California State Board of Optometry
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	February 16, 2024
TO	Board Members, California State Board of Optometry (CSBO)
FROM	Gregory Pruden, Executive Officer
SUBJECT	Agenda Item #8 – Update and Possible Discussion and Action on 2023-24 Legislation

Background and Update:
In 2023 the Board took positions on the following bills which are presented below: (click each bill number in the red text to link to page in PDF)

A. **AB 1028**

B. **AB 1570**

C. **SB 340**

The Legislature reconvened on January 3, 2024. New bills may be introduced until February 21, 2024, and staff is monitoring bill introductions for possible impacts to the Board. At this time, no new legislation has been identified with impacts to the Board.

For the benefit of new 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.

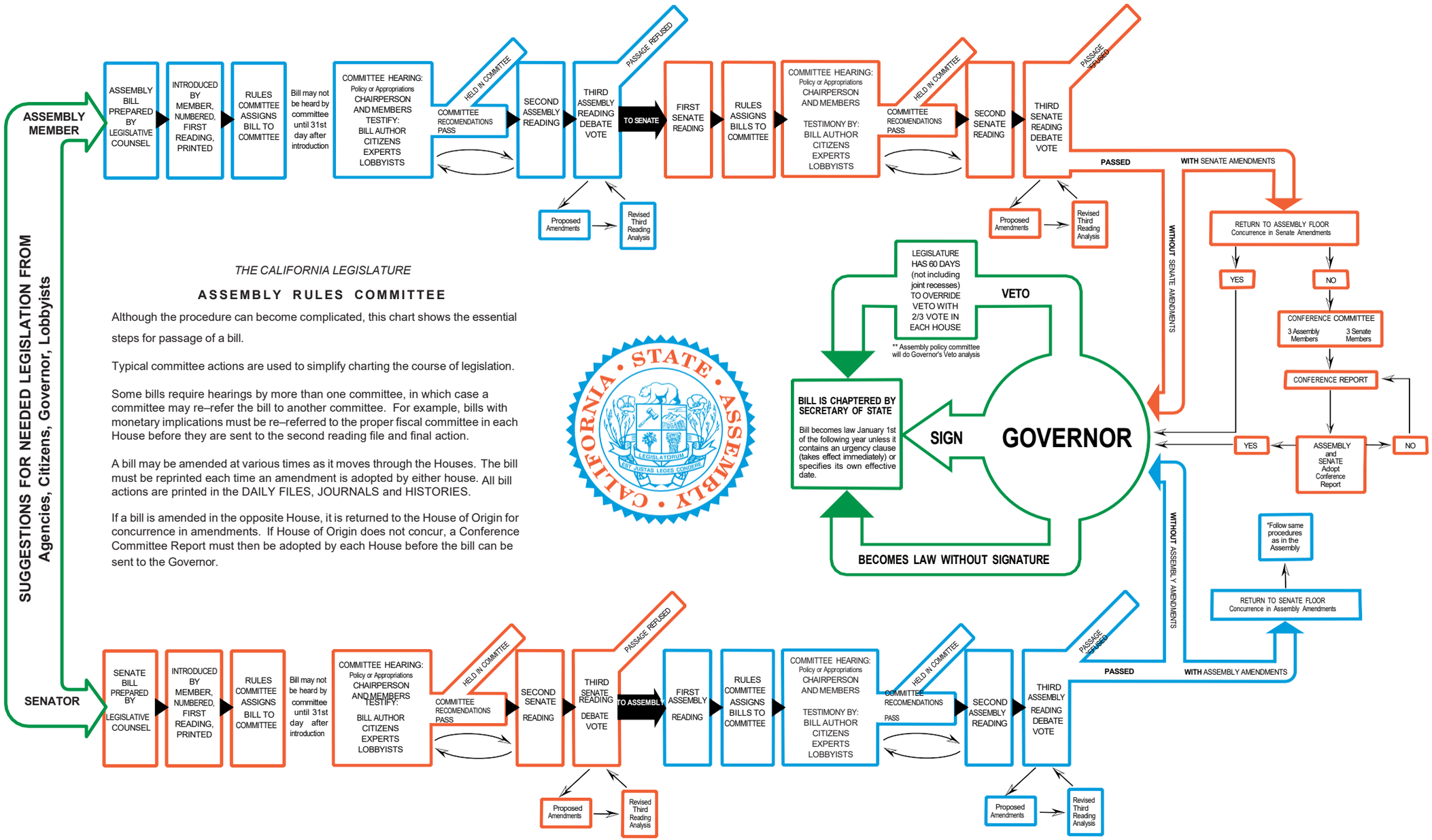
Possible positions include:

