THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

CASE OF THE MONTH

Navigating the Off-Label Use of Ketamine Therapy

by Yvette Ervin, JD

A simple internet search for ketamine will result in multiple stories and headlines ranging from, "Ketamine Might Have Power to Kill Cancer," to "Ketamine Horror While Youngsters' Use of Dreadful Drug Soars," and "Mind-Altering Ketamine Becomes New Pain Treatment," among others. Ketamine is growing in popularity among practitioners and the general population, with patients requesting it for issues such as depression, anxiety, and chronic pain.[1] Ketamine is FDA approved as an anesthetic agent given intravenously and is used in surgical procedures, but is not approved intravenously for any other indications. Despite this, ketamine's off-label use has grown, with many providers and patients seeing positive results for psychiatric disorders, such as chronic depression, that have been resistant to other treatments.[2] Yet ketamine's role in the high-profile passing of actor Matthew Perry again raises questions about its safety and if there is adequate oversight of those who administer it to treat psychiatric illness, even if they do not have any psychiatric training or expertise.[3]

This *Case of the Month* further examines this topic and serves as a cautionary tale for providers using ketamine therapy with their patients.

The Case of Valdes v. Brooks

In the case of *Valdes v. Brooks*,[4] a malpractice action was brought against Dr. Brooks, a board-certified anesthesiologist who founded Ketamine Infusions, a medical practice that administered ketamine to patients with treatment-resistant depression.

In 2016, Dr. Kloda sought treatment with Dr. Brooks for his depression. Dr. Kloda shared with Dr. Brooks his desire to try ketamine therapy as he had experienced suicidal ideations in the past and hoped that ketamine would prevent future thoughts. Dr. Kloda also informed Dr. Brooks that he was under the care of a psychiatrist, and "expressly prohibited" Dr. Brooks from contacting his psychiatrist.[5] Soon thereafter, Dr. Brooks initiated a ketamine treatment plan for Dr. Kloda.

After the completion of the initial ketamine treatment series, Dr. Kloda indicated to his husband, Mr. Valdes, that he had noted significant improvement in his mood. Mr. Valdes, however, opined that Dr. Kloda's depression worsened immediately after treatment.

Dr. Brooks recommended that Dr. Kloda return for a booster treatment if he noticed lessening improvement. Within three weeks of his initial

continued on page 2

Continued from page 1

treatment Dr. Kloda returned and continued receiving regular infusions. On January 26, 2017, Dr. Kloda saw his psychiatrist, who noted that his depression had returned to "baseline" despite his new treatment but concluded that Dr. Kloda was stable and presented no acute risk.

On January 30, 2017, Dr. Kloda called Dr. Brooks multiple times. When he finally reached him, Dr. Kloda shared that he had experienced several difficult days and wanted to get it under control.

During the visit that same day, Dr. Kloda told Dr. Brooks that he had experienced recent suicidal ideations that had subsided. In response to Dr. Brooks' question about whether he had any concrete plans to harm himself or weapons at home, Dr. Kloda responded that he did not, but admitted that had begun to prepare prescriptions and transfer notes for his existing patients. At the conclusion of the visit, Dr. Brooks determined that Dr. Kloda was not in imminent danger of self-harm. On February 2, 2017, Dr. Kloda attached several fentanyl patches to his body and died by suicide.

Mr. Valdes filed a lawsuit against Dr. Brooks and Ketamine Infusions alleging negligence, failure to obtain informed consent, failure to report suicidal ideation, wrongful death, and loss of consortium. Following discovery, the defense filed for summary judgment and the Court granted the motion, ending the case.

The Applicable Law

In New York, a plaintiff alleging medical malpractice must prove the following: (1) the standard of care in the locality where the treatment occurred, (2) that the defendant breached that established standard of care, and (3) that the breach was the proximate cause of the injury.[6] The plaintiff Mr. Valdes alleged three departures from the standard of care: (a) failure to communicate with Dr. Kloda's psychiatrist, (b) failure to develop a safety plan of action, and (c) failure to report Dr. Kloda's suicidal ideations to the authorities.

Failure to Communicate With Dr. Kloda's Psychiatrist

The Court rapidly disposed of this claim based on the protections afforded by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[7] While HIPAA permits disclosure of protected health information without patient consent under limited circumstances such as preventing serious and imminent harm or an emergency, those did not apply here, and did not allow for Dr. Brooks to communicate with Dr. Kloda's psychiatrist without his authorization. The plaintiff was also unable to establish that Dr. Kloda's death could have been prevented even if Dr. Brooks had communicated with his psychiatrist.

