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	May 31, 2024
TO	Board Members, California State Board of Optometry (CSBO)
FROM	Gregory Pruden, Executive Officer
SUBJECT	Agenda Item #10 – Update and Possible Discussion and 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. On April 5, the Legislation and Regulation Committee met and discussed and made recommendations on several legislative bills. 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.

Following the April 5 meeting, a subsequent bill with possible impact to the Board was identified (SB 1451) and it is included below.

The following bills are up for discussion and possible action at this meeting. However, only the highlighted bills require action at this meeting as the Board has not yet issued a position.

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 1451 (Ashby) Professions and vocations
i. SB 1468 (Ochoa Bogh and Roth) Healing arts boards: informational and educational materials for prescribers of narcotics: federal “Three Day Rule”
j. SB 1485 (Gonzalez) Consumer complaints

For the benefit of newer board 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

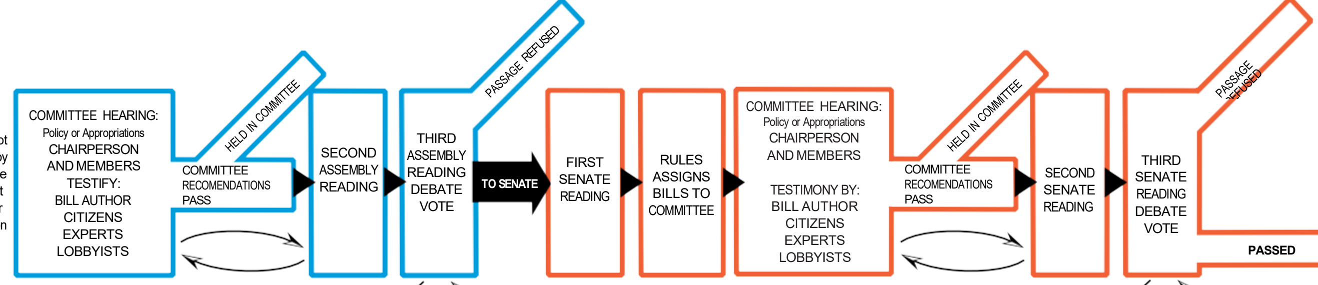
ASSEMBLY MEMBER

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



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.

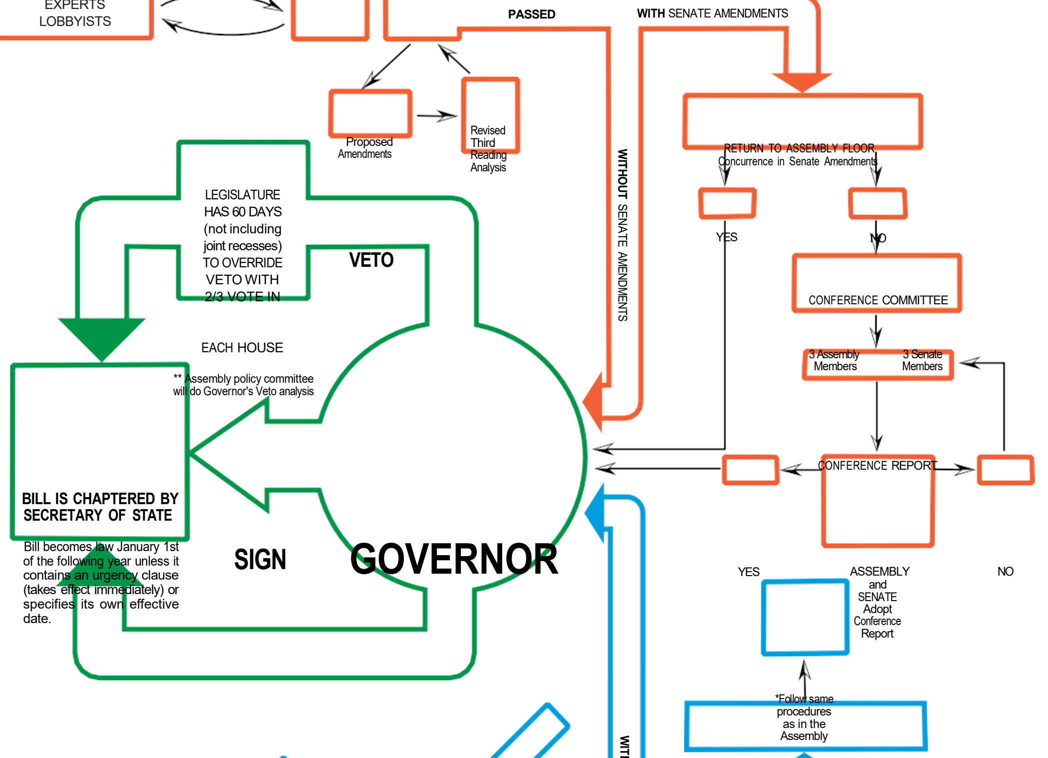
Typical committee actions are used to simplify charting the course of legislation.

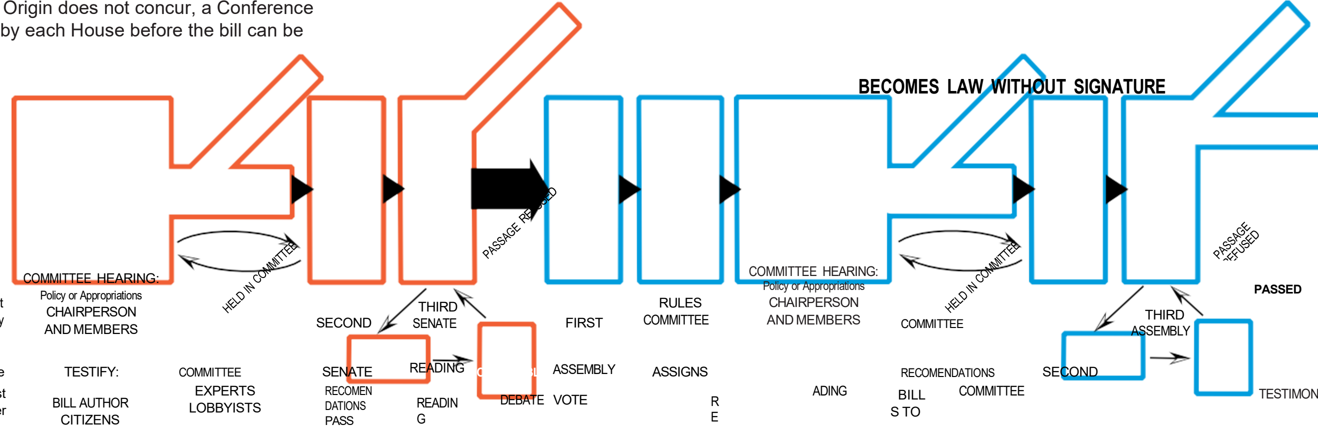
Some bills require hearings by more than one committee, in which case a committee may re–refer the bill to another committee. For example, bills with monetary implications must be re–referred to the proper fiscal committee in each House before they are sent to the second reading file and final action.

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.





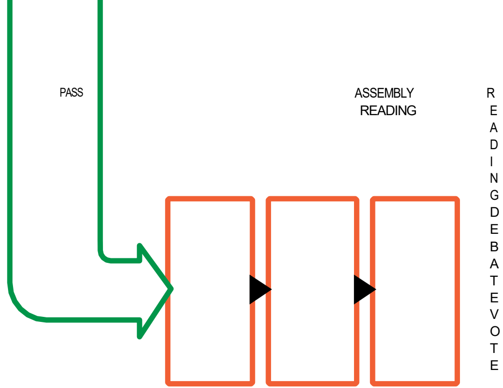
SENATOR

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



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

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

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

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

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

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

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

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

(B) The injured person's whereabouts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (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.

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

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

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

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

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

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

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

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

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 (1) An individual or agency that has information governed by
2 this subdivision shall not be required to disclose information. The
3 intent of this subdivision is to allow the voluntary disclosure of
4 information by the individual or agency that has the information.
5 (2) The following information may be disclosed pursuant to this
6 subdivision:
7 (A) Notwithstanding Section 56.10 of the Civil Code, medical
8 information.
9 (B) Notwithstanding Section 5328 of the Welfare and
10 Institutions Code, mental health information.
11 (C) Notwithstanding Section 15633.5 of the Welfare and
12 Institutions Code, information from elder abuse reports and
13 investigations, except the identity of persons who have made
14 reports, which shall not be disclosed.
15 (D) Notwithstanding Section 11167.5, information from child
16 abuse reports and investigations, except the identity of persons
17 who have made reports, which shall not be disclosed.
18 (E) State summary criminal history information, criminal
19 offender record information, and local summary criminal history
20 information, as defined in Sections 11075, 11105, and 13300.
21 (F) Notwithstanding Section 11163.2, information pertaining
22 to reports by health practitioners of persons suffering from physical
23 injuries inflicted by means of a firearm or abuse, if reported, and
24 information relating to whether a physician referred the person to
25 local domestic violence services, as recommended by Section
26 11161.
27 (G) Notwithstanding Section 827 of the Welfare and Institutions
28 Code, information in any juvenile court proceeding.
29 (H) Information maintained by the Family Court, including
30 information relating to the Family Conciliation Court Law pursuant
31 to Section 1818 of the Family Code, and Mediation of Custody
32 and Visitation Issues pursuant to Section 3177 of the Family Code.
33 (I) Information provided to probation officers in the course of
34 the performance of their duties, including, but not limited to, the
35 duty to prepare reports pursuant to Section 1203.10, as well as the
36 information on which these reports are based.
37 (J) Notwithstanding Section 10850 of the Welfare and
38 Institutions Code, records of in-home supportive services, unless
39 disclosure is prohibited by federal law.

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

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

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

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

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

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

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: Bill text

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.

1 (d) An optometrist certified pursuant to Section 3041.3 shall be
2 certified to administer authorized immunizations, as described in
3 subparagraph (D) of paragraph (5) of subdivision (a), after the
4 optometrist meets all of the following requirements:
5 (1) Completes an immunization training program endorsed by
6 the federal Centers for Disease Control and Prevention (CDC) or
7 the Accreditation Council for Pharmacy Education that, at a
8 minimum, includes hands-on injection technique, clinical
9 evaluation of indications and contraindications of vaccines, and
10 the recognition and treatment of emergency reactions to vaccines,
11 and maintains that training.
12 (2) Is certified in basic life support.
13 (3) Complies with all state and federal recordkeeping and
14 reporting requirements, including providing documentation to the
15 patient's primary care provider and entering information in the
16 appropriate immunization registry designated by the immunization
17 branch of the State Department of Public Health.
18 (4) Applies for an immunization certificate in accordance with
19 Section 3041.5.
20 (e) Other than for prescription ophthalmic devices described in
21 subdivision (b) of Section 2541, any dispensing of a therapeutic
22 pharmaceutical agent by an optometrist shall be without charge.
23 (f) An optometrist licensed under this chapter is subject to the
24 provisions of Section 2290.5 for purposes of practicing telehealth.
25 (g) For the purposes of this chapter, all of the following
26 definitions shall apply:
27 (1) "Adnexa" means the eyelids and muscles within the eyelids,
28 the lacrimal system, and the skin extending from the eyebrows
29 inferiorly, bounded by the medial, lateral, and inferior orbital rims,
30 excluding the intraorbital extraocular muscles and orbital contents.
31 (2) "Anterior segment" means the portion of the eye anterior to
32 the vitreous humor, including its overlying soft tissue coats.
33 (3) "Ophthalmologist" means a physician and surgeon, licensed
34 under Chapter 5 (commencing with Section 2000) of Division 2
35 of the Business and Professions Code, specializing in treating eye
36 disease.
37 (4) "Physician and surgeon" means a physician and surgeon
38 licensed under Chapter 5 (commencing with Section 2000) of
39 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 4/17/2024 / In Senate Committee on Rules

AUTHOR REASON FOR THE BILL

According to the author: "California faces major shortages of health workers, isn't producing enough new workers to meet future needs, and the current health workforce does not match the diversity of the state. These workforce supply and diversity problems have a major impact on health access, quality, and equity. There are sixteen health care professional oversight boards that "request" workforce data but do not require workforce data to be reported as condition as licensure. Without accurate information about the makeup of California's health workforce, it is difficult to assess whether or not programs designed to improve diversity and increase access to care in underserved areas are working as intended. This information will provide HCAI with data necessary to assess whether or not loan repayment programs intended to increase the diversity of the health workforce, and to encourage providers to serve in underserved areas, are working as intended."

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. The bill would also prohibit a board from denying an application solely because the applicant did not provide the required workforce data.

Under current law, healing arts boards, including CSBO, 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.

Suggested Motion:

I move to adopt the committee recommendation of a neutral position on AB 1991.

Attachment 1: Assembly Business and Professions Committee Analysis

Attachment 2: Bill text

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1991 (Bonta) – As Amended March 11, 2024

SUBJECT: Licensee and registrant records.

SUMMARY: Requires all healing arts boards under the Department of Consumer Affairs (DCA) to collect specified workforce data from their licensees and registrants at least biennially as a requirement of license or registration renewal, and requires that information to be subsequently provided to the Department of Health Care Access and Information (HCAI).

EXISTING LAW:

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

2) Establishes various boards, bureaus, and other entities within the jurisdiction of the DCA. (BPC § 101)

3) Establishes "healing arts" boards under the jurisdiction of DCA, which includes the following entities:

   a) Acupuncture Board;

   b) Board of Behavioral Sciences;

   c) State Board of Chiropractic Examiners;

   d) Dental Board of California;

   e) Dental Hygiene Board of California;

   f) Medical Board of California;

   g) California Board of Naturopathic Medicine;

   h) California Board of Occupational Therapy;

   i) California Board of Optometry;

   j) Osteopathic Medical Board of California;

   k) California State Board of Pharmacy;

   l) Physical Therapy Board of California;

   m) Physician Assistant Board;

   n) Podiatric Medical Board of California;

o) Board of Psychology;

p) Board of Registered Nursing;

q) Respiratory Care Board of California;

r) Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board;

s) Veterinary Medical Board;

t) Board of Vocational Nursing and Psychiatric Technicians.

(BPC §§ 500 *et seq.*)

4) Requires information retained by each board under the DCA relating to license applicants with criminal records to include the final disposition and demographic information, consisting of voluntarily provided information on race or gender. (BPC § 480(g))

5) Requires the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians, the Physician Assistant Board, and the Respiratory Care Board of California to collect specified workforce data from their respective licensees and registrants for future workforce planning at least biennially, with data collected at the time of electronic license or registration renewal as applicable. (BPC § 502(a)(1))

6) Provides that all other healing arts boards shall request the specified workforce data for future workforce planning at least biennially, with data collected at the time of electronic license or registration renewal as applicable. (BPC § 502(a)(2))

7) Specifies the following information as included within the workforce data collected or requested by healing arts boards:

a) Anticipated year of retirement.

b) Area of practice or specialty.

c) City, county, and ZIP Code of practice.

d) Date of birth.

e) Educational background and the highest level attained at time of licensure or registration.

f) Gender or gender identity.

g) Hours spent in direct patient care, including telehealth hours as a subcategory, training, research, and administration.

h) Languages spoken.

i) National Provider Identifier.

j) Race or ethnicity.

k) 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.

l) Work hours.

m) Sexual orientation.

n) Disability status.

