Date of Hearing: June 14, 2016

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Rudy Salas, Chair
SB 482(Lara) – As Amended June 6, 2016

SENATE VOTE: 28-11

SUBJECT: Controlled substances: CURES database

SUMMARY: Requires a health care practitioner, as specified, authorized to prescribe, order, administer, furnish, or dispense a controlled substance to consult the Controlled Substance Utilization Review and Evaluation System (CURES) database no earlier than 24 hours before prescribing a Schedule II, Schedule III, of Schedule IV controlled substance for the first time and at least annually thereafter. Provides that a health care practitioner who knowingly fails to consult the CURES database is subject to administrative sanctions by the appropriate state professional licensing board. Exempts a health care practitioner, as specified, or any person acting on behalf of the health care practitioner, from civil or administrative liability arising from false, incomplete, or inaccurate information submitted to or reported by the CURES database or for failure to consult the database, as specified.

EXISTING LAW:

The Business and Professions Code (BPC)

1) Establishes the Medical Practice Act which provides for the licensing and regulation of physicians and surgeons by the Medial Board of California (MBC) within the Department of Consumer Affairs (DCA).

2) Establishes the Dental Practice Act which provides for the licensing and regulation of dentists by the Dental Board of California within DCA.

3) Establishes the Veterinary Medicine Practice Act which provides for the licensing and regulation of veterinarians and registered veterinary technicians by the Veterinary Medical Board within DCA.

4) Establishes the Nursing Practice Act which provides for the certification and regulation of registered nurses, nurse practitioners and advanced practice nurses by the Board of Registered Nursing within DCA.

5) Provides that a certified nurse-midwife may furnish or order drugs or devices, including controlled substances, if furnished or ordered incidentally to the provision of family planning services, routine health care or perinatal care, or care rendered consistent with the certified nurse-midwife's practice; occurs under physician and surgeon supervision; and is in accordance with standardized procedures or protocols as specified. (BPC § 2746.51)

6) Provides that a nurse practitioner may furnish or order drugs or devices, including controlled substances, if it is consistent with a nurse practitioner's educational preparation or for which clinical competency has been established and maintained; occurs under physician and

surgeon supervision; and is in accordance with standardized procedures or protocols as specified. (BPC § 2836.1)

7) Establishes the Physician Assistant Practice Act which provides for the licensing of physician assistants by the Physician Assistant Committee, under the MBC, within the DCA.

8) Provides that a physician assistant while under the supervision of a physician and surgeon may administer or provide medication to a patient, or transmit orally or in writing a drug order under specified conditions and protocols adopted by the supervising physician and surgeon. (BPC § 3502.1)

9) Establishes the Osteopathic Act which provides for the licensing and regulation of osteopathic physicians and surgeons by the Osteopathic MBC within the DCA.

10) Establishes the Naturopathic Doctors Act which provides for the licensing of naturopathic doctors by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California within the DCA.

11) Establishes the Optometry Practice Act which provides for the licensure of optometrists by the California State Board of Optometry within the DCA.

12) Establishes the Podiatric Act which provides for the licensure of doctors of podiatric medicine by the California Board of Podiatric Medicine within the DCA.

13) Establishes the Pharmacy Law which provides for the licensure and regulation of pharmacies, pharmacists and wholesalers of dangerous drugs or devices by the Board of Pharmacy within the DCA.

14) Defines "dispense" as the furnishing of drugs or devices upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor or upon an order to furnish drugs or transmit a prescription from a certified nurse-midwife, nurse practitioner, physician assistant, naturopathic doctor, or pharmacist acting within the scope of his or her practice. Dispense also means and refers to the furnishing of drugs or devices directly to a patient by a physician, dentist, optometrist, podiatrist, or veterinarian, or by a certified nurse-midwife, nurse practitioner, naturopathic doctor, or physician assistant acting within the scope of his or her practice. (BPC § 4024)