- **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



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.

AB 1028 (McKinnor) Reporting of crimes: mandated reporters

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

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

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

BACKGROUND:
This bill is a reintroduction of AB 2790 (Wicks), which was held in the Senate Appropriations Suspense File. Supporters argue existing mandating reporting law dissuades many victims from seeking medical care or sharing information with health practitioners to avoid law enforcement involvement. Opponents argue the bill would lead to more domestic violence and have serious consequences.

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

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

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

FISCAL:
None

BOARD POSITION:
Neutral.

Action Requested:

None.

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

SENATE COMMITTEE ON PUBLIC SAFETY

Senator Aisha Wahab, Chair
2023 - 2024 Regular

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

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

HISTORY

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

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

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

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

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

Assembly Floor Vote: 45 - 17

PURPOSE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This bill contains findings and declarations.

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

This bill makes conforming cross-references.

COMMENTS

1. Need for This Bill

According to the author:

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

2. Health Care worker: mandate reporters

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

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

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

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

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

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

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

3. Prior Legislation

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

4. Argument in Support

A number of organizations that support this bill state:

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

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

5. Argument in Opposition

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

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

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

-- END –

AMENDED IN SENATE JUNE 28, 2023

AMENDED IN SENATE JUNE 27, 2023

california legislature—2023-24 regular session

ASSEMBLY BILL No. 1028

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

February 15, 2023

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

legislative counsel's digest

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

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

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

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

This bill would make other conforming changes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) The injured person's whereabouts.

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

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

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

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

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

(1) Murder, in violation of Section 187.

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

(3) Mayhem, in violation of Section 203.

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

(5) Torture, in violation of Section 206.

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

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

(8) Battery, in violation of Section 242.

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

(10) Incest, in violation of Section 285.

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

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

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

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

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

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

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

(18) Sodomy, in violation of Section 286.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) The injured person's whereabouts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

coordinated under the regulations promulgated under Section 11174.

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

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

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

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

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

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

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

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

(1) Experts in the field of forensic pathology.

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

(3) Coroners and medical examiners.

(4) Criminologists.

(5) District attorneys and city attorneys.

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

(7) Law enforcement personnel.

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

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

(10) Representatives of local child abuse agencies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Experts in the field of forensic pathology.

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

(3) Coroners and medical examiners.

(4) Criminologists.

(5) District attorneys and city attorneys.

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

(7) Law enforcement personnel.

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

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

(10) Representatives of local child abuse agencies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

O

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

UPDATE:
The bill passed out of its policy committee on 1-9-2024 on a 11-3 vote, but was held in the Assembly Appropriations Committee on 1-18-2024, and is now dead for the year.

FISCAL:
$315,000 in Fiscal Year 26-27 and ongoing. More information is in the Assembly Appropriations Committee Analysis.

BOARD POSITION:
Support if amended to address implementation concerns.

Action Requested:

None at this time.

Attachment 1: Bill text

Attachment 2: Assembly Business and Professions Committee Analysis

Attachment 3: Assembly Appropriations Committee Analysis

ASSEMBLY BILL No. 1570

Introduced by Assembly Member Low

February 17, 2023

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

legislative counsel's digest

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Corneal scraping with cultures.

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

(iii) Mechanical epilation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The conjunctiva.

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

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

(iv) An infection of the cornea.

