a support group
- Evidence of participation in a rehabilitation program (i.e. Alcoholics Anonymous) (if applicable)
- Evidence of completion of subsequent coursework or degree programs • Evidence of participating in psychotherapy

FISCAL
Unknown but likely minimal.

COMMITTEE RECOMMENDATION
Continue watching for future amendments.

Attachment 1: Bill text

SENATE BILL No. 1310

Introduced by Senator Grove

February 15, 2024

An act to amend Section 1192.7 of the Penal Code, relating to serious felonies.

LEGISLATIVE COUNSEL'S DIGEST

SB 1310, as introduced, Grove. Serious felonies.

Existing law defines the terms serious felony and violent felony for various purposes, including, among others, enhancing the punishment for felonies pursuant to existing sentencing provisions commonly known as the Three Strikes Law.

This bill would make technical, nonsubstantive changes to those provisions.

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

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

1 SECTION 1. Section 1192.7 of the Penal Code is amended to
2 read:
3 1192.7. (a) (1) It is the intent of the Legislature that district
4 attorneys prosecute violent sex crimes under statutes that provide
5 sentencing under a "one strike," "three strikes" or habitual sex
6 offender statute instead of engaging in plea bargaining over those
7 offenses.
8 (2) Plea bargaining in ~~any~~ *a* case in which the indictment or
9 information charges ~~any~~ *a* serious felony, ~~any~~ *a* felony in which
10 it is alleged that a firearm was personally used by the defendant,
11 or ~~any~~ *an* offense of driving while under the influence of alcohol,

drugs, narcotics, or ~~any~~ other intoxicating substance, or ~~any~~ combination thereof, is prohibited, unless there is insufficient evidence to prove the people's case, or testimony of a material witness cannot be obtained, or a reduction or dismissal would not result in a substantial change in sentence.

(3) If the indictment or information charges the defendant with a violent sex crime, as listed in subdivision (c) of Section 667.61, that could be prosecuted under Sections 269, 288.7, subdivisions (b) through (i) of Section 667, Section 667.61, or 667.71, plea bargaining is prohibited unless there is insufficient evidence to prove the people's case, or testimony of a material witness cannot be obtained, or a reduction or dismissal would not result in a substantial change in sentence. At the time of presenting the agreement to the court, the district attorney shall state on the record why a sentence under one of those sections was not sought.

(b) As used in this section, "plea bargaining" means any bargaining, negotiation, or discussion between a criminal defendant, or their counsel, and a prosecuting attorney or judge, whereby the defendant agrees to plead guilty or nolo contendere, in exchange for any promises, commitments, concessions, assurances, or consideration by the prosecuting attorney or judge relating to ~~any~~ *a* charge against the defendant or to the sentencing of the defendant.

(c) As used in this section, "serious felony" means any of the following:

(1) Murder or voluntary ~~manslaughter; (2) mayhem; (3) rape; (4) sodomy~~ *manslaughter.*

(2) Mayhem.

(3) Rape.

(4) Sodomy by force, violence, duress, menace, threat of great bodily injury, or fear of immediate and unlawful bodily injury on the victim or another ~~person; (5) oral~~ *person.*

(5) Oral copulation by force, violence, duress, menace, threat of great bodily injury, or fear of immediate and unlawful bodily injury on the victim or another ~~person; (6) lewd~~ *person.*

(6) Lewd or lascivious act on a child under 14 years of ~~age; (7) any~~ *age.*

(7) Any felony punishable by death or imprisonment in the state prison for ~~life; (8) any~~ *life.*

(8) Any felony in which the defendant personally inflicts great bodily injury on any person, other than an accomplice, or any felony in which the defendant personally uses a ~~firearm; (9) attempted murder; (10) assault~~ *firearm.*

(9) Attempted murder.

(10) Assault with intent to commit rape or ~~robbery; (11) assault~~ *robbery.*

(11) Assault with a deadly weapon or instrument on a peace ~~officer; (12) assault~~ *officer.*

(12) Assault by a life prisoner on a ~~noninmate; (13) assault~~ *noninmate.*

(13) Assault with a deadly weapon by an ~~inmate; (14) arson; (15) exploding~~ *inmate.*

(14) Arson.

(15) Exploding a destructive device or any explosive with intent to ~~injure; (16) exploding~~ *injure.*

(16) Exploding a destructive device or any explosive causing bodily injury, great bodily injury, or ~~mayhem; (17) exploding~~ *mayhem.*

(17) Exploding a destructive device or any explosive with intent to ~~murder; (18) any~~ *murder.*

(18) Any burglary of the first ~~degree; (19) robbery~~ *degree.*

(19) Robbery or bank ~~robbery; (20) kidnapping; (21) holding~~ *robbery.*

(20) Kidnapping.