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

16) Defines "practitioner" as a physician, dentist, veterinarian, podiatrist, or pharmacist, registered nurse or physician assistant acting within the scope of an experimental health workforce projects authorized by the Office of Statewide Health Planning and Development (HSC § 128125 et seq.), a certified nurse-midwife according to BPC provisions outlined above, a nurse practitioner according to BPC provisions outlined above, a physician assistant according to BPC provisions outlined above, or an optometrist licensed under the Optometry Practice Act. Includes in the definition of "practitioner" a pharmacy, hospital, or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct

research with respect to, or to administer, a controlled substance in the course of professional practice or research in this state. Also includes in the definition of "practitioner" a scientific investigator, or other person licensed, registered, or otherwise permitted, to distribute, dispense, conduct research with respect to, or administer, a controlled substance in the course of professional practice or research in this state. (BPC § 11026)

The Health and Safety Code (HSC)

17) Establishes the California Uniform Controlled Substances Act which regulates controlled substances. (HSC § 11000 et seq.)

18) Defines "dispense" to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, furnishing, packaging, labeling, or compounding necessary to prepare the substance for that delivery and "dispenser" as a practitioner who dispenses. (HSC §§ 11010, 11011)

19) Defines "drug" as:

    a) Substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them.

    b) Substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or animals.

    c) Substances (other than food) intended to affect the structure or any function of the body of man or animals. (HSC § 11014)

20) Defines "opiate" as any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. (HSC § 11020)

21) Classifies controlled substances in five schedules according to their danger and potential for abuse. (HSC § 11054-11058)

22) Prohibits any person other than a physician, dentist, podiatrist, veterinarian, naturopathic doctor (according to BPC provisions outlined above), pharmacist (according to BPC provisions above), certified nurse-midwife (according to BPC provisions outlined above), nurse practitioner (according to BPC provisions above); a pharmacist or registered nurse or physician assistant acting within the scope of an experimental health workforce project authorized by the Office of Statewide Health Planning and Development (HSC § 128125 et seq.); an optometrist licensed under the Optometry Practice Act., or an out-of-state prescriber acting in an emergency situation from writing or issuing a prescription for a controlled substance. (HSC § 11150)

23) Specifies that a prescription for a controlled substance shall only be issued for a legitimate medical purpose and establishes responsibility for proper prescribing on the prescribing practitioner. States that a violation shall result in imprisonment for up to one year or a fine of up to $20,000, or both. (HSC § 11153)

24) Requires special prescription forms for controlled substances to be obtained from security printers approved by DOJ, establishes certain criteria for features on the forms and requires controlled substance prescriptions to be made on the specified form. (HSC §§ 11161.5, 11162.1, 11164)

25) Establishes the Controlled Substances Utilization Review and Evaluation System (CURES) for electronic monitoring of Schedule II, III and IV controlled substance prescriptions. The CURES provides for the electronic transmission of Schedule II, III and IV controlled substance prescription information to the Department of Justice (DOJ) at the time prescriptions are dispensed. (HSC § 11165)

26) States that the purpose of CURES is to assist law enforcement and regulatory agencies in controlling diversion and abuse of Schedule II, III and IV controlled substances and for statistical analysis, education and research. (HSC § 11165 (a))

27) Establishes privacy protections for patient data and specifies that CURES data can only be accessed by appropriate state, local and federal persons or public agencies for disciplinary, civil or criminal actions. Specifies that CURES data shall also only be provided, as determined by DOJ, to other agencies or entities for educating practitioners and others, in lieu of disciplinary, civil or criminal actions. Authorizes non-identifying CURES data to be provided to public and private entities for education, research, peer review and statistical analysis. (HSC § 11165 (c))

28) Provides that pharmacies or clinics, in filling a prescription for a federally Scheduled II, III or IV drug, shall provide weekly information to DOJ including the patient's name, date of birth, the name, form, strength and quantity of the drug, and the pharmacy name, pharmacy number and the prescribing physician information. (HSC § 11165 (d))

29) Provides that a licensed health care practitioner eligible to prescribe Schedule II, III or IV controlled substances, or a pharmacist, shall apply to participate in the CURES Prescription Drug Monitoring Program (PDMP) by January 1, 2016. Authorizes DOJ to deny an application or suspend a subscriber for certain violations and falsifying information. Provides that the history of controlled substances dispensed to a patient based on CURES data that is received by a practitioner or pharmacist shall be considered medical information, subject to provisions of the Confidentiality of Medical Information Act. (HSC § 11165.1)

