Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON PRIVACY AND CONSUMER PROTECTION
Rebecca Bauer-Kahan, Chair
AB 2871 (Maienschein) – As Introduced February 15, 2024

AS PROPOSED TO BE AMENDED

SUBJECT: Overdose fatality review teams

SYNOPSIS

California is facing an overdose epidemic. According to a California Health Care Foundation report, 9% of Californians have met the criteria for a Substance Use Disorder (SUD) within the last year. While the health care system is moving toward acknowledging SUDs as a chronic illness, only about 10% of people with an SUD within the last year received treatment. Overdose deaths from both opioids and psychostimulants (such as amphetamines), are soaring. This issue, compounded by the increased availability of fentanyl, has resulted in a ten-fold increase in fentanyl related deaths between 2015 and 2019.The Department of Public Health's (DPH) Opioid Overdose Dashboard reported 7,385 deaths related to "any" opioid overdose in 2022, with 6,473 (87.7%) of those deaths fentanyl related.

Similar to existing fatality review teams that study deaths caused by intimate partner violence, child abuse, or an unexpected death of someone who was homeless, the purpose of this bill is to allow a county to establish interagency working groups to review overdose fatalities and make recommendations for preventing future fatalities. In order to facilitate the needed information sharing, the bill establishes that information shared within or produced by the review team is confidential as to not reveal a decedent's personal information to the public.

As the bill came to this committee, it proposed eliminating all current privacy and confidentiality laws related to the sharing of information about a deceased person and their history in order to allow for the broad sharing of sensitive personal information among the team members, including, but not limited to, state, local and federal law enforcement, district attorneys, drug trafficking experts, and representatives from local nonprofits, religious organizations and others who work with individuals at high risk of overdose fatalities. Among the laws these teams would have been exempt from were attorney-client, doctor-patient, and psychotherapist-patient privileged communications. In addition, the bill waived the privacy provisions in the Confidentiality of Medical Information Act and the Lanterman-Petris-Short Act as it relates to the rights of individuals who are either voluntarily or involuntarily receiving behavioral health treatment.

This sweeping authority to gather and share large amounts of sensitive and privileged personal information, without first obtaining consent from the person's next of kin or ensuring that the information is protected, would have gone against the general policy direction of this Committee. The proposed Committee amendments are designed to ensure that all privacy protections remain in place.

This bill is sponsored by the County of San Diego and supported by the County Health Executives Association of California and the Urban Counties of California. There is no opposition. This bill passed the Health Committee on a 16-0 vote.

SUMMARY: Authorizes a county to establish an interagency overdose fatality review team to assist local agencies in identifying and reviewing overdose fatalities, facilitate communication among persons and agencies involved in overdose fatalities, and integrate local overdose prevention efforts through strategic planning, data dissemination, and community collaboration. Specifically, **this bill**:

1) Authorizes a county to develop standardized protocols for postmortem examinations involving an overdose to assist coroners and other persons who perform postmortem examinations in determining whether drugs contributed to a death or were the actual cause of death.

2) Permits an overdose fatality review team to be comprised of, but not limited to, the following:

    a) Experts in the field of forensic pathology.
    b) Medical personnel with expertise in overdose fatalities.
    c) Coroners and medical examiners.
    d) District attorneys and city attorneys.
    e) County or local staff, including, but not limited to, all of the following:
        i) Behavioral health services staff.
        ii) County counsel.
        iii) Emergency medical services staff.
        iv) Unhoused services staff.
        v) Medical care services staff.
        vi) Medical examiner staff.
        vii) Public health staff.
    f) Local, county, state, and federal law enforcement personnel.
    g) Local drug trafficking experts.
    h) Public health or behavioral health experts.
    i) Drug treatment providers.
    j) Representatives of local health plans, nonprofits, religious, or other organizations who work with individuals at high risk of overdose fatalities.
    k) Local professional associations of persons described in this subdivision.

3) Requires an oral or written communication or a document shared within or produced by an overdose fatality review team to be confidential.

4) Requires an oral or written communication or a document provided by a third party to an overdose fatality review team, or between a third party and an overdose fatality review team, to be confidential.

5) Permits recommendations of an overdose fatality review team, upon the completion of a review, to be disclosed at the discretion of a majority of the members of the overdose fatality review team.

6) Permits an organization represented on an overdose fatality review team to share information in its possession concerning the decedent who is the subject of review, information received from a person who was in contact with the decedent, or other information deemed by the organization to be pertinent to the review with other members of the team. Requires information shared by an organization to be confidential.