(BPC § 502(b))

8) Requires each board to maintain the confidentiality of the information it receives from licensees and registrants and to only release information in an aggregate form that cannot be used to identify an individual. (BPC § 502(c))

9) Requires the DCA, in consultation with HCAI, to specify for each board the specific information and data that will be collected or requested. (BPC § 502(d))

10) Requires each board, or the DCA on its behalf, to provide the workforce data it collects to HCAI on a quarterly basis in a manner directed by HCAI, including license or registration number and associated license or registration information. (BPC § 502(e))

11) Prohibits boards from requiring a licensee or registrant to provide the workforce data as a condition for license or registration renewal, or from disciplining licensees or registrants for not providing the information. (BPC § 502(f))

12) Requires licensed dentists to report to the Dental Board of California, upon initial licensure and any subsequent application for renewal, the licensee's practice status and any completed advanced educational program, as well as information regarding the licensee's cultural background and foreign language proficiency if reported by the licensee. (BPC § 1715.5)

13) Requires licensed dental hygienists to the Dental Hygiene Board, upon initial licensure and any subsequent application for renewal, the licensee's practice or employment status, as well as information regarding the licensee's cultural background and foreign language proficiency if reported by the licensee. (BPC § 1902.2)

14) Requires licensed physicians and surgeons to report to the Medical Board of California, immediately upon issuance of an initial license and at the time of license renewal, their practice status and any specialty board certification they hold, along with information relating to their cultural background and foreign language proficiency unless the licensee declines to provide that information. (BPC § 2425.3)

15) Requires licensed osteopathic physicians and surgeons to report to the Osteopathic Medical Board of California, either immediately upon issuance of an initial license or at the time of renewal, as provided, any specialty board certification they hold and their practice status, along with information relating to their cultural background and foreign language proficiency if reported by the licensee. (BPC § 2455.2)

16) Authorizes the Bureau of Real Estate Appraisers to request that a licensee identify their race, ethnicity, sexual orientation, gender, or gender identity. (BPC § 11347)

17) Requires the Board of Registered Nursing to incorporate regional forecasts into its biennial analyses of the nursing workforce and to develop a plan to address shortages. (BPC § 2717)

18) Authorizes the California Architects Board to request that a licensee identify their race, ethnicity, sexual orientation, gender, or gender identity. (BPC § 5552.2)

19) Establishes HCAI, previously established as the Office of Statewide Health Planning and Development, vested with responsibilities related to health planning and research development. (Health and Safety Code (HSC) §§ 127000 *et seq.*)

20) Provides for a Health Professions Career Opportunity Program to increase the number of ethnic minorities in health professional training and minority health professionals practicing in health shortage areas, subject to the appropriation of funds. (HSC §§ 127875 – 127885)

21) Requires HCAI to establish a health care workforce research and data center to serve as the central source of health care workforce and educational data in the state. (HSC § 128050)

22) Requires HCAI to work with the Employment Development Department's Labor Market Information Division, state licensing boards, and state higher education entities to collect, to the extent available, all of the following data:

    a) The current supply of health care workers, by specialty.

    b) The geographical distribution of health care workers, by specialty.

    c) The diversity of the health care workforce, by specialty, including, but not necessarily limited to, data on race, ethnicity, and languages spoken.

    d) The current and forecasted demand for health care workers, by specialty.

    e) The educational capacity to produce trained, certified, and licensed health care workers, by specialty and by geographical distribution, including, but not necessarily limited to, the number of educational slots, the number of enrollments, the attrition rate, and wait time to enter the program of study.

    (HSC § 128051)

23) Requires HCAI to prepare an annual report to the Legislature that does all of the following:

    a) Identifies education and employment trends in the health care profession.

    b) Reports on the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas.

    c) Recommends state policy needed to address issues of workforce shortage and distribution.

    d) Describes the health care workforce program outcomes and effectiveness.

    (HSC § 128052)

THIS BILL:

1) Provides that healing arts boards under the DCA that are not already required to collect workforce data from their licensees and registrants shall be required to collect that workforce data for future workforce planning at least biennially.

2) Requires a licensee or registrant to provide the workforce data information as a condition for license or registration renewal.

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

COMMENTS:

Purpose. This bill is sponsored by the author, who is Chair of the Assembly Committee on Health. According to the author:

> "California faces major shortages of health workers, isn't producing enough new workers to meet future needs, and the current health workforce does not match the diversity of the state. These workforce supply and diversity problems have a major impact on health access, quality, and equity. There are sixteen health care professional oversight boards that "request" workforce data but do not require workforce data to be reported as condition as licensure. Without accurate information about the makeup of California's health workforce, it is difficult to assess whether or not programs designed to improve diversity and increase access to care in underserved areas are working as intended. This information will provide HCAI with data necessary to assess whether or not loan repayment programs intended to increase the diversity of the health workforce, and to encourage providers to serve in underserved areas, are working as intended."

Background.

California has long faced significant gaps and inequities in its health care workforce. There has historically been a persistent shortage of accessible health professionals overall, which disproportionately impacts communities with concentrated populations of immigrant families and people of color. A recent study found that between 2010 and 2019, the number of primary care physicians in proportion to population remained largely unchanged nationally. Meanwhile, counties with a higher proportion of minorities saw a decline during that period.[1]

Compounding these issues of access is a significant lack of diversity among health care practitioners, with several minority groups remaining persistently underrepresented within the healing arts fields. A recent study of data from the American Community Survey and the Integrated Postsecondary Education Data System found that Black, Hispanic, and Native American people are nationally represented across 10 different health care professions.[2] As a result, minorities seeking to enter these professions face significant systemic obstacles, and patients who are representative of minority groups or immigrant communities often do not have access to practitioners who possess the cultural or linguistic competence to provide them with appropriate care.

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[1] Liu M, Wadhera RK. *Primary Care Physician Supply by County-Level Characteristics*, 2010-2019.
[2] Salsberg, Edward *et al*. "Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce." *JAMA network open* vol. 4,3 e213789. 1 March 2021.

Research cited by the California Health Care Foundation (CHCF) in its 2021 report "Health Workforce Strategies for California: A Review of the Evidence" found that while 39 percent of Californians identified as Latino/x in 2019, only 14 percent of medical school matriculants and 6 percent of active patient care physicians in California were Latino/x.[3] A 2018 study published by the Latino Policy & Politics Initiative at the University of California, Los Angeles found that while nearly 44 percent of the California population speaks a language other than English at home, many of the most commonly spoken languages are underrepresented by the physician workforce.[4] While the physician community has worked with the Medical Board of California to improve linguistic competency among providers, these efforts have yet to resolve systemic challenges with addressing language barriers in California.

Another issue resulting from underrepresentation in the health professions relates to implicit bias. According to the Stanford Encyclopedia of Philosophy, "implicit bias" can be described as "a term of art referring to relatively unconscious and relatively automatic features of prejudiced judgment and social behavior." In her 2019 book *Biased: Uncovering the Hidden Prejudice That Shapes What We See, Think, and Do*, Dr. Jennifer L. Eberhardt explains that "implicit bias is not a new way of calling someone a racist. In fact, you don't have to be a racist at all to be influenced by it. Implicit bias is a kind of distorting lens that's a product of both the architecture of our brain and the disparities in our society." Dr. Eberhardt goes on to describe how "bias is not limited to one domain of life. It is not limited to one profession, one race, or one country. It is also not limited to one stereotypic association."[5]

In December 2015, the American Journal of Public Health published a systematic review titled *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes*. The review concluded that "most health care providers appear to have implicit bias in terms of positive attitudes toward whites and negative attitudes toward people of color." Additional published studies suggest that implicit bias in regards to gender, sexual orientation and identity, and other characteristics has resulted in inconsistent diagnoses and courses of treatment being provided to patients based on their respective demographic. These trends take into account not only the characteristics of the person being treated, but those of the licensed professional in correlation to that patient.

The results of implicit bias can have serious consequences in the provision of health care. For example, one frequently cited statistic is that Black women have average maternal mortality rates that are three-to-four times higher than white women. While much of the research and action relating to implicit bias has been focused on the area of law enforcement and police procedure, there has been a growing call to also address the presence of implicit bias in the healing arts professions through additional awareness and training. In 2019, the Legislature enacted Assembly Bill 241 (Kamlager-Dove) to require continuing education courses for physicians and surgeons, nurses, and physician assistants to include the understanding of implicit bias and the promotion of bias-reducing strategies. While implementation of these requirements has undoubtedly had at least some impact on improving health care outcomes for minority patients, education and training is not a substitute for increasing diversity and representation among providers.

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[3] https://www.chcf.org/publication/health-workforce-strategies-california
[4] https://latino.ucla.edu/wp-content/uploads/2019/08/The_Patient_Perspective-UCLA-LPPI-Final.pdf
[5] Eberhardt, Jennifer L. *Biased: Uncovering the Hidden Prejudice That Shapes What We See, Think, and Do.* New York: Viking, 2019.

In February 2024, the Assembly Committee on Health held an informational hearing focused on Diversity in California's Health Care Workforce. This hearing included perspectives from various stakeholders and public health researchers, along with policymakers who provided updates on the state's efforts to increase diversity. The background paper for the hearing[6] cited research published in December 2022 by the Fitzhugh Mullan Institute for Health Workforce Equity at George Washington University in a report titled "The Race and Ethnicity of the California Health Care Workforce," which demonstrated that "a health workforce that reflects the racial and ethnic diversity of the population can improve access to, quality of, and outcomes of care."[7] As explained in the Health Committee's background paper, underrepresentation in the health care workforce both "contributes to health disparities" and "limits access to high-paying, meaningful professions for underrepresented minorities."

California has historically attempted to resolve these longstanding issues of representation and access through a number of different approaches. For example, the Legislature has previously enacted and funded loan repayment programs, such as the Dental Corps Loan Repayment Program of 2002, which provided grants to qualifying dentists who agreed to work for at least three years in a clinic or dental practice located in a dentally unserved area, or in which at least 50 percent of patients are from a dentally underserved population. The Health Professions Career Opportunity Program within HCAI similarly supports initiatives designed to enhance diversity and representation in the health professions by awarding grant funding through competitive programs.

As discussed in the Health Committee's background paper, it is often challenging to evaluate the long-term impacts of these programs, as "HCAI does not currently collect longitudinal data that could demonstrate which of these programs are more effective." During sunset review oversight hearings on healing arts boards that were held jointly in 2024 by the Assembly Committee on Business and Professions and the Senate Committee on Business, Professions, and Economic Development, committee members expressed frustration that there was not sufficient data to confirm whether any particular strategy to improve access has been successful. This is in large part due to a lack of consistent data from healing arts licensees to inform policymakers about how many practitioners of particular specialties are providing services in any given area of the state, or about the demographic makeup of those practitioners.

The California Health Workforce Research and Data Center, previously established in 2007 as the Healthcare Workforce Clearinghouse under the prior Office of Statewide Health Planning and Development, serves as California's central source for collection, analysis, and reporting of information on the healthcare workforce employment and educational data trends for the state. As part of its statutory duties, HCAI is mandated to prepare an annual report to the Legislature that accomplishes the following three goals: (1) identifying education and employment trends in the health care professions (2) reporting on the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas; and (3) recommending state policy needed to address issues of workforce shortage and distribution.

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[6] https://ahea.assembly.ca.gov/media/1665

[7] Bogucki C, Brantley E, Salsberg E. "The Race and Ethnicity of the California Health Workforce." Fitzhugh Mullan Institute for Health Workforce Equity. Washington, DC: George Washington University, 2022.

In 2014, the Legislature enacted Assembly Bill 2102, authored by Assemblymember Phil Ting and co-sponsored by the California Pan-Ethnic Health Network and the Latino Coalition for a Healthy California. The bill required four specified healing arts boards—the Board of Registered Nursing, the Physician Assistant Board, the Respiratory Care Board of California, and the Board of Vocational Nursing and Psychiatric Technicians—to collect and report specific demographic data related to its licensees. Specifically, AB 2102 mandated that the four boards collect the following data from licensees: (1) location of practice, including city, county, and zip Code; (2) race or ethnicity; (3) gender; (4) languages spoken; (5) educational background and (6) classification of primary practice site, such as clinic, hospital, managed care organization, or private practice. In order to implement AB 2102, the DCA and HCAI established an interagency agreement to facilitate the specified data collection and exchange.

Assemblymember Ting subsequently introduced Assembly Bill 2704 in 2020, which sought to replace the distinct data collection requirements for the four healing arts boards with a single statute requiring data collection for all healing arts boards. The bill ultimately was not set for a hearing in this committee. The next year, Assemblymember Ting reintroduced the bill as Assembly Bill 1236, adding sexual orientation and disability status to the list of required data points. This bill passed this committee but the author ultimately decided to hold the bill on the Assembly floor.

Instead, language was included in the omnibus health trailer bill as part of the Budget Act of 2021 consolidating the existing workforce data collection requirements for the four healing arts boards into one section with an expanded list of data points. However, the trailer bill did not require this data to be collected by any additional boards under the DCA; instead, it provided that all other healing arts boards *request* the information. The trailer bill also expressly provided that licensees could not be required to provide the information as a condition for license renewal, and that they could not be disciplined for failing to provide the information.

This bill would amend the consolidated data collection law enacted through the trailer bill to require all healing arts boards to collect the workforce data and report it to HCAI. The author cites recommendations in a 2019 report by the California Future Health Workforce Commission, which included among its goals an objective to "expand and scale pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers." The author believes that providing HCAI with workforce data for all healing arts licensees will allow legislators and policymakers to more effectively evaluate the success of efforts to improve representation and diversity in the state's health care professions.

Current Related Legislation.

AB 2862 (Gipson) would require boards under the DCA to prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States. *This bill is pending in this committee.*

AB 2860 (Garcia) recasts and expands provisions of law relating to the Licensed Physicians and Dentists from Mexico Pilot Program. *This bill is pending in the Assembly Committee on Appropriations.*

SB 1067 (Smallwood-Cuevas) would require healing arts boards to expedite the licensure process for applicants who intend to practice in a medically underserved area. *This bill is pending in the Senate Committee on Appropriations.*

Prior Related Legislation.

AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) consolidated workforce data collection requirements and requires all healing arts boards to request, if not require, that data.

AB 1236 (Ting) of 2021 would have consolidated workforce data collection requirements and required all healing arts boards to collect that data. *This bill died on the inactive file of the Assembly Floor.*

AB 2704 (Ting) of 2020 would have consolidated workforce data collection requirements and required all healing arts boards to collect that data. *This bill was not set for a hearing in this committee.*

AB 2102 (Ting, Chapter 420, Statutes of 2014) required four specified healing arts boards to collect and report specific demographic data related to its licensees.

ARGUMENTS IN SUPPORT:

The **California Pan-Ethnic Health Network** supports this bill, writing: "HCAI administers several Loan Repayment Programs that offer financial support to health professionals who agree to provide direct patient care in medically underserved areas. However, California has recently faced major shortages of health workers, not producing enough new workers to meet future needs, and the current health workforce does not match the state's diversity. Reports have also found that Hispanic and Black workers are very underrepresented in the existing health workforce in California. AB 1991 would help support workforce supply and diversity problems to help improve the impacts on health access, quality, and equity in our most underserved communities."

The **Latino Coalition for a Healthy California** also supports this bill, writing: "We urge you to support AB 1991, as California faces major shortages of health workers, isn't producing enough new workers to meet future needs, and the current health workforce does not match the diversity of the state. These workforce supply and diversity problems have a major impact on health access, quality, and equity. Specifically, there are sixteen health care professional oversight boards that 'request' workforce data but do not require workforce data to be reported as condition as licensure. Without accurate information about the makeup of California's health workforce, it is difficult to assess whether or not programs designed to improve diversity and increase access to care in underserved areas are working as intended."

ARGUMENTS IN OPPOSITION:

None on file.