Failure to Develop a Plan for Dr. Kloda

The Court noted that in New York, doctors must carefully examine the patient and exercise their medical judgment based on careful evaluation.[8] The Court determined that although Dr. Brooks' notes were "sparse," this alone was insufficient to negate his claim that he thoroughly examined Dr. Kloda, or to demonstrate that his treatment plan amounted to failure to exercise professional judgment.

Failure to Notify the Authorities

The Court dismissed this claim, again referencing the limitations of HIPAA and that Dr. Brooks made a good faith determination that there was no imminent threat to Dr. Kloda's life, and thus this HIPAA exception did not apply.

Takeaways

While the outcome of this case was favorable to Dr. Brooks, a slight change in the facts may have rendered a different result. The jury is still out regarding the effective use and clinical impact of ketamine, but if you are using ketamine to treat behavioral health disorders, there are measures you can take to minimize your risk for medical malpractice lawsuits.

continued on page 3

Continued from page 2

Care Coordination

The first issue that presented itself was Dr. Kloda's request that Dr. Brooks not communicate with his psychiatrist. Behavioral health treatments often involve multiple specialists to achieve optimal outcomes, including psychiatrists, psychologists, and other therapists in addition to a primary care provider. Dr. Brooks, an anesthesiologist, could have impressed upon Dr. Kloda the importance of being able to communicate and coordinate with his mental health providers, especially when ketamine was being used to treat his psychiatric illness.

Thorough Documentation

As a provider, you do not want the Court to comment that your documentation was "sparse." While Dr. Brooks was successful in defending the allegations in this case, it is easy to see how things could have turned out differently. Poor, scant, or careless documentation reflects negatively on the provider, intimating sub-par care and a lack of professionalism.

Off-Label Ketamine Use

The use of ketamine for off-label purposes can pose increased risk of a medical malpractice lawsuit. When assessing the off-label use, consider the following: the benefits of using it versus the risks of not using it all, whether other traditional treatment options have been carefully explored, and what risks the potential side effects pose to the individual patient.[9]

Telehealth Implications

The Valdes Court stated that, "A physician may be held liable if a mental health treatment decision was 'something less than a professional medical determination,' or was 'not the product of a careful evaluation.'"[10] While the United States Drug Enforcement Administration (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have extended flexibilities for providers prescribing controlled substances via telemedicine without first performing an in-person visit through 2024,[11] providers should keep abreast of these regulations and their locality's standard of care for treating behavioral health disorders and off-label ketamine use, which may require periodic in-person assessments.

Risk is inherent in the practice of medicine—whether you are administering established treatments and medications or the newest therapies. The deep-rooted risk management strategies of effective communication, medication safety, comprehensive patient education, and thorough documentation remain the best tools for preventing medical malpractice actions and defending your care.

Please call Membership Services at 800-610-6642 if you have questions about coverage for ketamine usage in your practice.

Yvette Ervin is a Senior Risk Management & Patient Safety Specialist. Questions or comments related to this article should be directed to YErvin@CAPphysicians.com.

References

[1]Jackson LLP Healthcare Lawyers, "Legal Issues in Prescribing Ketamine for Depression," www.jacksonllp.com, (Jan 4, 2024), https://jacksonllp.com/ketamine-legal-issues/

[2]Mandal S, Sinha VK, Goyal N. Efficacy of ketamine therapy in the treatment of depression. Indian J Psychiatry. 2019 Sep-Oct; 61(5):480-485. doi: 10.4103/psychiatry.IndianJPsychiatry_484_18. PMID: 31579184; PMCID: PMC6767816; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6767816/; Amit Anand et al., "Ketamine versus ECT for Nonpsychotic Treatment-Resistant Major Depression," N Engl J Med 2023; 388:2315-2325, https://www.nejm.org/doi/10.1056/NEJMoa2302399