7) Permits an overdose fatality review team to request information, as specified. Permits written and oral information, as specified, to be disclosed to an overdose fatality review team.

8) Requires information gathered, and recommendations made, by an overdose fatality review team to be used by the county to develop education, prevention, and intervention strategies that will lead to improved coordination of treatment services and prevent future overdose deaths.

9) Requires overdose fatality review teams to follow all state and federal privacy and data minimization laws.

10) States legislative findings that in order to protect the privacy of persons who have died due to a drug fatality, including confidential medical information, and to encourage the provision of comprehensive information about drug fatalities to the review teams, it is necessary to limit general access to information regarding those persons.

EXISTING LAW:

1) Provides, pursuant to the California Constitution, that all people have inalienable rights, including the right to pursue and obtain privacy. (Cal. Const., art. I, § 1.)

2) States that the "right to privacy is a personal and fundamental right protected by Section 1 of Article I of the Constitution of California and by the United States Constitution and that all individuals have a right of privacy in information pertaining to them." Further states these findings of the Legislature:

    a) The right to privacy is being threatened by the indiscriminate collection, maintenance, and dissemination of personal information and the lack of effective laws and legal remedies.

    b) The increasing use of computers and other sophisticated information technology has greatly magnified the potential risk to individual privacy that can occur from the maintenance of personal information.

    c) In order to protect the privacy of individuals, it is necessary that the maintenance and dissemination of personal information be subject to strict limits. (Civ. Code § 1798.1.)

3) Establishes under federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which sets standards for the privacy of individually identifiable health information and security standards for the protection of electronic protected health information, including, through regulations, that a HIPAA-covered entity may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on the provision of an authorization, except under specified circumstances. Provides that if HIPAA's provisions conflict with state law, the provision that is most protective of patient privacy prevails. (42 U.S.C. § 1320d, et seq.; 45 Code Fed. Regs. Part 164.)

4) Prohibits, under the state Confidentiality of Medical Information Act (CMIA), a health care provider, a health care service plan, a contractor, a corporation and its subsidiaries and affiliates, or any business that offers software or hardware to consumers, including a mobile application or other related device, as defined, from intentionally sharing, selling, using for

marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as expressly authorized by the patient, enrollee, or subscriber, as specified, or as otherwise required or authorized by law. States that a violation of these provisions that results in economic loss or personal injury to a patient is a crime. (Civ. Code § 56, et. seq.)

5) Defines, for purposes of the CMIA, medical information to mean any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health app information, mental or physical condition, or treatment. (Civ. Code § 56.05(i).)

6) Prohibits health care providers, health care service plans, or contractors, as defined, from sharing medical information without the patient's written authorization, subject to certain exceptions. (Civ. Code § 56.10(a).)

7) Permits a county to 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. (Pen. Code § 11163.3.)

8) Permits a county to establish a homeless death review committee to assist local agencies in identifying the root causes of death of homeless individuals and facilitating communication among persons who perform autopsies and the various persons and agencies involved in supporting the homeless population. (Pen. Code § 11163.72.)

9) Permits a county to establish an interagency child death review team to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases. (Pen. Code § 11174.32.)

10) Permits a county to establish an interagency elder and dependent adult death review team to assist local agencies in identifying and reviewing suspicious elder and dependent adult deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in elder and dependent adult abuse or neglect cases. (Pen. Code § 1174.5.)

FISCAL EFFECT: As currently in print, this bill is keyed fiscal.

COMMENTS:

1) **Need for this bill.** According to the Health Committee analysis of this bill, California is facing an overdose epidemic. A California Health Care Foundation report states that 9% of Californians have met the criteria for a Substance Use Disorder (SUD) within the last year. While the health care system is moving toward acknowledging SUDs as a chronic illness, only about 10% of people with an SUD within the last year received treatment. Overdose deaths from both opioids and psychostimulants (such as amphetamines), are soaring. This issue, compounded by the increased availability of fentanyl, has resulted in a ten-fold increase in fentanyl related deaths between 2015 and 2019. The Department of Public Health's (DPH) Opioid Overdose

Dashboard reported 7,385 deaths related to "any" opioid overdose in 2022, with 6,473 (87.7%) of those deaths fentanyl related.