(21) Holding of a hostage by a person confined in a state ~~prison; (22) attempt~~ *prison.*

(22) Attempt to commit a felony punishable by death or imprisonment in the state prison for ~~life; (23) any~~ *life.*

(23) Any felony in which the defendant personally used a dangerous or deadly ~~weapon; (24) selling,~~ *weapon.*

(24) Selling furnishing, administering, giving, or offering to sell, furnish, administer, or give to a minor any heroin, cocaine, phencyclidine (PCP), or any methamphetamine-related drug, as described in paragraph (2) of subdivision (d) of Section 11055 of the Health and Safety Code, or any of the precursors of methamphetamines, as described in subparagraph (A) of paragraph (1) of subdivision (f) of Section 11055 or subdivision (a) of *former* Section 11100 of the Health and Safety ~~Code; (25) any~~ *Code.*

(25) Any violation of subdivision (a) of Section 289 where the act is accomplished against the victim's will by force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another ~~person; (26) grand~~ *person.*

(26) Grand theft involving a ~~firearm; (27) carjacking; (28) any~~ *firearm.*

(27) Carjacking.

(28) Any felony offense, which would also constitute a felony violation of Section ~~186.22; (29) assault~~ *186.22.*

(29) Assault with the intent to commit mayhem, rape, sodomy, or oral copulation, in violation of Section ~~220; (30) throwing~~ *220.*

(30) Throwing acid or flammable substances, in violation of Section ~~244; (31) assault~~ *244.*

(31) Assault with a deadly weapon, firearm, machinegun, assault weapon, or semiautomatic firearm or assault on a peace officer or firefighter, in violation of Section ~~245; (32) assault~~ *245.*

(32) Assault with a deadly weapon against a public transit employee, custodial officer, or school employee, in violation of Section 245.2, 245.3, or ~~245.5; (33) discharge~~ *245.5.*

(33) Discharge of a firearm at an inhabited dwelling, vehicle, or aircraft, in violation of Section ~~246; (34) commission~~ *246.*

(34) Commission of rape or sexual penetration in concert with another person, in violation of Section ~~264.1; (35) continuous~~ *264.1.*

(35) Continuous sexual abuse of a child, in violation of Section ~~288.5; (36) shooting~~ *288.5.*

(36) Shooting from a vehicle, in violation of subdivision (c) or (d) of Section ~~26100; (37) intimidation~~ *26100.*

(37) Intimidation of victims or witnesses, in violation of Section ~~136.1; (38) criminal~~ *136.1.*

(38) Criminal threats, in violation of Section ~~422; (39) any~~ *422.*

(39) Any attempt to commit a crime listed in this subdivision other than an ~~assault; (40) any~~ *assault.*

(40) Any violation of Section ~~12022.53; (41) a~~ *12022.53.*

(41) A violation of subdivision (b) or (c) of Section ~~11418; (42) human~~ *11418.*

(42) Human trafficking of a minor, in violation of subdivision (c) of Section 236.1, except, with respect to a violation of paragraph (1) of subdivision (c) of Section 236.1, where the person who committed the offense was a victim of human trafficking, as

described in subdivision (b) or (c) of Section 236.1, at the time of the ~~offense; and (43) any~~ *offense.*

(43) Any conspiracy to commit an offense described in this subdivision.

(d) As used in this section, “bank robbery” means to take or attempt to take, by force or violence, or by intimidation from the person or presence of another any property or money or any other thing of value belonging to, or in the care, custody, control, management, or possession of, any bank, credit union, or any savings and loan association.

As used in this subdivision, the following terms have the following meanings:

(1) “Bank” means any member of the Federal Reserve System, and any bank, banking association, trust company, savings bank, or other banking institution organized or operating under the laws of the United States, and any bank the deposits of which are insured by the Federal Deposit Insurance Corporation.

(2) “Savings and loan association” means any federal savings and loan association and any “insured institution” as defined in Section 401 of the National Housing Act, as amended, and any federal credit union as defined in Section 2 of the Federal Credit Union Act.

(3) “Credit union” means any federal credit union and any state-chartered credit union the accounts of which are insured by the Administrator of the National Credit Union administration.

(e) The provisions of this section shall not be amended by the Legislature except by statute passed in each house by rollcall vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electors.

O

H. SB 1468 (Ochoa Bogh and Roth) Healing arts boards: informational and educational materials for prescribers of narcotics: federal “Three Day Rule”

Status: Amended 3/20/2024 / Referred to Committee on Rules

AUTHOR REASON FOR THE BILL

Unknown, but likely to spread awareness of the revised federal Three Day Rule in California. This rule has to do with policy around Opioid Use Disorder and medications used to treat it.