POLICY ISSUE(S) FOR CONSIDERATION:

This bill and current law provide that the workforce data is collected as part of the license renewal process, and this bill would confirm that licensees must report the information as part of their renewal application. However, the intent of the author is not for licensees to be denied renewal of their license simply because they declined to provide all the information required, some of which is arguably personal and sensitive. The author has therefore agreed to clarify that failure to provide the information is not on its own cause for a license renewal to be denied.

AMENDMENTS:

To ensure that licensees are not denied a license renewal simply because they did not provide all or part of the required workforce data, amend subdivision (f) in Section 1 of the bill as follows:

> *(f)(1) A licensee or registrant shall be required to provide the information listed in subdivision (b) as a condition for license or registration renewal.*
>
> *(2) Notwithstanding paragraph (1), a board described in paragraph (2) of subdivision (a) shall not deny an application for license or registration renewal solely because the licensee or registrant failed to provide any of the information listed in subdivision (b).*

REGISTERED SUPPORT:

California Pan-Ethnic Health Network
Latino Coalition for a Healthy California

REGISTERED OPPOSITION:

None on file.

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

AMENDED IN ASSEMBLY APRIL 17, 2024

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 502 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1991, as amended, Bonta. 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 prohibit certain boards, notwithstanding*

that condition, from denying an application for license or registration renewal solely because the licensee or registrant failed to provide any of the workforce data. The bill would delete the provision that specifies that a licensee or registrant shall not be subject to discipline for not providing that information.

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 502 of the Business and Professions Code
2 is amended to read:
3 502. (a) Notwithstanding any other law, both of the following
4 apply:
5 (1) The Board of Registered Nursing, the Board of Vocational
6 Nursing and Psychiatric Technicians of the State of California, the
7 Physician Assistant Board, and the Respiratory Care Board of
8 California shall collect workforce data from their respective
9 licensees and registrants as specified in subdivision (b) for future
10 workforce planning at least biennially. The data shall be collected
11 at the time of electronic license or registration renewal for those
12 boards that utilize electronic renewals for licensees or registrants.
13 (2) All other boards that are not listed in paragraph (1) that
14 regulate healing arts licensees or registrants under this division
15 shall collect workforce data from their respective licensees and
16 registrants as specified in subdivision (b) for future workforce
17 planning at least biennially. The data shall be required at the time
18 of electronic license or registration renewal for those boards that
19 utilize electronic renewals for licensees or registrants.
20 (b) In conformance with specifications under subdivision (d),
21 the workforce data collected or required by each board about its
22 licensees and registrants shall include, at a minimum, all of the
23 following information:
24 (1) Anticipated year of retirement.
25 (2) Area of practice or specialty.
26 (3) City, county, and ZIP Code of practice.
27 (4) Date of birth.
28 (5) Educational background and the highest level attained at
29 time of licensure or registration.
30 (6) Gender or gender identity.

1 (7) Hours spent in direct patient care, including telehealth hours
2 as a subcategory, training, research, and administration.
3 (8) Languages spoken.
4 (9) National Provider Identifier.
5 (10) Race or ethnicity.
6 (11) Type of employer or classification of primary practice site
7 among the types of practice sites specified by the board, including,
8 but not limited to, clinic, hospital, managed care organization, or
9 private practice.
10 (12) Work hours.
11 (13) Sexual orientation.
12 (14) Disability status.
13 (c) Each board shall maintain the confidentiality of the
14 information it receives from licensees and registrants under this
15 section and shall only release information in an aggregate form
16 that cannot be used to identify an individual other than as specified
17 in subdivision (e).
18 (d) The Department of Consumer Affairs, in consultation with
19 the Department of Health Care Access and Information, shall
20 specify for each board subject to this section the specific
21 information and data that will be collected or requested pursuant
22 to subdivision (b). The Department of Consumer Affairs'
23 identification and specification of this information and data shall
24 be exempt until June 30, 2023, from the requirements of the
25 Administrative Procedure Act (Chapter 3.5 (commencing with
26 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
27 Code).
28 (e) Each board, or the Department of Consumer Affairs on its
29 behalf, shall, beginning on July 1, 2022, and quarterly thereafter,
30 provide the individual licensee and registrant data it collects
31 pursuant to this section to the Department of Health Care Access
32 and Information in a manner directed by the Department of Health
33 Care Access and Information, including license or registration
34 number and associated license or registration information. The
35 Department of Health Care Access and Information shall maintain
36 the confidentiality of the licensee and registrant information it
37 receives and shall only release information in an aggregate form
38 that cannot be used to identify an individual.

1 (f) *(1)* A licensee or registrant shall be required to provide the
2 information listed in subdivision (b) as a condition for license or
3 registration renewal.
4 *(2) Notwithstanding paragraph (1), a board described in*
5 *paragraph (2) of subdivision (a) shall not deny an application for*
6 *license or registration renewal solely because the licensee or*
7 *registrant failed to provide any of the information listed in*
8 *subdivision (b).*
9 (g) This section does not alter or affect mandatory reporting
10 requirements for licensees or registrants established pursuant to
11 this division, including, but not limited to, Sections 1715.5, 1902.2,
12 2425.3, and 2455.2.

O

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

Status: Amended 4/3/2024 / Referred to Senate Committee on Business, Professions, and Economic Development

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.

Suggested Motion:

I move to adopt the committee recommendation of a support position.

Attachment 1: Assembly Business and Professions Committee Analysis

Attachment 2: Bill text

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

AMENDED IN ASSEMBLY APRIL 3, 2024

california legislature—2023–24 regular session

ASSEMBLY BILL No. 2327

Introduced by Assembly Member Wendy Carrillo
(Coauthors: Assembly Members Bains, Juan Carrillo, Flora, and Stephanie Nguyen)

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 amended, 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.~~ *2026, or before the board adopts those regulations, whichever is earlier.* 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:

SECTION 1. Section 3070.2 of the Business and Professions Code is amended to read:

3070.2. (a) As used in this section, “mobile optometric office” means a trailer, van, or other means of transportation in which the practice of optometry, as defined in Section 3041, is performed and which is not affiliated with an approved optometry school in California.

(b) This section shall not apply to any of the following:

(1) Optometric services provided remotely by an approved optometry school in California that meets the requirements of Section 1507 of Title 16 of the California Code of Regulations.

(2) A licensee engaged in the practice of optometry at a facility defined in paragraph (1), (2), or (3) of subdivision (a) of Section 3070.1.

(3) A federally qualified health center, as defined in Section 1396d(*l*)(2)(B) of Title 42 of the United States Code.

(4) A nonprofit or charitable organization exempt from taxation pursuant to Section 501(c)(3), 501(c)(4), or 501(c)(6) of the Internal Revenue Code (26 U.S.C. Sec. 501(c)(3), 501(c)(4), or 501(c)(6)), which utilizes the volunteer services of licensees engaging in the temporary practice of optometry pursuant to subdivision (b) of Section 3070.

(5) A free clinic, as defined in subparagraph (B) of paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code, which is operated by a clinic corporation, as defined in paragraph (3) of subdivision (b) of Section 1200 of the Health and Safety Code.

(6) A specialized vision health care service plan, as defined in subdivision (f) of Section 1345 of the Health and Safety Code, formed and existing pursuant to the provisions of the Nonprofit

1 Corporation Law (Division 2 (commencing with Section 5000) of
2 Title 1 of the Corporations Code).
3 (c) The ownership and operation of a mobile optometric office
4 shall be limited to a nonprofit or charitable organization that is
5 exempt from taxation pursuant to Section 501(c)(3) or 501(c)(4)
6 of the United States Internal Revenue Code that provides
7 optometric services to patients regardless of the patient's ability
8 to pay.
9 (1) The owner and operator of a mobile optometric office shall
10 register with the board. The owner and operator of a mobile
11 optometric office and the optometrist providing services shall not
12 accept payment for services other than those provided through the
13 Medi-Cal program or through any of the state's programs under
14 the Children's Health Insurance Program (CHIP) under Title XIX
15 (42 U.S.C. Sec. 1396 et seq.), or Title XXI (42 U.S.C. Sec. 1397aa
16 et seq.), of the Social Security Act.
17 (2) The medical operations of the mobile optometric office shall
18 be directed by a licensed optometrist and in every phase shall be
19 under the exclusive control of the licensed optometrist, including
20 the selection and supervision of optometric staff, the scheduling
21 of patients, the amount of time the optometrist or optician spends
22 with patients, the fees charged for optometric products and services,
23 the examination procedures, the treatment provided to patients,
24 and the followup care pursuant to this section.
25 (3) The owner and operator of a mobile optometric office shall
26 not operate more than 12 mobile optometric offices within the first
27 renewal period of two years, but may operate more than 12 offices
28 after the first renewal period is complete.
29 (d) An owner and operator who has obtained approval from the
30 board pursuant to paragraph (1) of subdivision (c) and wishes to
31 operate a mobile optometric office shall apply for a permit from
32 the board before beginning operation of each mobile optometric
33 office. The application shall be made on a board-prescribed form
34 that requests any information the board deems appropriate to
35 register a mobile optometric office pursuant to this section. The
36 form shall be accompanied by a nonrefundable fee of four hundred
37 seventy-two dollars ($472). The board may increase the fee, as
38 necessary to cover the reasonable regulatory costs of
39 administration, to not more than six hundred dollars ($600).

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

1 (3) An updated and current list of licensed optometrists,
2 registered opticians, and any other persons who have provided
3 care within each mobile optometric office since the last reporting
4 period.
5 (4) An updated and current list of licensed optometrists who
6 are available for followup care as a result of a complaint on a
7 volunteer basis or who accept Medi-Cal payments.
8 (5) Any other information the board deems appropriate to
9 safeguard the public from substandard optometric care, fraud, or
10 other violation of this chapter.
11 (g) The owner and operator of the mobile optometric office
12 shall notify the board of any change to the information provided
13 to the board pursuant to subdivision (d) within 14 days.
14 (h) (1) The owner and operator of the mobile optometric office
15 shall provide each patient and, if applicable, the patient's caregiver
16 or guardian, a consumer notice prescribed by the board that
17 includes the following:
18 (A) The name, license number, and contact information for the
19 optometrist.
20 (B) Optometrists providing services at a mobile optometric
21 office are regulated by the board and the contact information for
22 filing a complaint with the board.
23 (C) Information on how to obtain a copy of the patient's medical
24 information.
25 (D) Information on followup care available for the patient,
26 including a list of available Medi-Cal or volunteer optometrists.
27 This list shall be updated every six months and is subject to the
28 inspection by the board.
29 (E) Any other information the board deems appropriate to
30 safeguard the public from substandard optometric care, fraud, or
31 other violation of this chapter.
32 (2) The optometrist shall maintain a copy of the consumer notice
33 described in paragraph (1) in the patient's medical record.
34 (3) Upon request by the patient's caregiver or guardian, a copy
35 of the prescription made for the patient shall be provided.
36 (i) Any person who is employed by the owner and operator of
37 the mobile optometric office to drive or transport the vehicle shall
38 possess a valid driver's license.
39 (j) By January 1, 2026, the board shall adopt regulations
40 establishing a registry for the owners and operators of mobile

1 optometric offices and shall set a registration fee at an amount not
2 to exceed the reasonable regulatory costs of administration.
3 (k) The board may adopt regulations to conduct quality
4 assurance reviews for the owner and operator of a mobile
5 optometric office and optometrists engaging in the practice of
6 optometry at a mobile optometric office.
7 (*l*) The board shall not bring an enforcement action against an
8 owner and operator of a mobile optometric office based solely on
9 its affiliation status with an approved optometry school in
10 California for remotely providing optometric service before January
11 1, ~~2026.~~ *2026, or before the board adopts final regulations*
12 *pursuant to subdivision (j), whichever is earlier.*
13 (m) The owner and operator of a mobile optometric office shall
14 maintain records in the following manner, which shall be made
15 available to the board upon request for inspection:
16 (1) Records are maintained and made available to the patient
17 in such a way that the type and extent of services provided to the
18 patient are conspicuously disclosed. The disclosure of records shall
19 be made at or near the time services are rendered and shall be
20 maintained at the primary business office specified.
21 (2) The owner and operator of a mobile optometric office
22 complies with all federal and state laws and regulations regarding
23 the maintenance and protection of medical records, including, but
24 not limited to, the federal Health Insurance Portability and
25 Accountability Act of 1996 (42 U.S.C. Sec. 300gg).
26 (3) Pursuant to Section 3007, the owner and operator of the
27 mobile optometric office keeps all necessary records for a
28 minimum of seven years from the date of service in order to
29 disclose fully the extent of services furnished to a patient. Any
30 information included on a printed copy of an original document
31 to a patient shall be certified by the owner and operator of the
32 mobile optometric office as being true, accurate, and complete.
33 (4) If a prescription is issued to a patient, records shall be
34 maintained for each prescription as part of the patient's chart,
35 including all of the following information about the optometrist:
36 (A) Name.
37 (B) Optometrist license number.
38 (C) The place of practice and the primary business office.

1 (D) Description of the goods and services for which the patient
2 is charged and the amount charged. If no charge was made to the
3 patient, a description of the goods and services provided.
4 (5) The owners and operators of the mobile optometric offices
5 shall maintain accurate records of the mobile optometric offices,
6 including vehicle registration numbers and the year, make, and
7 model of each trailer or van.
8 (n) Any licensed optometrist who provides patient care in
9 conjunction with a mobile optometric office shall obtain a
10 statement of licensure pursuant to subdivision (a) of Section 3070
11 with the mobile optometric office's address as registered with the
12 board. If the licensee is not practicing optometry at a location other
13 than with the owner and operator of the mobile optometric office,
14 then the licensee shall list as their primary address of record the
15 owner and operator of the mobile optometric office's address as
16 registered with the board.
17 (o) All examinations performed at the mobile optometric office
18 shall be performed by a licensed optometrist who is certified to
19 use therapeutic pharmaceutical agents pursuant to Section 3041.3.
20 (p) This section does not apply to optometry services defined
21 in Section 3070.1.
22 (q) This section shall remain in effect only until July 1, 2035,
23 and as of that date is repealed.

O

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.

UPDATE

This bill is no longer moving this year.

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.

O

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:

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

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

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

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

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

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

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: No longer moving forward.

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.

UPDATE:

No longer moving forward this year.

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 1451 (Ashby) Professions and Vocations

Status: Amended 4/17/2024 / In Assembly

AUTHOR REASON FOR THE BILL

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

DESCRIPTION OF CURRENT LEGISLATION

This analysis only concerns itself with provisions of the bill that interest CSBO.

Existing law makes it a misdemeanor for a person who is not licensed as a physician and surgeon under the act, except as specified, to use certain words, letters, and phrases or any other terms that imply that the person is authorized to practice medicine as a physician and surgeon.

This bill would add the initials "D.O." to the list of prohibited terms under that provision. The bill would also prohibit a person from using the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D." or "D.O.," or any other terms or letters indicating or implying that the person is a physician and surgeon, physician, surgeon, or practitioner in a health care setting that would lead a reasonable patient to determine that the person is a licensed "M.D." or "D.O.".

BACKGROUND

In recent years, there has been an apparent increase in legislative efforts around the country by state medical associations to enact what are referred to as "Not-a-Doctor" bills. According to the American Optometric Association, there were at least seven states that had such legislation introduced in 2023 and this year there are at least three, including California with this bill.

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

While the Medical Practice Act expressly reserves use of the words "doctor" or "physician" for actively licensed physicians, this provision does not comprehensively reflect the current state of the law. For example, while podiatrists are independently licensed by the Podiatric Medical Board of California, their formal title is "doctors of podiatric medicine." Similarly, the California Board of Naturopathic Medicine licenses and regulates a profession statutorily referred to as "naturopathic doctors." Optometrists, dentists, chiropractors, psychologists, and other practitioners possessing professional doctorates are also expressly authorized by law to use the term "doctor." "Dr." is also commonly used as a social honorific for anyone who has received a doctoral degree,

including research doctorates not associated with licensure.