(B) Conditions or diseases of the sclera.

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

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

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

(A) Antiamoebics.

(B) Antineoplastics.

(C) Coagulation modulators.

(D) Hormone modulators.

(E) Immunomodulators.

(F) Neuromuscular blockers.

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

(A) A laboratory test or imaging study.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Is certified in basic life support.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Laser trabeculoplasty.

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

(3) Laser posterior capsulotomy after cataract surgery.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Eight laser trabeculoplasties.

(ii) Eight laser posterior capsulotomies.

(iii) Five laser peripheral iridotomies.

(iv) Five chalazion excisions.

(v) Four chalazion intralesional injections.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Date of Hearing: January 9, 2024

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Marc Berman, Chair
AB 1570 (Low) – As Amended January 3, 2024

SUBJECT: Optometry: certification to perform advanced procedures.

SUMMARY: Expands the scope of practice for optometrists certified to use therapeutic pharmaceutical agents to perform specified advanced procedures after graduating from an accredited school of optometry and meeting additional education and hands-on training requirements, including instruction involving both simulated eyes and live human patients.

EXISTING LAW:

1) Establishes the California State Board of Optometry (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. (Business and Professions Code (BPC) §§ 3000 *et seq.*)

2) Establishes the Medical Board of California (MBC) within the DCA for the licensure and regulation of physicians and surgeons, including ophthalmologists specializing in the diagnosis and treatment of eye disorders. (BPC §§ 2000 *et seq.*)

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) Provides that an optometrist diagnosing or treating eye disease shall be held to the same standard of care to which physicians and surgeons and osteopathic physicians and surgeons are held. (BPC § 3041.1)

6) Requires the CBO to establish educational and examination requirements for licensure to ensure the competence of optometrists to practice. (BPC § 3041.2)

7) 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)

8) Authorizes an assistant in any setting where optometry or ophthalmology is practiced who is acting under the direct responsibility and supervision of a physician and surgeon or optometrist to fit prescription lenses and perform specified services, including performing preliminary subjective refraction procedures in connection with finalizing procedures performed by an ophthalmologist or optometrist, subject to certain conditions, including at least 45 hours of documented training in subjective refraction procedures. (BPC § 2544)

THIS BILL:

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

2) Requires an optometrist diagnosing or suspecting angle closure glaucoma to attempt medical stabilization, if possible, and immediately refer the patient to an ophthalmologist.

3) Authorizes an optometrist certified to treat glaucoma to become additionally certified to perform the following set of advanced procedures on adult patients who are 18 years of age or older:

    a) Laser trabeculoplasty.

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

    c) Laser posterior capsulotomy after cataract surgery.

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

    e) Closure of a wound resulting from a procedure to excise or drain nonrecurrent lesions of the adnexa.

    f) Injections for the treatment of chalazia and to administer local anesthesia required to excise or drain nonrecurrent lesions of the adnexa.

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

4) Requires an optometrist seeking to become certified to perform advanced procedures to complete a CBO-approved course of at least 32 hours on those procedures, and pass the Laser and Surgical Procedures Examination of the National Board of Examiners in Optometry, within three years prior to beginning a CBO-approved training program.

5) Requires an optometrist seeking to become certified to perform the above advanced procedures to complete a CBO-approved training program within three years of completing coursework and exam requirements, which shall include the following practical training:

    a) Hands-on instruction of the equivalent of an entire procedure on no less fifteen simulated eyes or other appropriate models before performing the related procedure on live human patients, as specified.

    b) The performance of at least 52 complete surgical procedures on live human patients, as specified, with a specific number of performances required for each procedure.

6) Specifies additional requirements for a CBO-approved training program, including a requirement that at least 40 percent of procedures be performed in a cohort model consisting of at least five optometrists, or a greater percentage if required by the CBO.

7) Requires the program course administrator to certify that an optometrist is competent to perform advanced procedures using a form approved by the CBO.