[3]Leana S. Wen, "Matthew Perry's Death Offers Tragic Lesson About Ketamine,"(pub. Dec. 18, 2023), www.washingtonpost.com, (Jan. 4, 2024), "https://www.washingtonpost.com/opinions/2023/12/18/matthew-perry-ketamine-autopsy-lesson/; Ethan Minkin, "Ketamine Clinics and Malpractice: Recent Litigation," (pub. Oct. 18, 2023), www.harris-silwoski.com, (Jan.4, 2024), https://harris-sliwoski.com/psychlawblog/ketamine-clinics-and-malpractice-recent-new-york-litigation/

[4]Valdes v. Brooks, 19-cv-617 (JGK) (S.D.N.Y. Oct. 13, 2021)

[5]Ethan Minkin, "Ketamine Clinics and Malpractice: Recent Litigation," (pub. Oct. 18, 2023), www.harris-silwoski.com, (Jan.4, 2024), https://harris-sliwoski.com/psychlawblog/ketamine-clinics-and-malpractice-recent-new-york-litigation/

[6]Nichols v. Stamer, 854 N.Y.S.2d 220, 221-22 (App. Div. 2008)

[7]United States Department of Health & Human Services, "Summary of the HIPAA Privacy Rule," www.hhs.gov; (Jan. 4, 2024), https://www.hhs.gov/sites/default/files/privacysummary.pdf

[8]57 N.Y.S.3d at 547 (quoting Ballek v. Aldana-Bernier, 957 N.Y.S.2d 108, 110 (App. Div. 2012)).

[9]Jackson LLP Healthcare Lawyers, "Legal Issues in Prescribing Ketamine for Depression."

[10]Valdes v. Brooks, 19-cv-617

[11]Federal Register, "Second Temporary Extension of Covid-19 Telemedicine Flexibilities for Prescriptions of Controlled Substances," www.federalregister.gov, (Jan. 4, 2023), https://www.federalregister.gov/documents/2023/10/10/2023-22406/second-temporary-extension-of-covid-19-telemedicine-flexibilities-for-prescription-of-controlled

Risk Management and Patient Safety News

What Is the Physician's Responsibility When the Patient Initiates Termination?

by Dona Constantine, RN, BS

The Cooperative of American Physicians (CAP) frequently receives calls from physicians asking about the process for terminating a patient relationship. We also frequently receive calls from physicians inquiring about their responsibility when it is the patient who initiates the termination.

A physician is required to follow specific steps when discharging or terminating a patient from their practice to avoid allegations of abandonment. However, a patient is not obligated to follow any formal protocol when they decide to end the relationship. They may provide formal, informal, or no notice of their intention to leave your practice. Although it is important to respect the patient's decision to leave, we recommend, if possible, communicating with the patient to determine their reason for parting ways.

You may learn that their decision was made in response to a real or perceived problem in your office. This realization could provide you with an opportunity to mitigate the problem, salvage the relationship, and avoid similar problems in the future.

In his article, *When Patients Leave: Why They Fire the Doctor*, Steward Gandoff notes, "Surveys among patients point mainly to complaints about patient satisfaction. Generally, patients found fault with communications, long wait times, practice staff professionalism, and to a lesser degree, issues of billing. Service is the primary reason that patients leave."[1]

Patients may also leave a practice because of personality styles or because their health insurance changed and does not include the practice as a provider.

Regardless of the reason for ending the relationship, it is important, if possible, to assist with a transfer of care.

In his article, *Patient-Initiated Terminations*, Edward Richards, LSU Law Center, writes, "Unfortunately, patients sometimes stop coming before they are fully recovered from the acute condition that brought them to the physician. When this happens, the physician must make some effort to determine whether the patient is knowingly forgoing further care, has found another physician, or is staying away out of ignorance or a misunderstanding of the physician's instructions . . . If the patient has not made arrangements for care, the physician should reiterate the need for care and offer to help the patient find a new physician. These efforts will help ensure that the patient receives proper care. If, despite the physician's efforts, the patient does not follow through in seeking proper care, there will be evidence that the original physician made a good-faith effort to help the patient."[2]

To reduce your liability exposure when a patient voluntarily chooses to leave your practice and promote a positive outcome for you and your patient, consider the following risk reduction strategies:

- Be professional in all interactions with the patient and maintain confidentiality.