30) Requires health practitioners who prescribe or administer a controlled substance classified in Schedule II to make a record containing the name and address of the patient, date, and the character, name, strength, and quantity of the controlled substance prescribed, as well as the pathology and purpose for which the controlled substance was administered or prescribed. (HSC § 11190 (a) and (b))

31) Requires prescribers who are authorized to dispense Schedule II, III or IV controlled substance in their office or place of practice to record and maintain information for three years for each such prescription that includes the patient's name, address, gender, and date of birth, prescriber's license and license number, federal controlled substance registration number, state medical license number, NDC number of the controlled substance dispensed, quantity dispensed, diagnosis code, if available, and original date of dispensing. Requires that this information be provided to DOJ on a monthly basis. (HSC § 11190 (c))

THIS BILL:

1) Exempts a health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, from civil or administrative liability arising from any false, incomplete, or inaccurate information submitted to, or reported by, the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

2) Requires a health care practitioner authorized to prescribe, order, administer, furnish, or dispense a controlled substance to consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least annually thereafter if the substance remains part of the treatment of the patient.

3) Defines "first time" to mean the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, furnish, or dispense a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

4) Requires a health care practitioner to obtain a patient's controlled substance history from the CURES database no earlier than 24 hours before he or she prescribes, orders, administers, furnishes, or dispenses a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

5) Exempts veterinarians from the duty to consult the CURES database.

6) Exempts health care practitioners from the duty to consult the CURES database in any of the following circumstances:

    a) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered or dispensed to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities:

        i) A clinic licensed under the Department of Public Health (DPH).

        ii) An outpatient setting.

        iii) A health facility, including acute care hospitals and skilled nursing facilities.

        iv) A county medical facility.

        v) A dental place of practice.

    b) If a health care practitioner prescribes, orders, administers, furnishes, or dispenses a controlled substance to a patient currently receiving hospice care.

    c) Any time all of the specified circumstances are satisfied. Requires the health care practitioner who does not consult the CURES database under the circumstances to document the reason he or she did not consult the database in the patient's medical record. The required circumstances are as follows:

i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

iii) The quantity of controlled substance prescribed, ordered, administered, furnished, or dispensed does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

d) If the CURES database is not operational, as determined by the Department of Justice (DOJ), or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. Requires a health care practitioner to, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

e) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

f) If the CURES database cannot be accessed because of exceptional circumstances, as demonstrated by a health care practitioner.

7) Requires that a health care practitioner who knowingly fails to consult the CURES database, be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

8) Provides that the requirement to consult the CURES database does not create a private cause of action against a health care practitioner.

9) Provides that the requirement does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

10) Provides that the requirement is not operative until six months after the DOJ certifies that the CURES database is ready for statewide use. Requires the DOJ to notify the Secretary of State and the office of the Legislative Counsel of the date of the certification.

11) States that all applicable state and federal privacy laws govern the duties required by this bill.

12) States that the provisions of this bill, once they become law, are severable. States that if any provision or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

FISCAL EFFECT: According to the Senate Appropriations Committee analysis, "No significant costs are anticipated by the Department of Justice. The Department has almost completed a substantial upgrade to CURES and anticipates that by July 2015 the system will have the capability to meet the demand expected due to this bill. Minor costs to the relevant boards that license prescribers, such as the Medical Board of California, the Osteopathic Medical Board, and the Dental Board [are anticipated]. Licensing boards will incur some additional cost

to notify their licensees of the new requirement to check CURES. Those costs are expected to be minor for the impacted boards."

COMMENTS:

Purpose. This bill is co-sponsored by the Consumer Attorneys of California and the California Narcotics Officers' Association. According to the author, "According to the Centers for Disease Control and Prevention, drug overdoses are the top cause of accidental death in the United States. Nearly 23,000 people died from an overdose of pharmaceuticals in 2013 nationally—more than 70 percent of them from opiate prescription painkillers. The CURES database is an invaluable investigative, preventative, and educational tool for law enforcement and the healthcare community. The current voluntary approach has not been able to attract sufficient participation to make it truly effective. SB 482 requires all prescribers to consult the CURES system before issuing Schedule II, III, and IV drugs. This will enable prescribers to make informed decisions about their patient's care and limit the number of people who doctor shop and over use prescription drugs."