DESCRIPTION OF CURRENT LEGISLATION

This bill would require the State Board of Optometry (Board), the Medical Board of California, the Dental Board, the Podiatric Medical Board, the Veterinary Medical Board, the Board of Naturopathic Medicine, Physician Assistant Board, and the Board of Registered Nursing to develop and biannually disseminate to each licensee informational and educational material regarding the “Three Day Rule,” and would require the Medical Board of California to also biannually disseminate the material it develops to each acute care hospital in the state.

BACKGROUND

Under 21 CFR 1306.07(b), a practitioner is authorized to dispense “narcotic drugs to a person for the purpose of initiating maintenance treatment or detoxification treatment (or both),” even if that practitioner is not registered with the federal Drug Enforcement Administration as a narcotic treatment program. Prior to August 2023, a limitation of this regulation included that “not more than one day’s medication may be administered to the person or for the person’s use at one time. Such emergency treatment may be carried out for not more than three days and may not be renewed or extended.” This became known as the “Three Day Rule.”

In December 2020, the President signed into law a bill directing the Attorney General to revise the Three Day Rule to allow for practitioners to dispense a three-day supply of narcotic drugs to one person for their one-time use for the purpose of initiating maintenance treatment or detoxification. The new rule became final on August 8, 2023 and can be found here: Dispensing of Narcotic Drugs To Relieve Acute Withdrawal Symptoms of Opioid Use Disorder. The text of the rule can be found here: Title 21, Chapter II, Part 1306, General Information, Section 1306.07.

The purpose of the federal rule prior to the changes in 2023 was to allow the practitioner flexibility in emergency situations when confronted with a patient undergoing withdrawal. The drug commonly used in these situations is Buprenorphine, sold under brand names Subutex and Suboxone. In those cases, it would not be practical to require practitioners to obtain a separate DEA registration as a narcotic treatment program. The exception in the law allowed for the practitioner to provide relief from withdrawal symptoms while arranging care in a treatment program.

Prior to August 2023, the Three-Day Rule meant that only one-day’s treatment could be provided, for up to three-days. Often presenting to emergency departments, patients would only receive a one-day supply of medicine and would have to return to the emergency department to receive more medicine while they waited to be placed in treatment. The change to allowing three days of medicine to be dispensed at one time will mean the patient can make only one emergency room visit and return home with a two-day supply while they wait for treatment placement.

ANALYSIS

The bill requires the Board to develop informational and education material regarding the Three Day Rile and to disseminate it to licensees biannually. The bill specifically impacts the Board because it defines a “prescriber” to be a person authorized to write or issue a prescription pursuant to Health and Safety Code section 11150. That code section, Health and Safety Code section 11150, provides that no person other than specified healing arts providers, including optometrists, shall write or issue a prescription.

Under the optometrist scope of practice found at Business and Professions Code section 3041 (a)(5)(B), the only controlled substances that can be prescribed are codeine or hydrocodone with compounds and tramadol, limited to three days, with a referral to an ophthalmologist if pain persists.

Buprenorphine is commonly dispensed in emergency rooms when patients present with withdrawal symptoms and are waiting for treatment. It may not be common for an optometrist to see these situations or patients. However, some optometrists may be working in medical or health facilities or be in community or other public health clinics where these situations may be more common. Staff is unsure the impact these broader policy changes have on the field of optometry and looks to this committee for better guidance. As a license type with controlled substance prescribing authority, albeit limited in scope, it is important for optometrists to be aware of opioid use disorder and the medications used to treat it.

FISCAL

Unknown but potential for some costs to develop and materials and disseminate. Staff would look to collaborate with other board’s and DCA to develop common materials for distribution and would anticipate electronically providing the materials to mitigate costs. Any requirement to develop a brochure or pamphlet for distribution to all licensees would likely have significant costs.

COMMITTEE RECOMMENDATION

Continue to watch and research the bill.

Attachment 1: Bill text

AMENDED IN SENATE MARCH 20, 2024

SENATE BILL No. 1468

Introduced by Senators Ochoa Bogh and Roth

February 16, 2024

An act to ~~amend Section 108~~ *add Article 10.8 (commencing with Section 750) to Chapter 1 of Division 2* of the Business and Professions Code, relating to ~~professions and vocations.~~ *healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1468, as amended, Ochoa Bogh. ~~Department of Consumer Affairs.~~ *Healing arts boards: informational and educational materials for prescribers of narcotics: federal "Three Day Rule."*

Existing law regulates healing arts practitioners by various boards under the Department of Consumer Affairs. Existing federal regulations, known as the "Three Day Rule," authorize a practitioner who is not specifically registered to conduct a narcotic treatment program to dispense not more than a 3-day supply of narcotic drugs, in accordance with applicable federal, state, and local laws, to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment while arrangements are being made for referral for treatment, as specified.