continued on page 5

Continued from page 4

- If possible, confirm the patient's conscious decision to leave your practice and discuss why.
  - You may be able to clarify a misunderstanding so the patient remains with your practice.
  - The feedback may assist you in improving your practice to avoid other patients leaving for the same reason(s).
- Send letter(s) to the patient 1) confirming that the patient has terminated the relationship; 2) emphasizing the need for follow-up care; and 3) where possible, referring the patient to other sources of care.[3] If known, document the reason that the patient chose to leave and any discussions to confirm the date of termination.
  - For high-risk patients, send letters by both certified and regular mail detailing why treatment(s) and medication(s) are recommended, the consequences of not adhering to the regimen, and the importance of following up in a timely manner.
  - For other patients, send letter by regular mail indicating the ongoing need for treatment and consequences of not following up.
  - Include an authorization form for Release of Medical Records with each letter.
- Document any discussions you or your staff had with the patient in the medical record.
- Review the patient's insurance to determine any contractual obligations relating to termination of physician-patient relationship, e.g., notifying an HMO.

Dona Constantine is a Senior Risk Management & Patient Safety Specialist. Questions or comments related to this article should be directed to DConstantine@CAPphysicians.com.

References

[1]Stewart Gandolf, *When Patients Leave: Why They Fire the Doctor*, Healthcare Success Blog, accessed 1/19/2024, https://healthcaresuccess.com/blog/healthcare-marketing/why-patients-leave.html

[2]Edward Richards, *Patient-Initiated Terminations*, p.1, Public Health Law Map- Beta 5.7, LSU Law Center, 2009 https://biotech.law.lsu.edu/map/index.htm

[3]Gandolf, *When Patients Leave: Why They Fire the Doctor*

Important Notice: 2024 Credit Card Fees

Effective January 1, 2024, CAP members making payments to CAP by credit card will be charged a 3% fee.

The 3% fee is in place so that the significant costs associated with credit card processing fees are no longer absorbed by CAP and no longer shared as a collective cost by the entire membership, including those who do not use credit cards.

By implementing the 3% fee, CAP can reduce costs to help keep rates for medical malpractice coverage as stable and as affordable as possible.

This fee applies to any credit card payment made online, or by autopay, mail, phone, or other method. This fee is now a standard practice among many businesses, merchants, and even medical groups themselves.

In addition to the 3% credit card fee, CAP no longer accepts payments made by debit card.

Automated Clearing House (ACH) payments using your bank account may be the best method for making individual/one-time payments or automatic payments every month.

To avoid the fee in the future, set up one-time or automatic monthly ACH payments when you log in to your account.

Here's How:

1. Visit https://member.capphysicians.com to log in to your CAP account. If you do not have an account, you will need to register to create one at https://member.capphysicians.com/register.

2. Once logged in, make sure to go paperless if you have not already done so by selecting the green "Set Up Paperless Billing" button.

3. Select the "Via Email Only" button.

4. Verify your email address and click the "Save Changes" button.

5. Then, simply click on the "Pay CAP Bill" button (agree to the terms and conditions when prompted) and follow the instructions to set up autopay payments by clicking on the "Set Up Autopay Payments" and providing the required information for recurring payments made by ACH.

For assistance with your account, or if you have questions about your membership or the new credit card fee, please call 800-610-6642 or email MS@CAPphysicians.com.

FEBRUARY 2024

Ask My Practice

By Andie Tena

Boost Productivity and Performance With a Free Practice Management Assessment

Clinical excellence aside, the care you provide for your patients may be impacted by the efficiency and effectiveness of your practice operations. A regularly scheduled practice evaluation can help you stay ahead of policies and procedures that support optimal workflow and a healthy bottom line, even when you think your business is running like a well-oiled machine.

As an exclusive benefit, CAP members have access to *My Practice*, CAP's free practice management and business services solutions program. In addition to being available for general practice-related inquiries, *My Practice* offers CAP members a free virtual practice management assessment.

Now is a good time to get your free practice evaluation and improve any areas that might need your attention.

Here's what you can expect to review during your consultation:

- The appointment scheduling process and how to maximize your schedule
- New regulations that impact your practice
- Insurance verification best practices
- New patient intake protocols
- Patient check in/check out best practices
- Billing, collections, and accounts receivable workflows
- Referral procedures
- Patient communications management, and much more!

Practice management consultants can be costly, and the results may not always meet your expectations. Through *My Practice*, you can take advantage of free practice management services, including your practice management virtual assessment.

This service is different from CAP's popular Risk Management Practice Survey and is a great way to become more familiar with all that is available to you through your CAP membership.