In order to ensure that licensed healthcare professionals authorized to utilize the title "Doctor" or "Dr.", according to the specified requirements and limitations for the use of that term in various Business and Professions Code practice acts, are not in violation of the Medical Practice Act due to the changes in this bill, the Author is proposing to amend the bill moving forward to clarify that licensees whose practice act authorizes limited use of the title are not prevented from continuing to do so.

ANALYSIS

Optometrists in California are already limited in using the prefix "Doctor" or "Dr." and this bill is not intended to further limit or otherwise prevent or prohibit optometrists in California from using those prefixes consistent with existing law. Optometrists who use the prefix "Doctor" or "Dr." without the correct suffix may have their license revoked or suspended. Existing law, found at Business and Professions Code section 3098, states:

> "When the holder uses the title of "Doctor" or "Dr." as a prefix to his or her name, without using the word "optometrist" as a suffix to his or her name or in connection with it, or, without holding a diploma from an accredited school of optometry, the letters "Opt. D." or "O.D." as a suffix to his or her name, it constitutes a cause to revoke or suspend his or her optometrist license."

The author has also committed to further amendments to clarify that existing use of the title "Doctor" or "Dr." as authorized by the Optometry Practice Act, and others, continues to be authorized.

FISCAL

No fiscal impact is expected.

COMMITTEE RECOMMENDATION

The Committee did not discuss or make a recommendation on this bill.

Suggested Motion

I move to watch SB 1451 for further amendments that clarify optometrists ability to refer to themselves as doctors, consistent with existing law, and when those amendments are made, to support the bill.

Attachment 1: Senate Committee on Business, Professions, and Economic Development Analysis
Attachment 2: Bill text

SENATE COMMITTEE ON
BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
Senator Angelique Ashby, Chair
2023 - 2024 Regular

Bill No:	SB 1451	**Hearing Date:**	April 22, 2024
Author:	Ashby		
Version:	February 16, 2024		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Sarah Mason		

Subject: Professions and vocations

SUMMARY: Makes various changes to the operations of programs governed by practice acts in the Business and Professions Code and various professions regulated by these programs, stemming from prior sunset review oversight efforts.

Existing law:

1) Establishes the Dental Hygiene Board of California, until January 1, 2028, tasked with oversight of registered dental hygienists (RDH), registered dental hygienists in alternative practice (RDHAP), and registered dental hygienists in extended functions (RDHEF). States that in establishing the DHB, the intent of the Legislature was to permit the full utilization of RDHs, RDHAPs, and registered dental hygienists in extended functions (RDHEFs) in order to meet the dental care needs of all of the state's citizens. (Business and Professions Code (BPC) § 1900 *et. seq.*)

2) Authorizes a RDH to perform the following procedures under direct supervision of a licensed dentist, after submitting the Dental Hygiene Board evidence of satisfactory completion of a course of instruction, approved by the board, in the procedures:

   a) Soft-tissue curettage.

   b) Administration of local anesthesia.

   c) Administration of nitrous oxide and oxygen, whether administered alone or in combination with each other. (BPC § 1909)

3) Provides for the licensure of RDHAPs, who must meet the same requirements as RDHs in addition to either meeting minimum experience and higher education requirements, or possessing a letter of acceptance into the employment utilization phase of the Health Workforce Pilot Project. Requires a RDHAP to provide the Dental Hygiene Board documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services. (BPC §§ 1922 and 1930)

4) Authorizes an RDHAP, in only limited settings including residences of the homebound; schools; residential facilities and other institutions; and, dental health professional shortage areas (DHPSA), as certified by the Department of Health Care Access and Information (HCAI) to:

   a) Perform functions that may be performed by a registered dental assistant

b) Provide assessment and development, planning, and implementation of a dental hygiene care plan, including oral health education, counseling, and health screenings

c) Perform preventive and therapeutic interventions, including oral prophylaxis, scaling, and root planing.

d) Apply topical, therapeutic, and subgingival agents used for the control of caries and periodontal disease. (BPC § 1926)

5) Enacts the Medical Practice Act, which provides for the licensure and regulation of physicians and surgeons. (BPC) §§ 2000 *et seq.*)

6) Enacts the Osteopathic Act, which provides for the licensure and regulation of osteopathic physicians and surgeons who possess effectively the same practice privileges and prescription authority as those regulated by the MBC. (BPC §§ 2450 *et seq.*)

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

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

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

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

11) Establishes the Board of Registered Nursing (BRN) to provide for the licensure and regulation of the practice of nursing and authorizes the BRN to issue a certificate to practice as a NP. (Business and Professions Code (BPC) §§ 2700 et seq.)

12) Defines an advanced practice registered nurse, as those licensed RNs who have met specified requirements for registration as Nurse Practitioners, Nurse Anesthetists, Nurse Midwives, and Clinical Nurse Specialists, as specified. (BPC § 2725.5)

13) Authorizes an independently practicing NP to perform specified functions in a defined healthcare setting if the NP 1) has successfully passed a national NP-board certification examination; 2) holds a certificate from a national certifying body recognized by the BRN; 3) provides documentation that educational training was

consistent with standards established by the BRN and; 4) completed a transition to practice (TTP) program in California consisting of a minimum of three full-time equivalent years of practice or 4,600 hours. Authorizes an NP who meets these requirements to practice in an outpatient health facility, except for a correctional treatment center or a state hospital; a health facility including a general acute care hospital; a county hospital; a medical group practice, including a professional medical corporation, as specified, another form of corporation controlled by physicians, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that provide healthcare services; and a licensed hospice facility. (BPC §§ 2837.103, 2837.104)

14) Defines a TTP for purposes of NP independent practice to mean "additional clinical experience and mentorship provided to prepare a NP to practice independently, and includes, but is not limited to, managing a panel of patients, working in a complex healthcare setting, interpersonal communication, interpersonal collaboration and team-based care, professionalism and business management of a practice." (BPC § 2837.101(c))

15) Requires the BRN to define the minimum standards for TTP, and allows clinical experience to include experience obtained before January 1, 2021, if the experience meets the requirements established by the BRN. (BPC § 2837.101(c))

16) Establishes the Respiratory Care Board of California (RCP) to administer and enforce the Respiratory Care Practice Act until January 1, 2027. (Business and Professions Code (BPC) §§ 3700 and 3710)

17) Defines "respiratory care" as a health care profession performed under the supervision of a medical director in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions. (BPC § 3702)

18) Specifies various activities that are not prohibited by the Respiratory Care Practice Act, including a licensed LVN employed by a home health agency who has met certain training requirements performing RCB-specified respiratory services. (BPC § 3765 (i))

19) Establishes the Board of Vocational Nursing to license and regulate licensed vocational nurses (LVNs) and psychiatric technicians and administer the Vocational Nursing Practice Act and the Psychiatric Technicians Law. (BPC) §§ 2840-2895.5 and §§ 4500-4548)

20) Establishes the Board of Barbering and Cosmetology (BBC), until January 1, 2027, responsible for administering the Barbering and Cosmetology Act and regulating specified practices through the licensure of barbers, cosmetologists, hairstylists, electrologists, manicurists, and estheticians and oversight of establishments. (Business and Professions Code § 7301 *et. seq.*)

21) Specifies that in order to become a licensed hairstylist, an applicant must be at least 17, complete 10th grade (or the equivalent of public school 10th grade), is not

subject to denial based on having been convicted of a crime within a certain time frame that is substantially related to the qualifications, functions, or duties of being a hairstylist, and has either completed a course in hairstyling from a BBC-approved school or practiced hairstyling, as defined, in another state for a specified period of time. (BPC § 7322)

This bill:

1) Specifies that if the DHPSA certification is removed, a RDHAP with an existing practice in the area may continue to provide dental hygiene services.

2) Clarifies that no person shall use the words "doctor" or "physician," the letters or prefix Dr., the initials M.D. or D.O., or any other terms or letters indicating or implying that the person is a physician and surgeon, physician, surgeon, or practitioner in a health care setting that would lead a reasonable patient to determine that person is a licensed M.D. or D.O.

3) Makes various changes to provisions in the Nursing Practice Act related to nurse practitioners, including:

   a) Specifying that clinical experience, for purposes of the TTP, shall not be limited to experience in a single category that a NP may practice in and include experience obtained before January 1, 2021, but does not include clinical experience obtained before a person is certified as a NP by BRN.

   b) Authorizes a NP who has been practicing for a minimum of three full-time equivalent years or 4,600 hours within the last 5 years, as of January 1, 2023, to be deemed to have satisfied the TTP.

   c) Requires proof of completion of a TTP to be provided to BRN on a form prescribed by BRN as an attestation from either a licensed physician and surgeon or a certified NP practicing independently as authorized by the Nursing Practice Act.

   d) Clarifies that a licensed physician and surgeon or a certified NP who attests to the completion of a TTP is not required to specialize in the same category as the applicant.

   e) Clarifies that a licensed physician and surgeon or a certified NP practicing who attests to the completion of a TTP is not required to verify competence, clinical expertise, or any other standards related to the practice of the applicant and is only required to attest to the completion of the TTP.

   f) Provides that a licensed physician and surgeon or a certified NP who attests to the completion of a TTP is not liable for any civil damages and is not subject to an administrative action, sanction, or penalty for attesting only to the completion of a TTP.

4) Clarifies that BRN shall not require a NP practicing independency as authorized by the Nursing Practice Act to tell a patient the individual has a right to see a physician and surgeon.

5) Clarifies that OPES does not need to assess the alignment of competencies tested in national NP examinations for national NP certification examinations discontinued before January 1, 2017.

6) Clarifies that LVNs who have met specified requirements may perform specified respiratory care services as identified by the Respiratory Care Board in specified settings and according to certain patient-specific training satisfactory to their employer.

7) Clarifies that BBC can only charge a hairstylist application and examination fee in an amount equal to BBC's actual costs for developing, purchasing, grading, and administering the examination. Limits a hairstylist's initial license to not more than $50.

8) Replaces gendered language in the Structural Pest Control Act and eliminates the option for SPCB licensees to take challenge examinations in lieu of completing continuing education requirements.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by Legislative Counsel.

COMMENTS:

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

2. **Registered Dental Hygienists in Alternative Practice.** The Dental Hygiene Board regulates three categories of dental professionals: Registered Dental Hygienists, Registered Dental Hygienists in Alternative Practice, and Registered Dental Hygienists with Extended Functions:

   - A RDH is a dental professional authorized to perform all duties assigned to dental assistants (DA) and registered dental assistants (RDA), and those additionally enumerated in statute and regulation, under the supervision of a licensed dentist.

   - A RDHAP may perform all the functions of a DA, RDA, and RDH under general supervision, and certain RDH duties independently, if prescribed by a dentist or physician and under other qualifying conditions.

   - A RDHEF may perform all the functions of a DA, RDA, and RDH under general supervision, and other procedures specified in regulation under the direct supervision of a dentist.

Broadly, the practice of dental hygiene includes dental hygiene assessment and development, planning, implementation of a dental hygiene care plan, health education, counseling, and health screenings.

Dental hygiene does not include diagnosis or comprehensive treatment planning, placing or removal of permanent restorations, surgery, prescribing medication, or administering anesthesia or conscious sedation.

As policymakers have explored opportunities to expand access to oral health care, it has continued to be argued that dental hygienists are underutilized and could play a larger role in delivering dental services to vulnerable communities. A report published by the Legislative Analyst's Office (LAO) in September 2018 recommended expanding RDHAP scope of practice as a solution for improving access to dental care, particularly for the developmentally disabled. Specifically, the LAO argued that "given the valuable role that RDHAPs can play in increasing access to dental care for consumers (particularly among those who are homebound or have anxiety about going to the dentist)," the Department of Health Care Services should work with stakeholders and the Legislature to propose statutory scope of practice changes for consideration.

Similar issues were discussed during the 2018 joint sunset review oversight of DHBC in 2018. At the time, the committees discussed "whether it would be in the best interest of public health and safety to expand the unsupervised hygiene practices of an RDH." The committees also considered whether limiting the areas in which RDHAPs are authorized to provide unsupervised dental hygiene services creates unnecessary barriers to practice in other dental health care settings.

Because RDHs and RDHAPs possess meaningful education and training and are already entrusted to perform a range of procedures with varying degrees of dentist supervision, access to dental care could be responsibly expanded by continuing to empowering these professionals to provide additional services in more settings and with less supervision.

The issue of barriers to practice have been longstanding for RDHs, and particularly RDHAPs who are trained and authorized to provide unsupervised dental hygiene services in specified limited practice settings, settings that most likely result in a vulnerable and challenging patient populations - children, individuals with limited access to healthcare (and therefore likely with more advanced oral health conditions), and patients with compromised mobility or other health concerns that impede their ability to get dental care in more traditional settings. If an RDHAP chooses to practice in more traditional settings, like a dentist office, clinic, or hospital, they must perform those same services under general supervision licensed as an RDH. This does not align with the statutory authority of an RDHAP to be employed by a dentist, community clinic, free clinic, surgical clinic, chronic dialysis clinic, rehabilitation clinic, alternative birth center, specialty care clinic, clinic owned and operated by a federally recognized Indian tribe or tribal organization, or various iterations of a public hospital. Essentially, an RDHAP may not practice in many of the same settings as his or her employer.

Currently, a RDHAP may establish a practice in a dental health professional shortage area, but once that shortage is deemed to no longer exist, the RDHAP must relocate his or her practice. AB 502 (Chau, Chapter 516, Statutes of 2015) originally contained provisions that would have allowed a RDHAP to continue practicing. This language was later removed, but not before the California Health Benefits Review Program (CHBRP) performed an independent, evidence-based analysis of the legislation. It determined that the services RDHAPs provide are largely effective in improving oral health and that "The reductions in administrative barriers associated with RDHAP practice may result in increasing numbers of RDHAP licensees. Thus, the long-term effects would likely increase access to dental health services and improve dental health for patient populations in RDHAP practice settings. Essentially, CHBRP stated that RDHAPs improve oral health where they practice, and if there were fewer barriers to expanded practice, more people would benefit from their care.

The Federal Trade Commission (FTC) commented on a similar situation in Georgia, in which the FTC was asked to weigh in on a bill proposing to relax supervision requirements on dental hygienists providing care in certain settings. In stating its support for the legislation, the FTC wrote, "Various authorities have concluded that direct supervision of dental hygienists is not necessary for them to provide preventive services safely. According to the National Governors Association, there is no clear evidence to support state dental boards' concerns about quality and safety, which boards sometimes raise to justify restrictions on hygienists' practicing without supervision in settings where dentists are not available. The Institute of Medicine has likewise concluded that restrictive scope of practice and supervision laws and regulations governing dental hygienists 'are often unrelated to competence, education and training, or the safety' of the services they provide. The IOM recommends that state legislatures increase access to basic oral health care by amending dental practice acts to allow allied dental professionals such as hygienists to work to the full extent of their education and training 'in a variety of settings under evidence-supported supervision levels[.]'" FTC also noted that relaxing supervision standards could improve access and improve cost-effective care, since hygienists generally cost less than dentists.

Further, any concern about dentist involvement should be obviated by the existing requirements that a RDHAP is required to have a dentist of record with whom he or she consults, and the requirement that a RDHAP patient receive a prescription from a dentist or physician to continue receiving services after a certain period of time.