The author argues there is currently a lack of statutory authorization and protection for counties that want to conduct opioid fatality reviews while protecting confidential medical record information, confidential law enforcement information, pending investigative information, and information from health/behavioral health plans. This information is needed to further identify issues and gaps in addressing the opioid crisis.

Similar to existing fatality review teams, the purpose of this bill is to allow a county to establish those interagency working groups to review overdose fatalities and make recommendations for preventing future fatalities. In order to facilitate the needed information sharing, the author notes, and the bill establishes that information shared within or produced by the review team is confidential as to not reveal a decedent's personal information to the public.

2) **Author's statement.** According to the author:

> Confronting California's overdose epidemic will take collaboration across all sectors. By providing the specific statutory authorization needed to create Overdose Fatality Review Teams, this proposal would allow counties to look system-wide at individual deaths to find opportunities to increase safety and health in the future. This statutory authorization would increase the likelihood of implementation of opioid fatality reviews by counties. The bill would require all confidential information shared among members of the review team to remain confidential. Other death review teams for children, domestic violence, and elder abuse have yielded tremendous results with opportunities for improvement identified and acted on at both the system-wide and individual levels. Being able to implement drug fatality review teams would allow counties to maximize insights on how they can address the drug and opioid crisis locally for a growing crisis throughout the state.

3) **Existing Death Review Teams.** Los Angeles County established the nation's first Child Death Review Team (CDRT) in 1978. A major role of CDRTs is to function as a case-investigating agency, providing in-depth analysis by many agencies on the possible causes of infant deaths in specific cases. California's CDRTs also assist in identifying agency and systems problems and developing recommendations to prevent future child deaths. According to the National Center for Fatality Review and Prevention, CDRTs have influenced state and local policy changes on issues ranging from child homicide sentencing, safely surrendered babies, children left alone in cars, child maltreatment reporting, data collection, and more.

Building on the success of CDRTs, in 1995 the California Legislature authorized counties to establish interagency Domestic Violence Death Review Teams to ensure that incidents of domestic violence and abuse are recognized and to develop recommendations for policies and protocols for community prevention and intervention initiatives. In 2001, the Legislature authorized counties to establish interagency elder death teams to examine deaths associated with suspected elder abuse and neglect, identify, and work towards the implementation of prevention strategies to protect our elder population. In 2010 the statute was expanded to allow the review teams to also assist in dependent adult death reviews. Most recently, in 2023 the Legislature authorized counties to establish homeless death review committees to identify the root causes of the deaths of unhoused individuals and facilitate communication among persons and agencies involved in supporting the unhoused population. This bill builds upon these models to authorize overdose fatality review teams.

4) **Analysis.** The primary question before this Committee is whether or not the benefits of establishing overdose fatality review teams that include non-covered entities, such as law enforcement, require the elimination of individuals' privacy rights in order to accomplish the policy goals of this proposed legislation. For two reasons, this does not appear to be the case. First, privacy interests do not simply cease at death. The release of sensitive or privileged information of the dead may harm the reputation and dignity the dead and the psychological well-being of their surviving loved ones. Second, team members can still share information and discuss cases without violating established privacy protections. In the event that there is information that is needed that the team does not have access to, the team is free to reach out to the decedent's next of kin to request consent to review that information.

As the bill came to this committee, it proposed eliminating all current privacy and confidentiality laws related to the sharing of information about a deceased person and their history in order to allow for the broad sharing of sensitive personal information among the team members, including, but not limited to, state, local and federal law enforcement, district attorneys, drug trafficking experts, and representatives from local nonprofits, religious organizations and others who work with individuals at high risk of overdose fatalities. Among the laws eliminated would have been attorney-client, doctor-patient, and psychotherapist-patient privileged communications. In addition, the bill waived the privacy provisions in the Confidentiality of Medical Information Act and the Lanterman-Petris-Short Act as it relates to the rights of individuals who are either voluntarily or involuntarily receiving behavioral health treatment.[1]

This sweeping authority to gather and share large amounts of sensitive and privileged personal information, without first obtaining consent from the person's next of kin or ensuring that the information is protected, would have gone against the general policy direction of this Committee. The proposed Committee amendments, spelled out in detail in the following section, are designed to ensure that all privacy protections remain in place.