Background. *Drug Schedules.* According to the United States Drug Enforcement Agency, drugs, substances, and certain chemicals used to make drugs are classified into five distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. Schedule I drugs have the highest potential for abuse while Schedule V is the lowest.

Schedule	**Potential for Abuse**	**Accepted for Medical Use in the United States**	**Examples**
Schedule I	High potential for abuse Lack of accepted safety for use of the drug under medical supervision.	Not currently accepted for medical use in the United States	Heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), peyote, methaqualone, methylenedioxymethamphetamine ("ecstasy")
Schedule II	High potential for abuse Abuse may lead to severe psychological or physical dependence	Currently accepted for medical use in the United States	Hydromorphone (Dilaudid), methadone (Dolophine), meperidine (Demerol), oxycodone (OxyContin, Percocet), and fentanyl (Sublimaze, Duragesic), amphetamine (Dexedrine, Adderall), methamphetamine (Desoxyn), and methylphenidate (Ritalin)
Schedule III	Potential for abuse is less than schedule I and II drugs Abuse may lead to severe psychological of physical dependence	Currently accepted for medical use in the United States	Combination products containing less than 15 milligrams of hydrocodone per dosage unit (Vicodin), products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine), and buprenorphine (Suboxone)
Schedule IV	Lower potential for abuse is less than schedule III drugs Abuse may lead to limited physical or	Currently accepted for medical use in the United States	Alprazolam (Xanax), carisoprodol (Soma), clonazepam (Klonopin), clorazepate (Tranxene), diazepam (Valium), lorazepam (Ativan), midazolam (Versed), temazepam (Restoril), and triazolam

	psychological dependence relative to schedule II substances		(Halcion)
Schedule V	Low potential for abuse relative to schedule IV substances Abuse may lead to limited physical or psychological dependence relative to schedule IV substances	Currently accepted for medical use in the United States	Cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC, Phenergan with Codeine), and ezogabine.

Prescription Drug Overdose Deaths. According to the Centers for Disease Control and Prevention (CDC), drug overdoses are the top cause of accidental deaths in the United States. Overdose deaths involving prescription opioids have quadrupled since 1999, as well as sales of these prescription drugs. Additionally, approximately 20 percent of prescribers prescribe 80 percent of all prescription painkillers.

In the years spanning 1999 to 2014, over 165,000 people died in the United States from overdoses related to prescription opioids. During this time period, overdose rates were highest among people age 25 to 54 years. Overdose rates were higher among non-Hispanic whites and American Indian or Alaskan Natives, compared to non-Hispanic blacks and Hispanics. In addition, men were more likely to die from overdose, but the mortality gap between men and women is closing.

CURES. In 1996, California enacted the first prescription monitoring drug program in the United States. According to the California Department of Justice, CURES is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement. Access to CURES is limited to licensed prescribers and licensed pharmacists strictly for patients in their direct care; and regulatory board staff and law enforcement personnel for official oversight or investigatory purposes.

CURES receives about one million prescription records per week. The database contains approximately 400 million entries of controlled substance prescriptions dispensed in California. The system retains seven years of prescription data that is de-identified.

As of February 5, 2016, there were 74, 258 registrants of the CURES system. All California licensed prescribers authorized to prescribe scheduled drugs are required to register for access to CURES version 2.0 by July 1, 2016, or upon issuance of a Drug Enforcement Administration Controlled Substance Registration Certificate, whichever occurs later. Licensed pharmacists must register for access to CURES 2.0 by July 1, 2016, or upon issuance of a Board of Pharmacy Pharmacist License, whichever occurs later (Health and Safety Code §11165.1). Use of CURES by prescribers and dispensers for prescription abuse prevention or intervention is voluntary.

Other States. Forty nine states currently have prescription drug monitoring programs. Approximately 24 states have mandates for prescribers to check a state based prescription drug monitoring system (National Alliance for Model State Drug Laws, *Reporting Requirements and Exemptions to Reporting*, 2014).