8) Requires an optometrist to 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 the optometrist makes an intraoperative determination that a procedure being performed does not meet the statutory standard or if the optometrist receives a pathology report for a lesion indicating the possibility of malignancy.

9) Expressly states that the bill does not does not authorize performing blepharoplasty or any cosmetic surgery procedure, including injections, with the exception of removing acrochordons that meet other qualifying criteria.

10) Requires an optometrist to attest that they have performed at least two of each of the delineated procedures during the period of licensure preceding the renewal with each subsequent license renewal after being certified to perform the advanced procedures, and provides that an optometrist who fails to attest to the performance of those procedures shall have their certification forfeited.

11) Requires an optometrist to monitor and report the following information to the California State Board of Optometry on a form provided by the CBO or using an internet-based portal:

    a) At the time of license renewal or in response to a request of the CBO, 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.

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

12) Requires the CBO to review adverse treatment outcome reports in a timely manner, requesting additional information as necessary to make decisions regarding the need to impose additional training, or to restrict or revoke certifications based on its patient safety authority, and to provide a report on the data.

13) Authorizes the CBO to adopt regulations and set a fee for the implementation of the bill.

14) Makes additional technical changes to existing provisions relating to optometric scope of practice.

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

COMMENTS:

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

"Today's optometrists are trained to do much more than they are permitted in California. Optometrists in other states are performing minor surgical procedures, including the use of lasers to treat glaucoma with no adverse events and little to no requirements on training. AB 2236 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."

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 statute 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.

Scope of Practice Comparison with Ophthalmology. Optometry and ophthalmology are two distinct professions that share a great deal of practice scope and interest. Whereas optometrists are often considered mid-level practitioners with a narrow focus on diagnosing and treating specific eye conditions, ophthalmologists are physicians and surgeons working within a specialty that also places an emphasis on conditions of the eye. As a result, ophthalmologists may engage in virtually any activity within the practice of optometry, while also being authorized to perform a greater number of treatments and procedures than optometrists.

In the wake of what many regard to be a physician shortage in California, efforts have been made to expand the scope of practice for optometrists to provide services traditionally reserved for physicians and surgeons specializing in ophthalmology. For example, legislation enacted in recent years have allowed optometrists to treat glaucoma, use therapeutic pharmaceutical agents, employ the use of new drugs and technologies to treat certain conditions, and treat patients with topical and oral therapeutic pharmaceutical agents. These efforts have drawn on the extensive training optometrists receive to empower them to provide additional services and alleviate the need for patients to obtain care from an ophthalmologist.

Additional Advanced Procedures. Optometrists who meet the bill's requirements would be authorized to perform specified additional advanced procedures that may currently only be performed by ophthalmologists. Only optometrists who have met the requirements to become certified to use therapeutic pharmaceutical agents are eligible to obtain this further certification. The newly authorized procedures are as follows:

- **Laser trabeculoplasty** – a laser treatment for glaucoma that uses short pulses of low-energy light to target the melanin, or pigment, in specific ocular cells to improve drainage and lower intraocular pressure.

- **Laser peripheral iridotomy** – a procedure that uses a laser to create a hole in the iris, allowing the aqueous humor to traverse directly from the posterior to the anterior chamber, relieving a pupillary block; this bill would allow the procedure to be performed for the prophylactic treatment of a clinically significant narrow drainage angle of the anterior chamber of the eye.

- **Laser posterior capsulotomy** – the use of a laser to create an opening in an artificial lens that was placed into the eye during cataract surgery and subsequently became cloudy.

- **Excision or drainage of nonrecurrent lesions of the adnexa** – these procedures remove or drain noncancerous lesions of the parts of the area outside of the eyeball but within its orbit, not including the eyelid margin, lacrimal supply, or drainage systems, no deeper than the orbicularis muscle.

- **Closure of wounds, injections, and the administration of local anesthesia** required to perform the above excision or drainage.

- **Corneal crosslinking procedure** – a treatment where eyedrop medication and ultraviolet light is used to strengthen the tissues in the cornea, which treats conditions like keratoconus by reinforcing collagen fibers in the eye.