One reason the RDHAP license category was created was to serve areas of the state where dental hygiene services are scarce. Licensees are wary of opening a dental hygiene practice with the risk that they could lose the business if the shortage area designation is lifted, however just by virtue of removing formal population based data, that does not imply that the needs of those same communities and areas will also go away. The designation can be removed if more providers are successful in treating patients in the DHPSA and in theory, additional oral health providers have opted to serve in the shortage area.

Concerns remain that prohibiting a RDHAP from continuing to offer their narrow safe and effective services without supervision, as they can when a DHPSA

designation is in place, once the designation is removed does not appear to benefit patients and the public. There is no change in the training, education, and skills the RDHAP receives and no adjustment to the fact that they still have to comply with scope of practice and standard of care laws – the only result of continued prohibition that these trained professionals serve patients once a designation is removed is further exacerbation of access to care challenges.

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

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

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

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

   In 2009, the American Medical Association (AMA) launched an initiative branded by the organization as the "Truth in Advertising campaign." According to the AMA, the

goal of the campaign is to address confusion among patients regarding the qualifications of health providers from whom they receive care. A survey published by the AMA in 2018 found that "only half of patients surveyed believe that it is easy to identify who is a physician—and who is not—by reading what services they offer, their title, and other licensing credentials in advertising and marketing materials." Following the publication of its survey results, the AMA embarked on a campaign to seek both national and state legislation to reserve various professional titles for licensed physicians and surgeons. A model bill, the "Health Care Professional Transparency Act," has been introduced and passed in a number of states. Generally, the legislation requires all health care professionals to clearly and accurately describe their license type in advertisements, during patient encounters, and on name tags, and reserves the use of certain titles.

4. **Nurse Practitioners.** A NP is a registered nurse (RN) who possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary health care. NPs are licensed/certified by the BRN.

   A NP has earned a postgraduate nursing degree, such as a Master's or Doctorate degree, and has obtained a certificate from a national certifying body or BRN-approved educational program. At the state level, the BRN sets the educational standards for NP certification and education program approval. NPs must also pass a national certifying examination. There are six categories of practice for NPs, as identified in Title 14, California Code of Regulations (CCR) § 1481, including: family/individual across the lifespan, adult-gerontology, primary care or acute care, neonatal, pediatrics, primary care or acute care, women's health/gender related, and psychiatric-mental health across the lifespan.

   In 2020, the Legislature passed, and the Governor signed, AB 890 (Wood, Chapter 256, Statutes of 2020) into law. The bill established a new regulatory framework for NPs to practice independent of physician supervision. AB 890 created a three-tiered framework for NPs who choose to practice independently in California depending on the healthcare setting where the NP will practice. Under the provisions of AB 890, NPs have the option to practice independently of physician supervision either in a defined health care setting, or outside of those settings (a private practice). NPs may also continue to operate under the current structure, which allows NPs to practice in any healthcare facility under established protocols and procedures with physician supervision.

   AB 890 set education and experience requirements for an NP to be eligible to practice independent of physician supervision. NPs who want to practice independently in a defined healthcare setting (hospitals clinics, correctional treatment centers, etc.), often referred to as "103 NPs" based on reference to the enabling statute, are required to pass a national NP board certification examination, obtain certification as a NP from an accredited national certifying body, and complete the TTP in California, of a minimum of three full-time equivalent years of practice or 4,600 hours. NPs who want to practice independently outside of a defined healthcare setting, often referred to as "104 NPs", are required to meet all of the above requirements and provide proof of practice for three-years, in addition to satisfying the TTP requirement.

Twenty-five states permit NPs to practice independent of physician supervision, and only ten of those states require a TTP, including California. Of those states that require the TTP, California requires NPs to complete the longest of 3-years or 4,600 hours. The next longest is in Delaware, which specifies two-years or 4,000 hours. The other eight states require anywhere between 1,040-2,000 hours, but no more than two years of a TTP.

While AB 890 provided the definition of a TTP, it also required that the BRN define the minimum standards of the TTP through regulations by January 1, 2023. The BRN NP Advisory Committee met a number of times throughout 2021 and 2022 and, in its work to make recommendations to BRN on all matters relating to NPs, including, but not limited to, education, appropriate standard of care, and disciplinary action against NPs by the BRN, also discussed the TTP and drafted regulations to further define how to implement AB 890 and ensure NPs can practice independently.

The BRN regulations further expanding on the TTP included requirements more stringent than AB 890 and which in some cases, do not include references that sync with current NP certification and the training and clinical experience of a NP. BRN regulations require the individual attesting to the completion of the TTP to "specialize in the same specialty area or category" as the NP. NP categories are determined by the population of patients served and are not directly comparable to physician specialty training in a specific system of the body. Further, there are not matches between physician specialty types and NP categories. Categories of NPs include:

- Family/individual across the lifespan;
- Adult-gerontology, primary care or acute care;
- Neonatal;
- Pediatrics, primary care or acute care;
- Women's health/gender-related;
- Psychiatric-Mental Health across the lifespan.

While some categories have a corresponding physician specialty, such as pediatrics, a "women's health" NP may have clinical experiences with a wide range of physician specialists and BRN regulations could leave those individuals without a physician to attest to their completion of the TTP.

The BRN regulations also narrowly define the TTP so that it must be completed in "direct patient care in the role of a [NP] in the category…in which the applicant seeks certification as a NP…". The Nursing Practice Act defines the TTP as:

> "additional clinical experience and mentorship provided to prepare a nurse practitioner to practice independently. 'Transition to practice' includes, but is not limited to, managing a panel of patients, working in a complex health care setting, interpersonal communication, interpersonal collaboration and team-based care, professionalism, and business management of a practice."

It is unclear how professionalism and business management of a practice are considered direct patient care, and it is unclear why a NP should be limited to complying with TTP requirements by learning business management of a practice in their specific practice category.

The BRN regulations were adopted in 2022 and effective at the beginning of 2023. BRN began accepting applications for 103 and 104 NPs in January 2023.

March data from BRN for 103 NP applications is below

Nurse Practitioner 103 Application Statistics 1/18/2023 – 3/15/2024	
Applications Approved	1603
Applications Pending	578
Applications Expired	0
Applications Withdrawn	2035
Total Applications Received	**4216**

208 of the 578 pending applications were awaiting confirmation of the NP's national certification while 379 of those were awaiting provider attestation of the applicant's completed TTP. 41 of these pending applications had other issues.

Withdrawn applications have occurred for a number of reasons as well. 455 applications have been withdrawn because the applicant is certified by a retired or legacy national certifying organization. 855 applications have been withdrawn due to issues with provider attestation. 531 applications have been withdrawn because the applicant submitted multiple applications. 194 applications have been withdrawn for other reasons such as the TTP hours not being completed in California, TTP hours were completed prior to the individual being certified as an NP in California, TTP hours were completed outside of the 5 year framework, and TTP hours were not completed only in the direct patient care role of the NP's national certification.

5. **Respiratory Care Services.** SB 1436 (Roth, Chapter 624, Statutes of 2022) resolved a serious and long-standing consumer safety issue regarding the safe practice of respiratory care in health care facilities by allowing the Board to identify the basic respiratory tasks and services that could be safely delivered by LVNs. SB 1436 also recognized that health care reimbursement and the health care delivery model that has evolved since the 1990s, made it unfeasible to employ an RCP, in addition to a nurse, in the home care setting and as such, an exemption for home health agencies was included in SB 1436.

   Since the passage of SB 1436, RCB has been made aware that there are other licensed "home and community based" facilities and patients in the same predicament: With only one or a few patients requiring respiratory services making it unfeasible to hire an RCP, there are fears of patients being re-institutionalized or losing access to daily living services. In response to this issue, RCP conducted extensive research to identify all the types of small facilities outside of acute care facilities, and services that provide respiratory care. RCB also reviewed several

additional facilities and independent providers who provide for transporting and/or overseeing care of patients during daily activities, such as an outing, attending school, or providing a few hours of relief for parents in homecare.

There is currently no legal path for LVNs to provide respiratory care services beyond basic care. Patients receiving home and community-based services often require advanced respiratory care. Respiratory care services are not "skilled nursing services." Respiratory patients are often the most vulnerable of the home and community-based patient population with an overwhelming majority of those patients reliant upon Medi-Cal reimbursement. The language in this bill authorizes LVNs, with specified training, to perform tasks beyond basic respiratory tasks in the home and community-based settings where it is unfeasible to employ a RCP, which in turn will establish a legal pathway for trained LVNs to provide more advanced respiratory care allowing patients to have the choice to remain at home or in a home and community-based setting..

6. **Barbering and Cosmetology Hairstylist License.** BBC is responsible for licensing and regulating barbers, cosmetologists, hairstylists, estheticians, electrologists, manicurists, apprentices and establishments. BBC is an autonomous regulatory entity supported by licensing fees, with full policy and enforcement authority over the practices of hair, skin and nail care, and electrolysis in the state. The Act provides exemptions for: those involved in the health care field who, within their own scope of practice, may perform particular procedures which would constitute the practice of barbering or cosmetology; commissioned officers in the military service, or their attendants, when engaged in the actual performance of their official duties; persons employed in the movie, television, theatrical, or radio business; persons selling or demonstrating certain products. BBC is one of the largest boards in the country, with over 615,000 licensees. Annually, BBC issues approximately 261,000 licenses (initial and renewal licenses). Each profession has its own scope of practice, entry-level requirements, and professional settings, with some overlap in areas.

   In 2021, SB 803 (Roth, Chapter 648, Statutes of 2021) continued the operations of the BBC until January 1, 2027 and made various technical changes, statutory improvements, and policy reforms to the Act based on the joint sunset review oversight of BBC by the Senate Committee on Business, Professions, and Economic Development and Assembly Committee on Business and Professions. At the time, BBC suggested creating a hairstylist and waxing license to allow practitioners to obtain fewer training hours and gain faster entry to the profession. Stemming from workshops held throughout 2018 during its statutorily mandated review of the current requirements to obtain licensure, BBC decided that a hairstylist-only license, like the cosmetology license but not including skin and nail care, should be pursued. SB 803 established a separate hairstylist license and outlined a specified practice of hairstyling that includes arranging, dressing, curling, cleansing, and shampooing, among other hair-specific beautification practices that utilize instruments or require chemical products to be applied.

7. **Structural Pest Control.** The sphere of the SPCB's mission and vision is under the leadership of a 7-member appointed Board and the executive officer who serves at the Board's leisure. The SPCB's mission is to protect the general welfare of

Californians and the environment by promoting outreach, education, and regulation of the structural pest management profession. The SPCB's vision is to strive to be the national regulatory and environmental leader of pest management for consumer protection. In achieving these priorities, the SPCB actively follows its core values: 1) accountability, 2) consumer protection, 3) service, 4) transparency, and 5) professionalism.

The Structural Pest Control Act requires that licensees fulfill CE requirements by completing industry-relevant courses to stay fluent with technology and accepted professional practices. Instead of completing CE courses, current law also provides an alternative option of taking and successfully completing an examination.

Currently, BPC sections 8593 and 8593.1 require the SPCB offer examinations to its licensees to take in lieu of completing their CE requirements. The SPCB and DCA's OPES determined the challenge examination format is not an adequate substitute for the learning and experience acquired through the continuing education process.

On March 6, 2017, the United States Environmental Protection Agency (U.S. EPA) revised the federal rule for certification and recertification of applicators of restricted use pesticides under the Code of Federal Regulations Part 171 (40 CFR 171). This affects SPCB's Field Representative and Operator license types. Specifically, part 171.303(b)(4)(iii) of 40 CFR requires that if recertification is based upon written examination, the State must ensure the examination evaluates whether the licensee demonstrates the level of competencies required by 40 CFR section 171.103.

Aligning the SPCB challenge examinations with these competency standards would require SPCB to engage OPES for examination development services, for seven additional examinations. In the past, SPCB staff and specialists developed and administered these examinations, in-house, for its seven license categories. However, for an examination to be defensible and operate as a valid alternative to completing continuing education courses, it would need to be frequently updated by expert consultants such as educators and pesticide manufacturers. Without such experts on staff, it has been determined that SPCB does not have the necessary resources to ensure these examinations are adequately developed and administered. Additionally, the cost for SPCB to contract with OPES to develop and continuously update the examinations is substantial, and not feasible or practical.

8. **Arguments in Support.** The California Association of Nurse Practitioners notes that examinations discontinued before January 1,2017, have been deemed "legacy" certifications by the BRN. Legacy certifications are certification exams that were developed for certain populations of patients under stringent criteria and then offered to NPs to sit for the exams. Over time, as providing care to wider populations was emphasized, the legacy certifications were sunset so that no future applicants could apply for the certification. For example, one national NP certification exam, the Adult Nurse Practitioner, was created in 1976 and the prevailing thinking at the time was that the term "adult" included the continuum of young adult to the older adult. However, as geriatric care became more emphasized as an important subset of the adult population, the Adult Nurse Practitioner certification was sunset and the Adult Gerontology Nurse Practitioner certification

replaced it. Those who held the "legacy" certification, such as the Adult Nurse Practitioner certification, and were still in good standing could continue to hold that legacy certification as a valid national nurse practitioner certification. The organization says that the BRN refusal to approve applications from these individuals hinders the goals of AB 890 by blocking access to care, rather than increasing access to care.

Supporters write that "California is the largest and most diverse state in the nation, yet we have a severe health care provider gap, particularly among primary care and behavioral health providers. More than 11 million Californians – one-quarter of the state's population – live in a federally designated Primary Care Health Professional Shortage Area, and two-thirds of them are people of color. NPs are critical to addressing these shortages – not only do they accept greater numbers of uninsured, Medi-Cal, and Medicare patients compared to physicians, but NPs are also more likely to work in rural and underserved communities." According to supporters, "implementation barriers have delayed the application process for NPs who are qualified and seeking to be recognized to work without physician supervision. To address the urgent health needs of our state in a sustainable and equitable manner, we must ensure NPs are able to close the provider gap. By providing clarifying guidance surrounding legacy certifications, SB 1451 will help streamline the application process and enable California's most experienced NPs to expand access to quality, affordable care."

According to the California Dental Hygienists' Association, "The legislature's goal is to increase access to oral healthcare in dental deserts. Therefore, it is essential amend the statute and allow APs to keep their practices open if the DHPSA designation is removed… This uncertainty in statute is impeding AP hygienists from investing in and opening dental hygiene practices in shortage areas. APs would be incentivized to invest in these shortage areas if the risk of losing their practice was removed.

The Respiratory Care Board of California notes that this bill "addresses the immediate need to ensure patients are not in jeopardy of having their lives severely disrupted by providing additional exemptions allowing LVNs with appropriate training to practice respiratory care in home and community-based settings where it is not feasible to employ a licensed RCP. The Board strongly supports SB 1451 which addresses an overarching goal to ensure consumers continue to have access to respiratory care in all settings, while minimizing the risks in the quality of respiratory care to meet consumer demands for their own and their loved one's quality of life."

9. **Arguments in Opposition.** The California Dental Association opposes "allowing RDHAPs to continue their independent brick-and-mortar practices outside of a DHPSA designation for several reasons. The purpose behind the RDHAP license category is to provide care to individuals who are physically unable to get themselves to a dental office, like school children and those who are homebound, or because there are no dental offices nearby… In many of the past legislative attempts, CDA has offered rebuffed bill amendments that would align with the impetus for the RDHAP licensure category, such as ensuring that 30% of an RDHAP's brick and mortar practice's patient base be in service of Medi-Cal Dental

patients in the unlikely scenario a DHPSA designation was removed. This requirement is consistent with dentists and physicians receiving student loan repayment and would ensure access to dental care for the state's most vulnerable populations."