My Practice was created as part of CAP's commitment to providing you with valuable products, services, and resources to support a successful medical practice, so you can spend more time focusing on superior patient care.

You or any of your employees may contact *My Practice* to get started with your free practice assessment or to get help with any practice-related challenges, no matter how big or small. Call 213-473-8630 or email ATena@CAPphysicians.com for immediate assistance.

Andie Tena is CAP's Assistant Vice President of Practice Management Services. Questions or comments related to this column should be directed to ATena@CAPphysicians.com.

Top Business Insurance Products all Medical Practices Need

SYMPHONY RISK

As business owners, physicians should have a general understanding of how to protect their practices and themselves from various types of financial risks, in addition to those associated with medical malpractice liability.

Where do you start? What kind of coverage does a physician need? What should the limits be? How much will it cost? Who is a good source for help?

Start with an evaluation of your current business insurance coverages to ensure they are tailored to the specific needs and size of your medical practice.

Here are the essential business insurance programs you should consider adding to your portfolio if you are not currently covered:

Business Owner's Policy (BOP)

Combines a wide range of liability and property coverage into a package that is typically less expensive than purchasing the coverages individually.

Workers' Compensation Insurance

Protects you against lawsuits, fines, and penalties stemming from workplace incidents.

CyberRisk Liability Coverage

Provides additional protection above the $50,000 of protection you automatically receive as a CAP member to cover the high costs associated with dangerous cyberattacks.

Coverage for Medical Consultants

Offers protection from errors and omissions that may occur when performing duties outside of regular patient care, such as reviewing medical records for insurance companies, engaging in nonprofit work, evaluating criminal cases, or performing peer review.

Telemedicine Coverage for Patients Outside of California

Your medical malpractice coverage through CAP includes telemedicine for services provided to patients in California. If you are currently seeing and treating patients virtually outside of California, extra medical professional liability coverage is important for you to have.

Employment Practices Liability Insurance (EPLI)

EPLI covers the defense costs of lawsuits brought by employees, former employees, job applicants, or other third parties alleging discrimination, wrongful termination, or harassment, among other claims.

These products are brought to you by Symphony Health, a division of Symphony Risk Solutions. Symphony Health is CAP's preferred provider for your business and personal insurance needs, supplementing your medical malpractice coverage from CAP. Members have access to licensed professionals who can provide personalized assistance with a wide range of essential insurance coverages all in one place at competitive rates.

To learn more, email **healthcareservices@symphonyrisk.com** or call **800-819-0061**.

New California Healthcare Laws in 2024

by Gabriela Villanueva

In 2023, Governor Newsom signed 890 bills into law and vetoed 156.

Sourcing from bill summaries produced by the California Medical Association (CMA) and CAP's team of policy experts at Capitol Advocacy, here are some of the more significant healthcare laws affecting physicians:

AB 118 (Committee on Budget) Budget Act of 2023: Health.

SUMMARY: For dates of service no sooner than January 1, 2024, or on the effective date of any necessary federal approvals, whichever is later, requires the reimbursement rates for primary care services, obstetric care services, doula services, and certain outpatient mental health services to be the greater of 87.5% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services or the level of reimbursement. Requires the Department of Managed Health Care to annually review and revise the reimbursement rates, and to develop and implement a methodology for establishing rates or payments for the services. Payments would be supported by the managed care organization provider tax revenue or other state funds appropriated to the department as the state share for this purpose, including, but not limited to, funds transferred to the Medi-Cal Provider Payment Reserve Fund, and to the Healthcare Treatment Fund under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016. Requires each Medi-Cal managed care plan to reimburse a network provider furnishing those services at least the amount the network provider would be paid for those services in the Medi-Cal fee- for-service delivery system.

AB 119 (Committee on Budget) Medi-Cal: Managed Care Organization (MCO) Provider Tax.

SUMMARY: Medi-Cal services are provided pursuant to contracts with various types of managed care plans. The bill would restructure the MCO provider tax, with certain modifications to the above-described provisions, including changes to the taxing tiers and tax amounts, for purposes of the tax periods of April 1, 2023, through December 31, 2023, and the 2024, 2025, and 2026 calendar years. The bill would create the Managed Care Enrollment Fund to replace the Health Care Services Special Fund. Under the bill, moneys deposited into the fund would, upon appropriation, be available to the department for the purpose of funding the following subcomponents to support the Medi-Cal program: (1) the nonfederal share of increased capitation payments to Medi-Cal managed care plans; (2) the nonfederal share of Medi-Cal managed care rates for health care services; and (3) transfers to the Medi-Cal Provider Payment Reserve Fund, as established pursuant to specified provisions.