This bill would require each board that licenses a prescriber, as defined, to develop and biannually disseminate to each licensee informational and educational material regarding the "Three Day Rule," and would require the Medical Board of California to also biannually disseminate the material it develops to each acute care hospital in the state.

~~Existing law establishes the Department of Consumer Affairs, which is comprised of boards that license and regulate various professions and~~

~~vocations. Under existing law, each board within the department exists as a separate unit with specified functions.~~

~~This bill would make a nonsubstantive change to these provisions.~~

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

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

SECTION 1. Article 10.8 (commencing with Section 750) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

Article 10.8. Three Day Rule for Narcotic Drug Prescriptions

750. (a) For purposes of this section, "prescriber" means a person authorized to write or issue a prescription pursuant to Section 11150 of the Health and Safety Code.

(b) Each board that licenses a prescriber shall develop informational and educational material regarding the federal Drug Enforcement Administration's "Three Day Rule," as codified in subsection (b) of Section 1306.07 of Title 21 of the Code of Federal Regulations, in order to ensure prescriber awareness of existing medication-assisted treatment pathways to serve patients with substance use disorder and shall disseminate the informational and educational material to licensees biannually.

(c) The Medical Board of California shall also disseminate the informational and educational material it develops pursuant to subdivision (b) to each acute care hospital in the state biannually.

(d) The department and boards may consult with other state agencies as necessary to implement this section.

~~SECTION 1. Section 108 of the Business and Professions Code is amended to read:~~

~~108. Each board within the department exists as a separate unit, and has the functions of setting standards, holding meetings, and setting dates thereof, preparing and conducting examinations, passing upon applicants, conducting investigations of violations of laws under its jurisdiction, issuing citations and holding hearings for the revocation of licenses, and the imposing of penalties~~

1 ~~following those hearings, insofar as these powers are given by~~
2 ~~statute to each respective board.~~

O

I. SB 1485 (Gonzalez) Consumer complaints

AUTHOR REASON FOR THE BILL
Unknown. Spot bill, or a bill with no substantive impact, at this time.

DESCRIPTION OF CURRENT LEGISLATION
N/A

BACKGROUND
N/A

ANALYSIS
N/A

FISCAL
N/A

COMMITTEE RECOMMENDATION
Continue to watch.

Attachment 1: Bill text

SENATE BILL No. 1485

Introduced by Senator Gonzalez

February 16, 2024

An act to amend Section 326 of the Business and Professions Code, relating to consumer complaints.

LEGISLATIVE COUNSEL'S DIGEST

SB 1485, as introduced, Gonzalez. Consumer complaints.

The Consumer Affairs Act requires the Director of the Department of Consumer Affairs to administer and enforce that act to protect and promote the interests of consumers regarding the purchase of goods or services. The director, upon receipt of a consumer complaint relating to specified violations, is required to transmit any valid complaint to the local, state, or federal agency whose authority provides the most effective means to secure the relief. The act requires the director to advise the consumer of the action taken on the complaint, as appropriate, and of any other means that may be available to the consumer to secure relief.

This bill would make nonsubstantive changes to those consumer complaint provisions.

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

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

1 SECTION 1. Section 326 of the Business and Professions Code
2 is amended to read:
3 326. (a) Upon receipt of ~~any~~ *a* complaint pursuant to Section
4 325, the director may notify the person against whom the complaint

1 is made of the nature of the complaint and may request appropriate
2 relief for the consumer.
3 (b) *(1)* The director shall also transmit any valid complaint to
4 the local, ~~state~~ *state,* or federal agency whose authority provides
5 the most effective means to secure the relief.
6 ~~The~~
7 *(2) The* director shall, if appropriate, advise the consumer of
8 the action taken on the complaint and of any other means ~~which~~
9 *that* may be available to the consumer to secure relief.
10 (c) If the director receives a complaint or receives information
11 from any source indicating a probable violation of any law, rule,
12 or order of any regulatory agency of the state, or if a pattern of
13 complaints from consumers develops, the director shall transmit
14 any complaint ~~he or she~~ *the director* considers to be valid to any
15 appropriate law enforcement or regulatory agency and any evidence
16 or information ~~he or she~~ *the director* may have concerning the
17 probable violation or pattern of complaints or request the Attorney
18 General to undertake appropriate legal action. It shall be the
19 continuing duty of the director to discern patterns of complaints
20 and to ascertain the nature and extent of action taken with respect
21 to the probable violations or pattern of complaints.

O