10. **Policy Comments and Proposed Author's Amendments.**

Use of the term "Dr." and potential unintended consequences. Various health professional licensee practice acts authorize use of the term "Doctor" or "Dr." under specified circumstances and limitations. For example, an acupuncturist can use the term in connection with the practice of acupuncture if they possess an earned doctorate degree in specific disciplines and the title is related to the authorized practice of an acupuncturist. An optometrist can use the title as a prefix but must us the word "optometrist" as a suffix and only if they hold an Opt. D or O.D. diploma. A physical therapist and an occupational therapist who has received a doctoral degree can use the term if they also specify they are a physical therapist or occupational therapist. A naturopathic doctor is authorized to use the designation "Dr." if they also further identify themselves as a naturopathic doctor so long as they do not use any term that would indicate the practice of medicine other than naturopathic medicine. In order to ensure that licensed healthcare professionals authorized to utilize the title "Doctor" or "Dr.", according to the specified requirements and limitations for the use of that term in various Business and Professions Code practice acts, are not in violation of the Medical Practice Act due to the changes in this bill, the Author is proposing to amend the bill moving forward to clarify that licensees whose practice act authorizes limited use of the title are not prevented from continuing to do so.

RDHAP practice. In order to ensure access to quality dental care for vulnerable patients, the Author is proposing to amend the bill moving forward to facilitate better connection and collaboration between RDHAPs who continue to operate a practice in a dental shortage area and dentists who can increase comprehensive care opportunities to those patients.

SUPPORT AND OPPOSITION:

Support:

Bay Area Cancer Connections
Bay Area Council
California Access Coalition
California Association of Alcohol and Drug Program Executives, Inc
California Association of Nurse Anesthesiology
California Black Health Network
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Dental Hygienists' Association
California Hepatitis C Task Force
California Hospital Association
LeadingAge California

Liver Coalition
Looms for Lupus
Madera Community Hospital
Michelle's Place Cancer Resource Center
Patient Advocates United in San Diego County
Respiratory Care Board of California
SEIU California State Council
Sickle Cell Disease Foundation

Opposition:

California Dental Association

-- END --

AMENDED IN SENATE APRIL 17, 2024

SENATE BILL No. 1451

Introduced by Senator Ashby

February 16, 2024

An act to amend Sections 1926, *2054, 2837.101, 2837.103, 2837.104,* 2837.105, 3765, 7423, 8593, and 8593.1 of the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

SB 1451, as amended, Ashby. Professions and vocations.

(1) Existing law, the Dental Practice Act, establishes the Dental Hygiene Board of California to license and regulate dental hygienists. Existing law authorizes a registered dental hygienist in alternative practice to perform specified duties in dental health professional shortage areas, as certified by the Department of Health Care Access and Information, in accordance with specified guidelines.

This bill would authorize a registered dental hygienist in alternative practice with an existing practice in a dental health professional shortage area to continue to provide dental hygiene services if certification by the department is removed.

(2) Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensure and regulation of physicians and surgeons. Existing law makes it a misdemeanor for a person who is not licensed as a physician and surgeon under the act, except as specified, to use certain words, letters, and phrases or any other terms that imply that the person is authorized to practice medicine as a physician and surgeon.

This bill would add the initials "D.O." to the list of prohibited terms under that provision. The bill would also prohibit a person from using

the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D." or "D.O.," or any other terms or letters indicating or implying that the person is a physician and surgeon, physician, surgeon, or practitioner in a health care setting that would lead a reasonable patient to determine that the person is a licensed "M.D." or "D.O.". By expanding the scope of a crime, this bill would impose a state-mandated local program.

~~(2)~~

(3) Existing law, the Nursing Practice Act, provides for the licensure and certification of nurse practitioners by the Board of Registered Nursing. Existing law requires the Office of Professional Examination Services in the Department of Consumer Affairs, or an equivalent organization, to perform an occupational analysis of nurse practitioners performing specified functions, and requires the board and the office to assess the alignment of competencies tested in the national nurse practitioner certification examination with the occupational analysis.

This bill would make the provision requiring the assessment of the alignment of competencies inapplicable to a national nurse practitioner certification examination discontinued before January 1, 2017.

(4) Existing law establishes the Nurse Practitioner Advisory Committee to advise and give recommendations to the board on matters relating to Nurse Practitioners. Existing law requires the board, by regulation, to define minimum standards for transition to practice, as defined, and provides that clinical experience may include experience obtained before January 1, 2021, if the experience meets requirements established by the board.

This bill would specify that, for purposes of transition to practice, clinical experience shall not be limited to experience in a single category in which a nurse practitioner may practice, as specified, and would prohibit experience obtained before a person is certified as a nurse practitioner from being considered clinical experience for purposes of transition to practice requirements.

Existing law authorizes a nurse practitioner to perform specified functions without standardized procedures if the nurse practitioner satisfies certain requirements, including having completed a transition to practice in California of 3 full-time equivalent years of practice, or 4,600 hours.

This bill would deem a nurse practitioner who has been practicing as a nurse practitioner for 3 full-time equivalent years or 4,600 hours within the last 5 years, as of January 1, 2023, to have satisfied this

requirement. The bill would require proof of completion of a transition to practice to be provided to the board as an attestation from either a licensed physician and surgeon or a nurse practitioner. The bill would prohibit the board from requiring a nurse practitioner to tell a patient that the patient has a right to see a physician and surgeon, and would delete a provision requiring a nurse practitioner to use a certain phrase to inform Spanish language speakers that the nurse practitioner is not a physician and surgeon.

~~(3)~~

(5) Existing law, the Respiratory Care Practice Act, establishes the Respiratory Care Board of California to license and regulate the practice of respiratory care. Existing law authorizes a licensed vocational nurse who is employed by a home health agency to perform respiratory tasks and services identified by the board if, on or before January 1, 2025, the licensed vocational nurse has completed patient-specific training satisfactory to their employer, and, on and after January 1, 2025, the licensed vocational nurse has completed that training in accordance with guidelines promulgated by the Respiratory Care Board of California, in collaboration with the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

This bill would extend those dates to January 1, 2028. The bill, on and after January 1, 2028, would also authorize a licensed vocational nurse to perform respiratory care services identified by the board while practicing in certain settings identified in the bill if the license vocational nurse has completed patient-specific training satisfactory to their employer and holds a current and valid certification of competency for each respiratory task to be performed, as specified.

~~(4)~~

(6) Existing law, the Barbering and Cosmetology Act, establishes the State Board of Barbering and Cosmetology to license and regulate barbering and cosmetology, and establishes a hairstylist application and examination fee of $50 or a fee determined by the board, not to exceed the reasonable cost of developing, purchasing, grading, and administering the examination.

This bill would instead require the hairstylist application and examination fee to be the actual cost to the board for developing, purchasing, grading, and administering the examination, and would establish that an initial licensee fee for a hairstylist shall be not more than $50.

~~(5)~~

(7) Existing law establishes the Structural Pest Control Board in the Department of Consumer Affairs to license and regulate structural pest control operators, structural pest control field representatives, and structural pest control applicators. Existing law requires those licensees, as a condition of license renewal, to submit proof to the board that they have informed themselves of the developments in the field of pest control by completing continuing education courses or equivalent activity approved by the board, or taking and completing an examination given by the board, as specified.

This bill would delete the authorization for a licenseholder to take and complete an examination given by the board to satisfy that requirement.

(8) 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: ~~no~~ *yes*.

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

1 SECTION 1. Section 1926 of the Business and Professions
2 Code is amended to read:
3 1926. In addition to practices authorized in Section 1925, a
4 registered dental hygienist in alternative practice may perform the
5 duties authorized pursuant to subdivision (a) of Section 1907,
6 subdivision (a) of Section 1908, and subdivisions (a) and (b) of
7 Section 1910 in the following settings:
8 (a) Residences of the homebound.
9 (b) Schools.
10 (c) Residential facilities and other institutions and medical
11 settings that a residential facility patient has been transferred to
12 for outpatient services.
13 (d) Dental health professional shortage areas, as certified by the
14 Department of Health Care Access and Information in accordance
15 with existing office guidelines. If the dental health professional
16 shortage area certification is removed, a registered dental hygienist

in alternative practice with an existing practice in the area may continue to provide dental hygiene services.

(e) Dental offices.

SEC. 2. Section 2054 of the Business and Professions Code is amended to read:

2054. (a) Any person who uses in any sign, business card, or letterhead, or, in an advertisement, the words “doctor” or “physician,” the letters or prefix “Dr.,” the initials ~~“M.D.,”~~ *“M.D.” or “D.O.,”* or any other terms or letters indicating or implying that ~~he or she~~ *the person* is a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, or that ~~he or she~~ *the person* is entitled to practice hereunder, or who represents or holds ~~himself or herself~~ *themselves* out as a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, without having at the time of so doing a valid, unrevoked, and unsuspended certificate as a physician and surgeon under this chapter, is guilty of a misdemeanor. *No person shall use the words “doctor” or “physician,” the letters or prefix “Dr.,” the initials “M.D.” or “D.O.,” or any other terms or letters indicating or implying that the person is a physician and surgeon, physician, surgeon, or practitioner in a health care setting that would lead a reasonable patient to determine that person is a licensed “M.D.” or “D.O.”.*

(b) Notwithstanding subdivision (a), any of the following persons may use the words “doctor” or “physician,” the letters or prefix “Dr.,” or the initials ~~“M.D.”:~~ *“M.D.” or “D.O.”:*

(1) A graduate of a medical *or an osteopathic medical* school approved or recognized by the *medical or osteopathic medical* board while enrolled in a postgraduate training program approved by the board.

(2) A graduate of a medical *or an osteopathic medical* school who does not have a certificate as a physician and surgeon under this chapter if ~~he or she~~ *the individual* meets all of the following requirements:

(A) If issued a license to practice medicine in any jurisdiction, has not had that license revoked or suspended by that jurisdiction.

(B) Does not otherwise hold ~~himself or herself~~ *themselves* out as a physician and surgeon entitled to practice medicine in this state except to the extent authorized by this chapter.

(C) Does not engage in any of the acts prohibited by Section 2060.

(3) A person authorized to practice medicine under Section 2111 or 2113 subject to the limitations set forth in those sections.

SEC. 3. Section 2837.101 of the Business and Professions Code is amended to read:

2837.101. For purposes of this article, the following terms have the following meanings:

(a) “Committee” means the Nurse Practitioner Advisory Committee.

(b) “Standardized procedures” has the same meaning as that term is defined in Section 2725.

(c) “Transition to practice” means additional clinical experience and mentorship provided to prepare a nurse practitioner to practice independently. “Transition to practice” includes, but is not limited to, managing a panel of patients, working in a complex health care setting, interpersonal communication, interpersonal collaboration and team-based care, professionalism, and business management of a practice. The board shall, by regulation, define minimum standards for transition to practice. ~~Clinical experience may include experience obtained before January 1, 2021, if the experience meets the requirements established by the board.~~ *For purposes of the transition to practice:*

(1) Clinical experience shall not be limited to experience in a single category that a nurse practitioner may practice in pursuant to Section 2836.

(2) Clinical experience may include experience obtained before January 1, 2021, but clinical experience obtained before a person is certified by the board as a nurse practitioner shall not be included.

SEC. 4. Section 2837.103 of the Business and Professions Code is amended to read:

2837.103. (a) (1) Notwithstanding any other law, a nurse practitioner may perform the functions specified in subdivision (c) pursuant to that subdivision, in a setting or organization specified in paragraph (2) pursuant to that paragraph, if the nurse practitioner has successfully satisfied the following requirements:

(A) Passed a national nurse practitioner board certification examination and, if applicable, any supplemental examination

1 developed pursuant to paragraph (4) of subdivision (a) of Section
2 2837.105.
3 (B) Holds a certification as a nurse practitioner from a national
4 certifying body accredited by the National Commission for
5 Certifying Agencies or the American Board of Nursing Specialties
6 and recognized by the board.
7 (C) Provides documentation that educational training was
8 consistent with standards established by the board pursuant to
9 Section 2836 and any applicable regulations as they specifically
10 relate to requirements for clinical practice hours. Online educational
11 programs that do not include mandatory clinical hours shall not
12 meet this requirement.
13 (D) Has completed a transition to practice in California *or*
14 *another state* of a minimum of three full-time equivalent years of
15 practice or 4600 hours. *A nurse practitioner who has been*
16 *practicing as a nurse practitioner for a minimum of three full-time*
17 *equivalent years or 4,600 hours within the last 5 years, as of*
18 *January 1, 2023, may be deemed to have satisfied this requirement.*
19 *For purposes of this subparagraph:*
20 *(i) Proof of completion of a transition to practice shall be*
21 *provided to the board, on a form prescribed by the board, as an*
22 *attestation from either a licensed physician and surgeon, a certified*
23 *nurse practitioner practicing pursuant to this section, or a certified*
24 *nurse practitioner practicing pursuant to Section 2837.104.*
25 *(ii) A licensed physician and surgeon or a certified nurse*
26 *practitioner who attests to the completion of a transition to practice*
27 *is not required to specialize in the same category as the applicant*
28 *pursuant to Section 2836.*
29 *(iii) A licensed physician and surgeon or a certified nurse*
30 *practitioner practicing pursuant to this section or Section 2837.104*
31 *who attests to the completion of a transition to practice is not*
32 *required to verify competence, clinical expertise, or any other*
33 *standards related to the practice of the applicant and shall only*
34 *attest to the completion of the transition to practice, as defined in*
35 *Section 2837.101.*
36 *(iv) A licensed physician and surgeon or a certified nurse*
37 *practitioner practicing pursuant to this section or Section 2837.104*
38 *who attests to the completion of a transition to practice shall not*
39 *be liable for any civil damages and shall not be subject to an*

1 *administrative action, sanction, or penalty for attesting only to the*
2 *completion of a transition to practice.*
3 (2) A nurse practitioner who meets all of the requirements of
4 paragraph (1) may practice, including, but not limited to,
5 performing the functions authorized pursuant to subdivision (c),
6 in one of the following settings or organizations in which one or
7 more physicians and surgeons practice with the nurse practitioner
8 without standardized procedures:
9 (A) A clinic, as defined in Section 1200 of the Health and Safety
10 Code.
11 (B) A health facility, as defined in Section 1250 of the Health
12 and Safety Code, except for the following:
13 (i) A correctional treatment center, as defined in paragraph (1)
14 of subdivision (j) of Section 1250 of the Health and Safety Code.
15 (ii) A state hospital, as defined in Section 4100 of the Welfare
16 and Institutions Code.
17 (C) A facility described in Chapter 2.5 (commencing with
18 Section 1440) of Division 2 of the Health and Safety Code.
19 (D) A medical group practice, including a professional medical
20 corporation, as defined in Section 2406, another form of
21 corporation controlled by physicians and surgeons, a medical
22 partnership, a medical foundation exempt from licensure, or another
23 lawfully organized group of physicians and surgeons that provides
24 health care services.
25 (E) A home health agency, as defined in Section 1727 of the
26 Health and Safety Code.
27 (F) A hospice facility licensed pursuant to Chapter 8.5
28 (commencing with Section 1745) of Division 2 of the Health and
29 Safety Code.
30 (3) In health care agencies that have governing bodies, as
31 defined in Division 5 of Title 22 of the California Code of
32 Regulations, including, but not limited to, Sections 70701 and
33 70703 of Title 22 of the California Code of Regulations, the
34 following apply:
35 (A) A nurse practitioner shall adhere to all applicable bylaws.
36 (B) A nurse practitioner shall be eligible to serve on medical
37 staff and hospital committees.
38 (C) A nurse practitioner shall be eligible to attend meetings of
39 the department to which the nurse practitioner is assigned. A nurse
40 practitioner shall not vote at department, division, or other meetings

1 unless the vote is regarding the determination of nurse practitioner
2 privileges with the organization, peer review of nurse practitioner
3 clinical practice, whether a licensee's employment is in the best
4 interest of the communities served by a hospital pursuant to Section
5 2401, or the vote is otherwise allowed by the applicable bylaws.
6 (b) An entity described in subparagraphs (A) to (F), inclusive,
7 of paragraph (2) of subdivision (a) shall not interfere with, control,
8 or otherwise direct the professional judgment of a nurse practitioner
9 functioning pursuant to this section in a manner prohibited by
10 Section 2400 or any other law.
11 (c) In addition to any other practices authorized by law, a nurse
12 practitioner who meets the requirements of paragraph (1) of
13 subdivision (a) may perform the following functions without
14 standardized procedures in accordance with their education and
15 training:
16 (1) Conduct an advanced assessment.
17 (2) (A) Order, perform, and interpret diagnostic procedures.
18 (B) For radiologic procedures, a nurse practitioner can order
19 diagnostic procedures and utilize the findings or results in treating
20 the patient. A nurse practitioner may perform or interpret clinical
21 laboratory procedures that they are permitted to perform under
22 Section 1206 and under the federal Clinical Laboratory
23 Improvement Act (CLIA).
24 (3) Establish primary and differential diagnoses.
25 (4) Prescribe, order, administer, dispense, procure, and furnish
26 therapeutic measures, including, but not limited to, the following:
27 (A) Diagnose, prescribe, and institute therapy or referrals of
28 patients to health care agencies, health care providers, and
29 community resources.
30 (B) Prescribe, administer, dispense, and furnish pharmacological
31 agents, including over-the-counter, legend, and controlled
32 substances.
33 (C) Plan and initiate a therapeutic regimen that includes ordering
34 and prescribing nonpharmacological interventions, including, but
35 not limited to, durable medical equipment, medical devices,
36 nutrition, blood and blood products, and diagnostic and supportive
37 services, including, but not limited to, home health care, hospice,
38 and physical and occupational therapy.
39 (5) After performing a physical examination, certify disability
40 pursuant to Section 2708 of the Unemployment Insurance Code.