AB 470 (Valencia D) Continuing Medical Education: Physicians and Surgeons.

SUMMARY: Existing law, the Medical Practice Act, establishes the Medical Board of California within the Department of Consumer Affairs and sets forth its powers and duties relating to the licensure and regulation of physicians and surgeons. Existing law requires the board to adopt and administer standards for the continuing education of physicians and surgeons.

This bill would specify that these educational activities may also include activities that are

continued on page 10

Continued from page 9

designed to improve the quality of physician patient communication.

AB 571 (Petrie-Norris D) Medical Malpractice Insurance.

SUMMARY: Existing law defines "liability insurance" to include, among other things, insurance coverage against the legal liability of the insured, and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional services by any person who holds a certificate or license issued pursuant to the Medical Practice Act or the Osteopathic Initiative Act, or a license as a community clinic or health facility, as specified. This bill would prohibit an insurer from refusing to issue or renew or terminating professional liability insurance for health care providers, as specified, and from imposing a surcharge or increasing the premium or deductible solely based on any prohibited bases for discrimination, including a health care provider offering or performing abortion, contraception, gender-affirming health care, or care related to those health care services that are lawful in this state but unlawful in another state.

AB 816 (Haney D) Minors: Consent to Medical Care.

SUMMARY: Existing law authorizes a minor who is 12 years of age or older to consent to medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem. Existing law exempts replacement narcotic abuse treatment, as specified, from these provisions.

This bill would authorize a minor who is 16 years of age or older to consent to replacement narcotic abuse treatment that uses buprenorphine at a physician's office, clinic, or health facility, by a licensed physician and surgeon or other health care provider, as specified, whether or not the minor also has the consent of their parent or guardian. The bill would authorize a minor 16 years of age or older to consent to any other medications for opioid use disorder from a licensed narcotic treatment program as replacement narcotic therapy without the consent of the minor's parent or guardian only if, and to the extent, expressly permitted by federal law.

AB 1070 (Low D) Physician Assistants: Physician Supervision: Exceptions.

SUMMARY: Existing law, the Physician Assistant Practice Act, establishes the Physician Assistant Board within the jurisdiction of the Medical Board of California for the licensure and regulation of physician assistants. The act authorizes physician assistants to perform medical services as set forth by regulations and the act when those services are rendered pursuant to a practice agreement and under the supervision of a licensed physician and surgeon. Existing law prohibits a physician and surgeon from supervising more than 4 physician assistants at any one time.

This bill would also authorize a physician and surgeon to supervise up to 8 physician assistants at one time if all of the physician assistants are focused solely on performing in-home health evaluations to gather patient information and perform annual wellness visits or health evaluations that do not involve direct patient treatment or prescribing medication.

AB 1286 (Haney D) Pharmacy.

SUMMARY: Existing law authorizes the California State Board of Pharmacy to appoint an executive officer to exercise the powers and perform the duties delegated by the board. A violation of the Pharmacy Law is a crime. This bill would authorize a pharmacist-in-charge to make staffing decisions to ensure sufficient personnel are present in the pharmacy to prevent fatigue, distraction, or other conditions that may interfere with a pharmacist's ability to practice competently and safely. The bill would authorize a pharmacist on duty, if the pharmacist-in-charge is not available, to adjust staffing according to workload if needed. The bill would require a pharmacist-in-charge or pharmacist on duty to immediately notify store management of any conditions that present an immediate risk of death, illness, or irreparable harm

continued on page 11

Continued from page 10

to patients, personnel, or pharmacy staff. The bill would require store management to take immediate and reasonable steps to address and resolve those conditions, and, if those conditions are not resolved within 24 hours, would require the pharmacist-in-charge or pharmacist on duty to ensure the board is notified. The bill would require the executive officer, upon a reasonable belief that conditions within a pharmacy exist that present an immediate risk of death, illness, or irreparable harm to patients, personnel, or pharmacy staff, to issue a cease-and-desist order, as specified. The bill would make a failure to comply with the cease-and-desist order unprofessional conduct for a pharmacy corporation.