Significantly improved public health outcomes have been seen in states that have required prescribers to check their drug monitoring systems. According to information obtained from the CDC, in 2012, Tennessee required prescribers to check the state's prescription drug monitoring program before prescribing painkillers. Within one year, there was a 36 percent decline in patients who were seeing multiple prescribers to obtain the same drugs. In Virginia, the number of doctor shoppers fell by 73 percent after use of the database became mandatory. In Oklahoma, which requires mandatory checks for methadone, overdose rates dropped approximately 21 percent in a single year.

There are current efforts to link PDMP systems nationwide. The National Association of Boards of Pharmacies (NABP) InterConnect system permits authorized PDMP users in participating states to access interstate data by logging directly into the state PDMP in which they are a registered user. Currently, 33 states, excluding California, have PDMPs that are linked to the NABP InterConnect system.

Current Related Legislation. AB 611 (Dahle) of the current Legislative Session authorizes an individual designated to investigate a holder of a professional license to apply to the DOJ to obtain approval to access information contained in the CURES PDMP regarding the controlled substance history of an applicant or a licensee, for the purpose of investigating the alleged substance abuse of a licensee. Clarifies that only a subscriber who is a health care practitioner or a pharmacist may have an application denied or be suspended for accessing subscriber information for any reason other than caring for his or her patients. Specifies that an application may be denied, or a subscriber may be suspended, if a subscriber who has been designated to investigate the holder of a professional license accesses information for any reason other than investigating the holder of a professional license. STATUS: *The bill is currently pending in the Senate Committee on Business, Professions and Economic Development.*

Prior Related Legislation. SB 500 (Lieu) of 2014, would have required the MBC to update prescriber standards for controlled substances once every five years and add the American Cancer Society, specialists in pharmacology and specialists in addiction medicine to the entities the MBC may consult with in developing the standards. *STATUS: The bill was amended to deal with a different subject.*

SB 1258 (DeSaulnier) of 2014, would have made several changes to the ways that controlled substances are prescribed and tracked in CURES and would have required medical providers to use electronic prescribing systems, would have required additional reporting of controlled substance prescribing, and would have placed additional restrictions on the prescribing of controlled substances. *STATUS: The bill was held in the Senate Committee on Appropriations.*

SB 809 (DeSaulnier), Chapter 400, Statutes of 2013, established a funding mechanism to update and maintain CURES, required all prescribing health care practitioners to apply to access CURES information, and established processes and procedures for regulating prescribing licensees through CURES and securing private information.

SB 616 (DeSaulnier) of 2012, would have increased fees, up to $10 per licensee authorized to prescribe or dispense controlled substances, to fund CURES. *STATUS: The measure failed passage in the Assembly Committee on Business, Professions and Consumer Protection.*

SB 360 (DeSaulnier), Chapter 418, Statutes of 2011, updated CURES to reflect the new PDMP and authorizes DOJ to initiate administrative enforcement actions to prevent the misuse of confidential information collected through CURES.

SB 1071 (DeSaulnier) of 2010, would have imposed a tax on manufacturers or importers of Schedule II, III and IV controlled substances to pay for ongoing costs of the CURES program. Fees would have been collected by the BOE, at the rate of $0.0025 per pill included in Schedule II, III, and IV. *STATUS: The bill was held in the Senate Committee on Health.*

AB 2516 (Mendoza) of 2008, would have required a doctor to ensure that any prescription he or she make be electronically transmitted to a patient's pharmacy of choice. *STATUS: The measure was never heard in a policy committee of the Legislature.*

AB 1298 (Jones), Chapter 699, Statutes of 2007, sought to protect the privacy of personally identifiable unencrypted medical and health insurance information by requiring any state agency or business that operates in California to inform any potentially affected state resident of the loss of that individual's health information. The bill also prohibited any organization that holds electronic personal health record data from disclosing that information without patient consent.

ABX1 (Nunez) of 2007, would have required that by January 1, 2012 all prescribers, prescribers' agents, and pharmacies, have ability to transmit and receive e-prescriptions, and would have given licensing boards the authority to enforce this requirement. *STATUS: The measure failed passage in the Senate Committee on Health.*

AB 2986 (Mullin), Chapter 286, Statutes of 2006, required designated prescription forms for controlled substances and prescriptions for controlled substances to contain additional information identifying the final consumer and any refill information.

SB 734 (Torlakson), Chapter 487, Statutes of 2005, authorized tamper resistant online access to the CURES system for authorized physicians, pharmacists and law enforcement, pending the acquisition of private funding.