(6) Delegate tasks to a medical assistant pursuant to Sections 1206.5, 2069, 2070, and 2071, and Article 2 (commencing with Section 1366) of Chapter 3 of Division 13 of Title 16 of the California Code of Regulations.

(d) A nurse practitioner shall ~~verbally~~ inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. ~~For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase "enfermera especializada."~~

(e) A nurse practitioner shall not be required to tell a patient the patient has a right to see a physician and surgeon.

~~(e)~~

(f) A nurse practitioner shall post a notice in a conspicuous location accessible to public view that the nurse practitioner is regulated by the Board of Registered Nursing. The notice shall include the board's telephone number and the internet website where the nurse practitioner's license may be checked and complaints against the nurse practitioner may be made.

~~(f)~~

(g) A nurse practitioner shall refer a patient to a physician and surgeon or other licensed health care provider if a situation or condition of a patient is beyond the scope of the education and training of the nurse practitioner.

~~(g)~~

(h) A nurse practitioner practicing under this section shall have professional liability insurance appropriate for the practice setting.

~~(h)~~

(i) Any health care setting operated by the Department of Corrections and Rehabilitation is exempt from this section.

SEC. 5. Section 2837.104 of the Business and Professions Code is amended to read:

2837.104. (a) Beginning January 1, 2023, notwithstanding any other law, the following apply to a nurse practitioner who holds an active certification issued by the board pursuant to subdivision (b):

(1) The nurse practitioner may perform the functions specified in subdivision (c) of Section 2837.103 pursuant to that subdivision outside of the settings or organizations specified under subparagraphs (A) to (F), inclusive, of paragraph (2) of subdivision (a) of Section 2837.103.

1 (2) Subject to subdivision (f) and any applicable conflict of
2 interest policies of the bylaws, the nurse practitioner shall be
3 eligible for membership of an organized medical staff.
4 (3) Subject to subdivision (f) and any applicable conflict of
5 interest policies of the bylaws, a nurse practitioner member may
6 vote at meetings of the department to which nurse practitioners
7 are assigned.
8 (b) The board shall issue a certificate to perform the functions
9 specified in subdivision (c) of Section 2837.103 pursuant to that
10 subdivision outside of the settings and organizations specified
11 under subparagraphs (A) to (F), inclusive, of paragraph (2) of
12 subdivision (a) of Section 2837.103, if the nurse practitioner
13 satisfies all of the following requirements:
14 (1) Meets all of the requirements specified in paragraph (1) of
15 subdivision (a) of Section 2837.103.
16 (2) Holds a valid and active license as a registered nurse in
17 California and a master's degree in nursing or in a clinical field
18 related to nursing or a doctoral degree in nursing.
19 (3) Has practiced as a nurse practitioner in good standing for at
20 least three years, not inclusive of the transition to practice required
21 pursuant to subparagraph (D) of paragraph (1) of subdivision (a)
22 of Section 2837.103. The board may, at its discretion, lower this
23 requirement for a nurse practitioner holding a Doctorate of Nursing
24 Practice degree (DNP) based on practice experience gained in the
25 course of doctoral education experience.
26 (c) A nurse practitioner authorized to practice pursuant to this
27 section shall comply with all of the following:
28 (1) The nurse practitioner, consistent with applicable standards
29 of care, shall not practice beyond the scope of their clinical and
30 professional education and training, including specific areas of
31 concentration and shall only practice within the limits of their
32 knowledge and experience and national certification.
33 (2) The nurse practitioner shall consult and collaborate with
34 other healing arts providers based on the clinical condition of the
35 patient to whom health care is provided. Physician consultation
36 shall be obtained as specified in the individual protocols and under
37 the following circumstances:
38 (A) Emergent conditions requiring prompt medical intervention
39 after initial stabilizing care has been started.

1 (B) Problem which is not resolving as anticipated after an
2 ongoing evaluation and management of the situation.
3 (C) History, physical, or lab findings inconsistent with the
4 clinical perspective.
5 (D) Upon request of patient.
6 (3) Nurse practitioner consultation with a physician and surgeon
7 alone shall not create a physician-patient relationship. The nurse
8 practitioner shall be solely responsible for the services they provide.
9 (4) The nurse practitioner shall establish a plan for referral of
10 complex medical cases and emergencies to a physician and surgeon
11 or other appropriate healing arts providers. The nurse practitioner
12 shall have an identified referral plan specific to the practice area,
13 that includes specific referral criteria. The referral plan shall
14 address the following:
15 (A) Whenever situations arise which go beyond the competence,
16 scope of practice, or experience of the nurse practitioner.
17 (B) Whenever patient conditions fail to respond or the patient
18 is acutely decompensating in a manner that is not consistent with
19 the progression of the disease and corresponding treatment plan.
20 (C) Any patient with a rare condition.
21 (D) Any patient conditions that do not fit the commonly accepted
22 diagnostic pattern for a disease or disorder.
23 (E) All emergency situations after initial stabilizing care has
24 been started.
25 (d) A nurse practitioner shall ~~verbally~~ inform all new patients
26 in a language understandable to the patient that a nurse practitioner
27 is not a physician and surgeon. ~~For purposes of Spanish language~~
28 ~~speakers, the nurse practitioner shall use the standardized phrase~~
29 ~~"enfermera especializada."~~
30 *(e) A nurse practitioner shall not be required by the board to*
31 *tell a patient that the patient has a right to see a physician and*
32 *surgeon.*
33 ~~(e)~~
34 *(f)* A nurse practitioner shall post a notice in a conspicuous
35 location accessible to public view that the nurse practitioner is
36 regulated by the Board of Registered Nursing. The notice shall
37 include the board's telephone number and internet website where
38 the nurse practitioner's license may be checked and complaints
39 against the nurse practitioner may be made.
40 ~~(f)~~

1 *(g)* A nurse practitioner practicing pursuant to this section shall
2 maintain professional liability insurance appropriate for the practice
3 setting.
4 ~~(g)~~
5 *(h)* For purposes of this section, corporations and other artificial
6 legal entities shall have no professional rights, privileges, or
7 powers.
8 ~~(h)~~
9 *(i)* Subdivision ~~(g)~~ *(h)* shall not apply to a nurse practitioner if
10 either of the following apply:
11 (1) The certificate issued pursuant to this section is inactive,
12 surrendered, revoked, or otherwise restricted by the board.
13 (2) The nurse practitioner is employed pursuant to the
14 exemptions under Section 2401.
15 ~~SEC. 2.~~
16 *SEC. 6.* Section 2837.105 of the Business and Professions Code
17 is amended to read:
18 2837.105. (a) (1) The board shall request the department's
19 Office of Professional Examination Services, or an equivalent
20 organization, to perform an occupational analysis of nurse
21 practitioners performing the functions specified in subdivision (c)
22 of Section 2837.103 pursuant to that subdivision.
23 (2) The board, together with the Office of Professional
24 Examination Services, shall assess the alignment of the
25 competencies tested in the national nurse practitioner certification
26 examination required by subparagraph (A) of paragraph (1) of
27 subdivision (a) of Section 2837.103 with the occupational analysis
28 performed according to paragraph (1). This paragraph shall not
29 apply to a national nurse practitioner certification examination
30 discontinued before January 1, 2017.
31 (3) The occupational analysis shall be completed by January 1,
32 2023.
33 (4) If the assessment performed according to paragraph (2)
34 identifies additional competencies necessary to perform the
35 functions specified in subdivision (c) of Section 2837.103 pursuant
36 to that subdivision that are not sufficiently validated by the national
37 nurse practitioner board certification examination required by
38 subparagraph (A) of paragraph (1) of subdivision (a) of Section
39 2837.103, the board shall identify and develop a supplemental
40 exam that properly validates identified competencies.

1 (b) The examination process shall be regularly reviewed
2 pursuant to Section 139.
3 ~~SEC. 3.~~
4 *SEC. 7.* Section 3765 of the Business and Professions Code is
5 amended to read:
6 3765. This act does not prohibit any of the following activities:
7 (a) The performance of respiratory care that is an integral part
8 of the program of study by students enrolled in approved
9 respiratory therapy training programs.
10 (b) Self-care by the patient or the gratuitous care by a friend or
11 member of the family who does not represent or hold themselves
12 out to be a respiratory care practitioner licensed under the
13 provisions of this chapter.
14 (c) The respiratory care practitioner from performing advances
15 in the art and techniques of respiratory care learned through formal
16 or specialized training.
17 (d) The performance of respiratory care in an emergency
18 situation by paramedical personnel who have been formally trained
19 in these modalities and are duly licensed under the provisions of
20 an act pertaining to their specialty.
21 (e) Temporary performance, by other health care personnel,
22 students, or groups, of respiratory care services, as identified and
23 authorized by the board, in the event of an epidemic, pandemic,
24 public disaster, or emergency.
25 (f) Persons from engaging in cardiopulmonary research.
26 (g) Formally trained licensees and staff of child day care
27 facilities from administering to a child inhaled medication as
28 defined in Section 1596.798 of the Health and Safety Code.
29 (h) The performance by a person employed by a home medical
30 device retail facility or by a home health agency licensed by the
31 State Department of Public Health of specific, limited, and basic
32 respiratory care or respiratory care related services that have been
33 authorized by the board.
34 (i) The performance, by a vocational nurse licensed by the Board
35 of Vocational Nursing and Psychiatric Technicians of the State of
36 California who is employed by a home health agency licensed by
37 the State Department of Public Health, of respiratory tasks and
38 services identified by the board, if the licensed vocational nurse
39 complies with the following:

1 (1) Before January 1, 2028, the licensed vocational nurse has
2 completed patient-specific training satisfactory to their employer.
3 (2) On or after January 1, 2028, the licensed vocational nurse
4 has completed patient-specific training by the employer in
5 accordance with guidelines that shall be promulgated by the board
6 no later than January 1, 2028, in collaboration with the Board of
7 Vocational Nursing and Psychiatric Technicians of the State of
8 California.
9 (j) The performance of respiratory care services identified by
10 the board by a licensed vocational nurse who satisfies the
11 requirements in paragraph (1) in the settings listed in paragraph
12 (2).
13 (1) (A) The licensed vocational nurse is licensed pursuant to
14 Chapter 6.5 (commencing with Section 2840).
15 (B) The licensed vocational nurse has completed patient-specific
16 training satisfactory to their employer.
17 (C) The licensed vocational nurse holds a current and valid
18 certification of competency for each respiratory task to be
19 performed from the California Association of Medical Product
20 Suppliers, the California Society for Respiratory Care, or another
21 organization identified by the board.
22 (2) A licensed vocational nurse may perform the respiratory
23 care services identified by the board pursuant to this subdivision
24 in the following settings:
25 (A) At a congregate living health facility licensed by the State
26 Department of Public Health that is designated as six beds or fewer.
27 (B) At an intermediate care facility licensed by the State
28 Department of Public Health that is designated as six beds or fewer.
29 (C) At an adult day health care center licensed by the State
30 Department of Public Health.
31 (D) As an employee of a home health agency licensed by the
32 State Department of Public Health or an individual nurse provider
33 working in a residential home.
34 (E) At a pediatric day health and respite care facility licensed
35 by the State Department of Public Health.
36 (F) At a small family home licensed by the Department of Social
37 Services that is designated as six beds or fewer.
38 (G) As a private duty nurse as part of daily transportation and
39 activities outside a patient's residence or family respite for home-
40 and community-based patients.

1 (3) This subdivision is operative on January 1, 2028.
2 (k) The performance of pulmonary function testing by persons
3 who are currently employed by Los Angeles County hospitals and
4 have performed pulmonary function testing for at least 15 years.
5 ~~SEC. 4.~~
6 *SEC. 8.* Section 7423 of the Business and Professions Code is
7 amended to read:
8 7423. The amounts of the fees required by this chapter relating
9 to licenses for individual practitioners are as follows:
10 (a) (1) Cosmetologist application and examination fee shall be
11 the actual cost to the board for developing, purchasing, grading,
12 and administering the examination.
13 (2) A cosmetologist initial license fee shall not be more than
14 fifty dollars ($50).
15 (b) (1) An esthetician application and examination fee shall be
16 the actual cost to the board for developing, purchasing, grading,
17 and administering the examination.
18 (2) An esthetician initial license fee shall not be more than forty
19 dollars ($40).
20 (c) (1) A manicurist application and examination fee shall be
21 the actual cost to the board for developing, purchasing, grading,
22 and administering the examination.
23 (2) A manicurist initial license fee shall not be more than
24 thirty-five dollars ($35).
25 (d) (1) A barber application and examination fee shall be the
26 actual cost to the board for developing, purchasing, grading, and
27 administering the examination.
28 (2) A barber initial license fee shall be not more than fifty dollars
29 ($50).
30 (e) (1) An electrologist application and examination fee shall
31 be the actual cost to the board for developing, purchasing, grading,
32 and administering the examination.
33 (2) An electrologist initial license fee shall be not more than
34 fifty dollars ($50).
35 (f) An apprentice application and license fee shall be not more
36 than twenty-five dollars ($25).
37 (g) The license renewal fee for individual practitioner licenses
38 that are subject to renewal shall be not more than fifty dollars
39 ($50).