Optometrists seeking this additional certification would be required to complete a CBO-approved course of at least 32 hours that is designed to provide education on the advanced procedures, including, but not limited to, medical decisionmaking that includes cases that would be poor surgical candidates, an overview and case presentations of known complications, practical experience performing the procedures, including a detailed assessment of the optometrist's technique, and a written examination for which the optometrist achieves a passing score. The optometrists would also be required to pass both sections of the Laser and Surgical Procedures Examination of the National Board of Examiners in Optometry or its equivalent.

In addition to the above coursework requirement, this bill would also require optometrists to complete a CBO-approved training program. This program would include the performance of all required procedures involving sufficient direct experience with live human patients to permit certification of competency, by an accredited California school of optometry. The bill requires that there be at least fifteen procedures on simulated eyes or models, divided equally between laser procedures, excision and drainage procedures, and corneal crosslinking procedures.

After the completion of the hands-on instruction using simulated eyes, this bill would require the performance of at least 52 complete surgical procedures on live human patients. At a minimum, these procedures would be required to include the following:

- Eight laser trabeculoplasties.
- Eight laser posterior capsulotomies.
- Five laser peripheral iridotomies.
- Five chalazion excisions.
- Four chalazion intralesional injections.
- Seven excisions of an authorized lesion of greater than or equal to two millimeters in size.
- Five excisions or drainages of other authorized lesions.
- Ten surgical corneal crosslinkings involving removal of epithelium.

This bill's hands-on training requirements are intended to compensate for the additional practical instruction received by ophthalmologists in medical school that is not typically received by optometrists during their prelicensure education. The bill would allow some of the procedures to be completed under a preceptorship model and would require at least 40 percent of procedures to be performed under a cohort model with at least five optometrists. Upon the optometrist's completion of all certification requirements, the course administrator, who must be a qualified educator, is required to certify that the optometrist is competent to perform advanced procedures using a form approved by the CBO.

In order to gauge whether the performance of advanced procedures by optometrists as authorized under the bill correlates with any increase in patient harm, this bill would require optometrists to report any adverse treatment outcomes that required a referral to or consultation with another health care provider to the CBO. The CBO would then review these adverse treatment outcome reports in a timely manner, requesting additional information as necessary to make decisions regarding the need to impose additional training, or to restrict or revoke certifications based on its patient safety authority. The CBO would subsequently be required to compile a report summarizing the data collected, including, but not limited to, percentage of adverse outcome distributions by unidentified licensee and CBO interventions, and would make the report available on its internet website.

As of 2022, ten other states reportedly allow optometrists to perform procedures involving lasers to treat eye conditions. This includes Alaska, Arkansas, Colorado, Indiana, Kentucky, Louisiana, Mississippi, Oklahoma, Virginia, and Wyoming. This bill would provide very specific types of laser procedures to be performed for specified conditions. These procedures are consistent with those allowed in most other states where advanced procedures are permitted.

Prior Related Legislation.

AB 2236 (Low) of 2022 was substantially similar to this proposal but would have only required certification applicants to have performed one corneal crosslinking procedure, among other minor differences. *This bill was vetoed by the Governor.*

AB 407 (Salas, Chapter 652, Statutes of 2021) expanded and revised the scope of practice for qualified optometrists and optometric assistants to diagnose and treat specified disorders and dysfunctions of the visual system and authorized optometric assistants to perform preliminary subjective refraction procedures under specified conditions.

AB 1467 (Salas and Low) of 2019 would have authorized an optometrist to provide services outlined in a delegation of services agreement between the optometrist and an ophthalmologist. *This bill died in the Senate Committee on Business, Professions, and Economic Development.*

AB 443 (Salas, Chapter 549, Statutes of 2017) expanded the scope of practice for optometrists to include additional procedures including the administration of specific immunizations for optometrists who meet certain training requirements.