5) **Proposed Committee amendments.** The following amendments remove the sections of the bill that could have compromised the individual and their family's right to privacy:

> **11679.** (a) (1) ***Consistent with paragraph (9) of subdivision (b) of Section 56.10 of the Civil Code, a provider of health care, as defined in Section 56.05 of the Civil Code, or a covered entity, as defined in Section 160.103 of Title 45 of the Code of Federal Regulations, shall provide to the members of the county overdose fatality review team any information, including protected health information, and mental health records excluding psychotherapy notes, in its possession that is directly related to the review authorized under 11675 about the individual involved in the case. The provision of information under this paragraph is a disclosure required by law, which may be made only to the extent permitted under subdivision (a) of Section 164.512 of Title 45 of the Code of Federal Regulations. The information disclosed shall include substance use disorder patient records only to the extent permitted by Part 2 (commencing with Section 2.1) of Title 42 of the Code of Federal Regulations.***
>
> ~~(1) Written and oral information may be disclosed to an overdose fatality review team established pursuant to this division. The team may make a request in writing for the~~

[1] The Lanterman-Petris-Short Act (Welf. & Inst. Code §§ 5000, et seq).

~~information sought and a person with information of the kind described in paragraph (3) may rely on the request in determining whether information may be disclosed to the team.~~

(2) An individual or agency that has information governed by this division is not required to disclose that information.

(***3b***) The following ***additional*** information***,*** ~~may be disclosed~~ ***only to the extent required for carrying out the reviews authorized by*** ~~pursuant to~~ this division***, may be disclosed***:

~~*(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~~***1***) State summary criminal history information, as defined in Section 11105 of the Penal Code, criminal offender record information, as defined in Section 11075 of the Penal Code, and local summary criminal history information, as defined in Section 13300 of the Penal Code.

(~~D~~***2***) 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.

~~(E) Notwithstanding Section 12300 of the Welfare and Institutions Code, records relating to in-home supportive services, unless disclosure is prohibited by federal law.~~

~~(b) Written and oral information may be disclosed under this section notwithstanding Sections 2263, 2918, 4982, and 6068 of the Business and Professions Code, 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, and the psychotherapist-patient privilege protected by Article 7 (commencing with Section 1010) of Chapter 4 of Division 8 of the Evidence Code.~~

6) **Related legislation.** AB 271 (Quirk-Silva, Chap. 135, Stats. 2023) was a similar bill that allows counties to establish "homeless death review committees" in order better understand the root causes of death among people experiencing homelessness. That bill was not heard by this Committee.

SB 863 (Min, Chap. 986, Stats 2022) authorizes a county domestic violence death review team to assist local agencies in identifying and reviewing domestic violence near-death cases, as defined.

AB 2654 (Lackey, 2021) would have reconvened the State Child Death Review Council by removing the requirement that funds are appropriated for it in the Budget Act in order to be operative. AB 2654 was held in the Assembly Appropriations Committee.

AB 2660 (Maienschein, 2021) would have required each county to establish an interagency child death review team no later than January 1, 2024. AB 2660 was vetoed by the Governor.

ARGUMENTS IN SUPPORT: According to the sponsors, the County of San Diego:

California's drug fatality crisis is well-documented. The most recent available data indicates that over 11,000 Californians died from drug overdoses in 2022, more than double the number from 2018. Two-thirds of those deaths are from opioids and 60 percent are from fentanyl alone.

Addressing California's drug fatality crisis will require a system-wide effort from local health, social service, and public safety agencies, nonprofits, community groups, and others who have expertise or work with people who are most at risk. While overdose fatality reviews can currently be conducted to a limited degree, the ability to share information about individuals, much of which is confidential by law, is limited. Other death review teams for children, domestic violence, and elder abuse have yielded tremendous results with opportunities for improvement identified and acted on at both the system-wide and individual levels. Being able to implement drug fatality review teams would allow counties to maximize insights on how they can address the drug and opioid crisis locally.

AB 2871 would provide the specific statutory authorization needed to create Overdose Fatality Review Teams. It would detail and protect processes and allow for greater sharing of confidential medical and other information needed to further identify issues and gaps in addressing the overdose fatality crisis. Finally, AB 2871 would require all confidential information shared among members of the review team to remain confidential.

REGISTERED SUPPORT / OPPOSITION:

Support

County Health Executives Association of California (CHEAC)
County of San Diego (sponsor)
San Diego County District Attorney's Office
Urban Counties of California (UCC)

Support if Amended

County of Fresno

Opposition

None on file.

Analysis Prepared by: Julie Salley / P. & C.P. / (916) 319-2200