SB 151 (Burton), Chapter 406, Statutes of 2004, made CURES permanent, among other provisions.

AB 3042 (Takasugi), Chapter 738, Statutes of 1996, established CURES as a three-year pilot program.

ARGUMENTS IN SUPPORT:

The American Insurance Association supports the bill and writes, "CURES in a PDMP, and such programs have been shown to improve and control the prescription of narcotic pain killers, assist clinical practices, protect patients and improve outcomes. The CURES database collects and makes available to prescribers information about prescriptions of controlled substances."

CalChamber also supports the bill and writes, "SB 482 … requires all prescribers to check California's CURES database to verify that patient does not have an existing prescription for an opioid pain killer or other Schedule II or III medication before renewing or issuing a new prescription…This simple safeguard will make it easier for physicians to identify high-risk patients, discourage "doctor shopping"… and shine a much needed light on the handful of

prescribers that are responsible for the vast majority of these inappropriate Schedule II and III prescriptions."

The Teamsters support the bill and write in their letter, "It's time we took decisive action to prevent prescription drug addiction… SB 482 will help prevent this practice and help identify those individuals at risk so they can get appropriate treatment for their addiction."

The Center for Public Interest Law (CPIL) writes in support, "California should join the growing list of states that require prescribers and dispensers to consult with their PDMP before prescribing addictive narcotics. CPIL urges your support for SB 482."

Consumer Watchdog shares their support, "Experience in California and other states shows that the databases will seldom be used when they are not mandatory. According to the California Department of Justice, just 50,000 (less than 25%) of all eligible prescribers are currently signed up for the CURES database, let alone consulting it. This is a tragic failure of the system for which patients…pay the price."

NAMI California supports the bill and writes, "This bill is a common sense measure…Many individuals living with mental illness see multiple providers for legitimate reasons, including difficulty obtaining timely mental health provider appointments, housing instability, and the frequency of inpatient hospitalizations. This can result in a multitude of prescriptions, which would be better monitored through a mandated use of CURES."

ShatterProof writes in support, "California has always led the way for the rest of the country on policy issues, and SB 482 is a bill that does just this. The bill has almost universal community support, and is an important step toward ending the devastation to our youth, our families and our communities."

ARGUMENTS IN OPPOSITION:

The California Medical Association opposes the bill for several reasons including:

1) The language regarding frequency of checking the CURES database is confusing.

2) The bill allows the Department of Justice to make the determination that the database if ready to handle the duty to consult requirement. We recommend that the state Chief Information Officer be designated to make that determination.

3) The bill must increase the frequency of reporting of prescribing information to every 24 hours.

4) The language establishing that Section 11165.4 does not limit a practitioner's liability for negligent failure to diagnose or treat a patient.

5) We continue to seek amendments to clarify the CURES disclosure and privacy structure.

6) California is one of three states that have a prescription drug monitoring program housed in a law enforcement entity.

IMPLEMENTATION ISSUES:

1) The bill requires that a prescriber check the CURES system at least annually after initially prescribing a Schedule II, III, or IV substance to a patient. This may be burdensome for prescribers who have patients who are taking multiple drugs which are prescribed at various points in time.

2) Presently, the Centers for Diseases Control and Prevention recommend that emergency room personnel prescribe no more than three days of drugs to patients. This bill would allow an emergency room prescriber to prescribe ten days of drugs— more than three times the amount of time that the Centers for Disease Control and Prevention recommend.

AMENDMENTS:

1) In response to implementation issue number 1 raised above, the author should amend the bill to require that prescribers check the database, at least once every four months, if they have prescribed any Schedule II, III, or IV drugs to a patient.

2) In response to implementation issue number 2 raised above, the author should amend the bill to require that emergency room personnel prescribe no more than seven days of Schedule II, III, or IV substances.

REGISTERED SUPPORT:

Consumer Attorneys of California and California Narcotics Officers' Association (co-sponsors)
American Insurance Association
California Chamber of Commerce
California Teamsters Public Affairs Council
Center for Public Interest Law
Consumer Watchdog
National Alliance on Mental Illness
ShatterProof

REGISTERED OPPOSITION:

California Medical Association

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