SB 1406 (Correa, Chapter 352, Statutes of 2008) expanded the scope of practice for optometrists, including establishing requirements for glaucoma certification and the requirement related to an acute closed-angle attack.

ARGUMENTS IN SUPPORT:

The **California Optometric Association** (COA) is sponsoring this bill, arguing in its letter of support that recent amendments to the bill address the opposition's concerns. According to the COA: "The need for this bill is clear. Optometric patients deserve access to the best treatments and latest technology available and should not have to set up a separate appointment to see a more expensive health care provider for treatments that optometrists are trained to provide and have safely performed in other states for decades." The COA argues that "the opposition to this bill comes from physicians that don't want to see competition in the marketplace for these procedures even though ophthalmologists have considerable backlog with patients waiting for lengthy amounts of time. The problems this bill will address will only get worse if we don't accept the safe solution being offered."

ARGUMENTS IN OPPOSITION:

The **California Medical Association** (CMA) opposes this bill, writing: "This bill would expand the scope of practice for optometrists to perform advanced surgical and laser procedures with minimal training. These procedures include corneal crosslinking and laser trabeculoplasty, among others. Under this bill, optometrists would then qualify to perform these advanced procedures after completing only forty-three various eye surgical procedures. An oppose position is recommended because this bill would put patients at harm by allowing undertrained optometrists to perform the aforementioned procedures." The CMA argues that "although proponents argue that optometrists may have already received training in some procedures as part of their education, this bill creates loopholes in how the program operates and the training is not as rigorous as needed for patient safety. As a result, CMA believes that AB 1570 will create conditions where optometrists will be certified to perform surgical procedures without having been exposed to those procedures in training, which presents a clear threat to patients."

REGISTERED SUPPORT:

California Optometric Association *(Sponsor)*
Community Health Centers

North Orange County Regional Health Foundation
Ruby's Place
Southern California College of Optometry at Marshall B. Ketchum University
United Nurses Associations of California/Union of Health Care Professionals
VSP Global
Western University of Health Sciences
95 individuals

REGISTERED OPPOSITION:

American Academy of Ophthalmology
American Association for Pediatric Ophthalmology and Strabismus
American College of Surgeons
American Glaucoma Society
American Society of Ophthalmic Plastic and Reconstructive Surgery
American Society of Retina Specialists
Association of University Professors of Ophthalmology
California Academy of Eye Physicians and Surgeons
California Medical Association
California Orthopedic Association
California Society of Dermatology and Dermatalogic Surgery
California Society of Plastic Surgeons
Stanford University School of Medicine
5 individuals

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

Date of Hearing: January 18, 2024

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

Policy Committee: Business and Professions Vote: 11 - 3

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

SUMMARY:

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

Specifically, this bill:

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

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

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

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

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

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

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

FISCAL EFFECT:

The Board estimates net costs of this bill as follows:

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

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

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

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

COMMENTS:

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

> Today's optometrists are trained to do much more than they are permitted in California. Optometrists in other states are performing minor surgical procedures, including the use of lasers to treat glaucoma with no adverse events and little to no requirements on training. [This bill] provides additional training that will be more rigorous than any other state and will ensure that patients will have access to the care they need.

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

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

3) **Prior Legislation.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FISCAL:
None.

Board Position:
Support.

Action Requested:

None at this time.

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

Date of Hearing: June 27, 2023

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

SENATE VOTE: 40-0

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

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

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

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

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

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

EXISTING LAW:

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

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

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

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

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

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

FISCAL EFFECT: According to Senate Appropriations Committee:

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

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

COMMENTS:

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

2) **BACKGROUND**.

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

funding.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

g) **Medi-Cal Provider Billing for Prescription Lenses**.

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

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

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

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

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

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

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

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

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

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

7) **POLICY COMMENTS**.

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

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

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

REGISTERED SUPPORT / OPPOSITION:

Support

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

Opposition

CalPIA

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

SENATE BILL No. 340

Introduced by Senator Eggman
(Principal coauthor: Senator Wilk)

February 7, 2023

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

legislative counsel's digest

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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