1 (h) A hairstylist application and examination fee shall be the
2 actual cost to the board for developing, purchasing, grading, and
3 administering the examination.
4 (i) A hairstylist's initial license fee shall be no more than fifty
5 dollars ($50).
6 (j) Notwithstanding Section 163.5 the license renewal
7 delinquency fee shall be 50 percent of the renewal fee in effect on
8 the date of renewal.
9 ~~SEC. 5.~~
10 *SEC. 9.* Section 8593 of the Business and Professions Code is
11 amended to read:
12 8593. (a) The board shall require as a condition to the renewal
13 of each operator's and field representative's license that the holder
14 submit proof satisfactory to the board that they have informed
15 themselves of developments in the field of pest control either by
16 completion of courses of continuing education in pest control
17 approved by the board or equivalent activity approved by the board.
18 (b) The board shall develop a correspondence course or courses
19 with any educational institution or institutions as it deems
20 appropriate. This course may be used to fulfill the requirements
21 of this section. The institution may charge a reasonable fee for
22 each course.
23 ~~SEC. 6.~~
24 *SEC. 10.* Section 8593.1 of the Business and Professions Code
25 is amended to read:
26 8593.1. The board shall require as a condition to the renewal
27 of each applicator's license that the holder thereof submit proof
28 satisfactory to the board that they have completed courses of
29 continuing education in pesticide application and use approved by
30 the board or equivalent activity approved by the board.
31 *SEC. 11. No reimbursement is required by this act pursuant*
32 *to Section 6 of Article XIII B of the California Constitution because*
33 *the only costs that may be incurred by a local agency or school*
34 *district will be incurred because this act creates a new crime or*
35 *infraction, eliminates a crime or infraction, or changes the penalty*
36 *for a crime or infraction, within the meaning of Section 17556 of*
37 *the Government Code, or changes the definition of a crime within*

1 *the meaning of Section 6 of Article XIII B of the California*
2 *Constitution.*

O

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

Status: Amended 5/17/2024 / Senate Second Reading File

AUTHOR REASON FOR THE BILL

According to the author, SB 1468 seeks to address the need for increased education and engagement amongst providers around how to confidently manage patients with opioid use disorder. Reports have shown that providers have not been enforcing the new DEA rule because of a lack of comfortability.

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, and the Board of Registered Nursing to develop and annually disseminate via the email address on file for each licensee informational and educational material regarding the “Three Day Rule,” and would require the Medical Board of California to also annually disseminate the material it develops to each acute care hospital in the state. The bill would also require the informational and educational material to be posted on each board’s website.

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 were 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 annually via the email address on file. The Board would also be required to post the information on its website.

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.

CSBO is not authorized by law to require applicants and licensees to supply email addresses to communicate with the Board. The Board therefore does not have email addresses for every licensee. The Board has a List Serv that it would utilize to distribute the material and it would post the material on its website and also distribute it via social media.

FISCAL

The Department of Consumer Affairs fiscal notes that boards are not required to collect email or other electronic messaging information from their licensees. To effectively implement the requirements of this bill, boards would need to mail the information directly to their licensees' addresses on record. Annual costs for printing and postage is estimated to be $774,000 based on an estimate of 300,000 total licensees across all impacted boards, to be reimbursed by the boards as follows:

Board	**Estimated impacted Licensees**	**Total Annual**	**Absorbable Yes/No**
Board of Pharmacy	62,298	$161,000	No

Dental Board	33,487	$86,000	No
Medical Board	119,558	$308,000	No
Physician Assistant	14,294	$37,000	No
Podiatric Medicine Board	1,829	$5,000	No
State Board of Optometry	6,968	$18,000	No
Osteopathic Medical Board	9,621	$25,000	No
Naturopathic Medical Board	823	$2,000	No
Board of Registered Nursing	29,665	$77,000	Yes
Veterinary Medical Board	12,199	$31,000	No

However, the May 17, 2024, amendments likely mitigate these fiscal impacts since the material must now be sent electronically instead of through the physical mail.

COMMITTEE RECOMMENDATION

Continue to watch and research the bill.

Suggested Motion or Update

I move to support this bill.

Attachment 1: Senate Committee on Business, Professions, and Economic Development Analysis

Attachment 2: Senate Appropriations Committee Analysis

Attachment 3: Bill text

SENATE COMMITTEE ON
BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
Senator Angelique Ashby, Chair
2023 - 2024 Regular

Bill No:	SB 1468	**Hearing Date:**	April 8, 2024
Author:	Ochoa Bogh and Roth		
Version:	March 20, 2024		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Sarah Mason		

Subject: Healing arts boards: informational and educational materials for prescribers of narcotics: federal "Three Day Rule."

SUMMARY: Requires each health professional licensing board that licenses a prescriber to develop informational and educational material regarding the federal Drug Enforcement Administration's (DEA) "Three Day Rule" in order to ensure prescriber awareness of existing medication-assisted treatment pathways to serve patients with substance use disorder

Existing law:

1) Establishes various practice acts in the Business and Professions Code (BPC) governed by various boards within the Department of Consumer Affairs (DCA) which provide for the licensing and regulation of health care professionals including: physicians and surgeons (under the Medical Practice Act), dentists (under the Dental Practice Act), veterinarians (under the Veterinary Medicine Practice Act); registered nurses, nurse practitioners (NP) and certified nurse-midwives (CNM) (under the Nursing Practice Act); physician assistants (PA) (under the Physician Assistant Practice Act); osteopathic physicians and surgeons (under the Osteopathic Medical Practice Act); naturopathic doctors (ND) (under the Naturopathic Doctors Act); optometrists (under the Optometry Practice Act); doctors of podiatric medicine (under the Podiatric Act) and; pharmacies, pharmacists and wholesalers of dangerous drugs or devices (under the Pharmacy Law). (Business and Professions Code (BPC) §§ 500 *et seq.*)

2) Specifies certain requirements regarding the dispensing and furnishing of dangerous drugs and devices, and prohibits a person from furnishing any dangerous drug or device except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian or ND. (BPC § 4059)

3) Establishes continuing education (CE) and continuing medical education (CME) requirements for health care providers, including a course on the risks of addiction associated with the use of Schedule II drugs, and including but not limited to:

   a) Dentists must complete not less than 50 hours of approved CE during the two-year period immediately preceding the expiration of their license. (BPC § 1645)

b) Physicians and surgeons licensed by the Medical Board of California (MBC) must complete a one-time CME course of 12 hours in the subjects of pain management and the treatment of terminally ill and dying patients, among other requirements and other considerations MBC must make for required CME established through regulations. (BPC § 2190.5)

c) Osteopathic physicians and surgeons licensed by the Osteopathic Medical Board of California (OMBC) must complete a minimum of 100 hours of American Osteopathic Association CE hours during each two-year cycle. (BPC § 2454.5)

d) Certified nurse-midwives certified by the Board of Registered Nursing (BRN) who hold an active furnishing number, who are currently authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration (DEA) must provide documentation of CE specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the BRN. (BPC § 2746.51)

e) Nurse practitioners certified by the BRN who hold an active furnishing number, who are authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with DEA must complete a course including Schedule II controlled substances based on standards developed by BRN. (BPC § 2836.1)

f) Optometrists certified to use therapeutic pharmaceutical agents must complete a total of 50 hours of CE every two years in order to renew his or her certificate 35 of which must be on the diagnosis, treatment, and management of ocular disease, including pain medication. Requires the Board of Optometry to encourage every optometrist to take a course or courses in pharmacology and pharmaceuticals as part of his or her CE. (BPC § 3059)

g) Physician assistants licensed by the Physician Assistant Board (PAB) must complete no more than 50 hours of CE every two years. The PAB shall, as it deems appropriate, accept certification by the National Commission on Certification of Physician Assistants, or another qualified certifying body, as determined by the PAB, as evidence of compliance with CE requirements. (BPC § 3524.5)

4) Establishes the Uniform Controlled Substances Act which regulates controlled substances and defines an opiate as any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. (Health and Safety Code (HSC) § 11020)

5) Prohibits any person other than a physician, dentist, podiatrist, veterinarian, ND (according to certain supervision and protocol requirements), pharmacist (according to certain authorization and according to certain policies and procedures), CNM (if furnished or ordered incidentally to the provision of family planning services, routine health care or perinatal care, or care rendered consistent with the CNM's practice;

occurs under physician and surgeon supervision; and is in accordance with standardized procedures or protocols as specified), NP (if it is consistent with a NP's educational preparation or for which clinical competency has been established and maintained; occurs under physician and surgeon supervision; and is in accordance with standardized procedures or protocols as specified); a pharmacist or registered nurse or PA acting within the scope of an experimental health workforce project authorized by the Office of Statewide Health Planning and Development (HSC §§ 128125 *et seq.*); an optometrist licensed under the Optometry Practice Act, or an out-of-state prescriber acting in an emergency situation from writing or issuing a prescription for a controlled substance. (HSC § 11150)

6) States that a prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice, and that the responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. (HSC § 11153)

7) Requires a prescriber to offer a prescription for naloxone hydrochloride (NH) or another drug approved by the Food and Drug Administration (FDA) for the complete or partial reversal of opioid depression to a patient when one or more of the following circumstances are present:

   a) The prescription dosage is 90 or more morphine milligram equivalents of an opioid medication per day.

   b) An opioid medication is prescribed concurrently with a prescription for benzodiazepine.

   c) The patient presents with an increased risk for overdose, as specified. (BPC § 741(a))

8) Requires a prescriber to provide education on overdose prevention and the use of NH to patients, a minor's parent or guardian, and one or more persons designated by the patient, as specified. (BPC § 741(b-c))

This bill:

1) Requires each health professional licensing board that licenses a prescriber to 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. Authorizes the Department of Consumer Affairs and health professional licensing boards to consult with other state agencies as necessary to implement these provisions.

2) Requires MBC to disseminate the informational and educational material it develops to each acute care hospital in the state biannually.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by Legislative Counsel.

COMMENTS:

1. **Purpose.** The Author is the Sponsor of this bill. According to the Author, SB 1468 seeks to address is the need for increased education and engagement amongst providers around how to confidently manage patients with opioid use disorder. Reports have shown that providers have not been enforcing the new DEA rule because of a lack of comfortability.

2. **Background.**

   Opioids. Opioids are a class of drugs prescribed and administered by health professionals to manage pain. The term "opioid" is commonly used to describe both naturally occurring opiates derived from the opium poppy as well as their manufactured synthetics. Common examples of prescription opioids include oxycodone (OxyContin, Percocet); hydrocodone (Vicodin, Norco, Lorcet); codeine; and morphine. Heroin is also an opioid, but is ineligible for lawful prescription in the United States. In addition to providing pain relief, opioids can be used as a cough suppressant, an antidiarrheal, a method of sedation, and a treatment for shortness of breath.

   The majority of pharmaceutical opioids are Schedule II drugs under the federal Controlled Substances Act, considered by the DEA to have a high potential for abuse that may lead to severe psychological or physical dependence. However, combination drugs containing lower doses of opioids combined with other active ingredients are typically less restricted; for example, cough syrups containing low doses of codeine are frequently classified Schedule V medications.

   In October of 2017, the White House declared the opioid cr isis a national public health emergency, formally recognizing what had long been understood to be a growing epidemic responsible for devastation in communities across the country. According to the Centers for Disease Control and Prevention (CDC), as many as 50,000 Americans died of an opioid overdose in 2016, representing a 28 percent increase over the previous year. The California Department of Public Health estimated that nearly 2,000 Californians died of an opioid overdose in 2016.

   The nature of the country's opioid crisis has evolved over the past several years as illicitly manufactured fentanyl has replaced prescribed pain management medication as the dominant source of opioid-related overdoses. Fentanyl is a synthetic opioid that is up to 100 times stronger than morphine. Fentanyl is often pressed into pills to imitate more common (and less potent) pharmaceutical products, and other drugs can be unknowingly "laced" with fentanyl. Over 70,000 Americans died of a fentanyl overdose in 2021, including 5,961 deaths in California – approximately 83% of all opioid-related deaths in California.

The abuse of prescription drugs was historically viewed as a criminal concern analogous to street narcotics cases regularly investigated by law enforcement. In recent years, however, an expert consensus has evolved around the opinion that the opioid crisis must be addressed through the lens of public health policy. It is widely accepted that health professionals must continue to play a critical role in any meaningful solutions through safe-prescribing and the medication-assisted treatment of opioid use disorder.

Three-Day Rule. The Easy Medication Access and Treatment for Opioid Addiction Act was signed into federal law on December 11, 2020 as Public Law 116–215. One of the provisions of the Act directed DEA to revise 21 CFR 1306.07(b) "so that practitioners . . . are allowed to dispense not more than a three-day supply of narcotic drugs to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both)." On August 8, 2023, the DEA expanded and revised this regulation to allow non-physician practitioners to prescribe narcotic drugs under the "Three Day Rule."

SUPPORT AND OPPOSITION:

Support:

Smart Justice California

Opposition:

None received.

-- END --

SENATE COMMITTEE ON APPROPRIATIONS

Senator Anna Caballero, Chair
2023 - 2024 Regular Session

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

Version: March 20, 2024
Urgency: No
Hearing Date: May 16, 2024
Policy Vote: B., P. & E.D. 11 - 0
Mandate: No
Consultant: Janelle Miyashiro

Bill Summary: SB 1468 requires each health professional licensing board under the Department of Consumer Affairs (DCA) that licenses a prescriber to develop informational and educational material regarding the federal Drug Enforcement Administration’s (DEA) “Three Day Rule” in order to ensure prescriber awareness of existing medication-assisted treatment pathways to serve patients with substance use disorder.

*********** ANALYSIS ADDENDUM – SUSPENSE FILE ***********

The following information is revised to reflect amendments adopted by the committee on May 16, 2024

Fiscal Impact:

- Unknown, but potentially minor costs for impacted boards to disseminate the required information to their respective licensees electronically and post information on their internet websites (various special funds).

- Minor and absorbable costs to the Office of Information Services within DA.

Author Amendments: Specify that dissemination of informational and educational materials to licensees be done through electronic means and add a coauthor.

Committee Amendments: Add a coauthor.

-- END --

AMENDED IN SENATE MAY 17, 2024

AMENDED IN SENATE MARCH 20, 2024

SENATE BILL No. 1468

Introduced by Senators Ochoa Bogh and Roth
(Coauthors: Senators Becker and McGuire)

February 16, 2024

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

LEGISLATIVE COUNSEL'S DIGEST

SB 1468, as amended, Ochoa Bogh. 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~~ *annually* disseminate to each licensee informational and educational material regarding the "Three Day Rule," and *to post that material on their internet website. The bill* would require the Medical Board of California to also ~~biannually~~ *annually* disseminate the material it develops to each acute care hospital in the state.

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

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

SECTION 1. 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) *(1)* 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.~~ *disorder.*

(2) Each board shall annually disseminate the informational and educational material developed pursuant to paragraph (1) to each licensed prescriber’s email address on file with the board.

(3) Each board shall post the informational and educational material developed pursuant to paragraph (1) on their internet website.

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

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

O

J. SB 1485 (Gonzalez) Consumer complaints

Status: No longer moving forward.

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.

UPDATE
No long moving forward this year.

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

is made of the nature of the complaint and may request appropriate relief for the consumer.

(b) *(1)* The director shall also transmit any valid complaint to the local, ~~state~~ *state,* or federal agency whose authority provides the most effective means to secure the relief.

~~The~~

(2) The director shall, if appropriate, advise the consumer of the action taken on the complaint and of any other means ~~which~~ *that* may be available to the consumer to secure relief.

(c) If the director receives a complaint or receives information from any source indicating a probable violation of any law, rule, or order of any regulatory agency of the state, or if a pattern of complaints from consumers develops, the director shall transmit any complaint ~~he or she~~ *the director* considers to be valid to any appropriate law enforcement or regulatory agency and any evidence or information ~~he or she~~ *the director* may have concerning the probable violation or pattern of complaints or request the Attorney General to undertake appropriate legal action. It shall be the continuing duty of the director to discern patterns of complaints and to ascertain the nature and extent of action taken with respect to the probable violations or pattern of complaints.

O