AB 1557 (Flora R) Pharmacy: Electronic Prescriptions.

SUMMARY: Existing law establishes in the Department of Consumer Affairs the California State Board of Pharmacy to license and regulate the practice of pharmacy. The Pharmacy Law authorizes a prescriber or a prescriber's authorized agent to electronically enter a prescription into a pharmacy's or hospital's computer from a location outside of the pharmacy or hospital. The Pharmacy Law makes those provisions inapplicable to prescriptions for controlled substances classified in Schedule II, III, IV, or V, except as permitted pursuant to specified provisions. That law generally punishes a knowing violation of its provisions as a misdemeanor. This bill would delete the provision, making the authorization to electronically enter a prescription inapplicable to controlled substances. The bill would also authorize a pharmacist located and licensed in the state to, on behalf of a licensed health care facility, from a location outside of the facility, verify medication chart orders for appropriateness before administration consistent with federal requirements, as established in the health care facility's policies and procedures. The bill would require a health care facility to maintain a record of a pharmacist's verification of a medication chart order pursuant to that provision, as specified. By expanding the scope of the crime of violating the Pharmacy Law, this bill would impose a state-mandated local program.

SB 525 (Durazo D) Minimum Wages: Health Care Workers.

SUMMARY: Establishes minimum wage schedules for covered health care employees, as defined, depending on the nature of the employer. Physician groups with fewer than 25 physicians are excluded. For any covered health care facility employer, as defined, with 10,000 or more full-time equivalent employees (FTEE), as defined, any covered health care facility employer that is a part of an integrated health care delivery system or a health care system with 10,000 or more FTEEs, a covered health care facility employer that is a dialysis clinic or is a person that owns, controls, or operates a dialysis clinic, or a covered health facility owned, affiliated, or operated by a county with a population of more than 5,000,000 as of January 1, 2023, require the minimum wage for covered health care employees to be $23 per hour from June 1, 2024, to May 31, 2025, inclusive, $24 per hour from June 1, 2025, to May 31, 2026, inclusive, and $25 per hour from June 1, 2026, and until as adjusted as specified.

SB 345 (Skinner D) Healthcare Services: Legally Protected Healthcare Activities.

SUMMARY: Existing law makes specified actions by licensed health care providers' unprofessional conduct and, in certain cases, a criminal offense. This bill would prohibit a healing arts board, as defined, from denying an application for a license or imposing discipline upon a licensee or health care practitioner on the basis of a civil judgment, criminal conviction, or disciplinary action in another state if that judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive sensitive services, as defined, that would be lawful if provided in this state, regardless of the patient's location. The bill would further provide that the performance, recommendation, or provision of a

continued on page 12

Continued from page 11

legally protected health care activity by a licensee or health care practitioner acting within their scope of practice for a patient who resides in a state in which the performance, recommendation, or provision of that legally protected health care activity is illegal, does not, by itself, constitute professional misconduct, upon which discipline or other penalty may be taken.

SB 385 (Atkins D) Physician Assistant Practice Act: Abortion by Aspiration: Training.

SUMMARY: The Physician Assistant Practice Act establishes the Physician Assistant Board to license and regulate physician assistants. Existing law makes it a crime to perform an abortion without holding a license to practice as a physician and surgeon, or without holding a specified license or certificate under the Physician Assistant Practice Act that authorizes the holder to perform specified functions necessary for an abortion in the first trimester of pregnancy. The act requires a physician assistant to complete training and comply with certain protocols, as specified, to receive authority from the physician assistant's supervising physician and surgeon to perform an abortion by aspiration techniques.

This bill would revise the training requirements to instead require a physician assistant to achieve clinical competency by successfully completing requisite training, as described, in performing an abortion by aspiration techniques. The bill would set forth what types of training qualify. The bill would remove the requirement that a physician assistant follow certain protocols to receive authority from the physician assistant's supervising physician and surgeon to perform an abortion by aspiration techniques.

SB 667 (Dodd D) Healing Arts: Pregnancy and Childbirth.

SUMMARY: Existing law authorizes a certified nurse-midwife to practice with a physician and surgeon under mutually agreed-upon policies and protocols, as specified, to provide a patient with care outside of that scope of services or to provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium. This bill would revise and recast those provisions to, among other things, authorize a certified nurse-midwife, pursuant to policies and protocols that are mutually agreed upon with a physician and surgeon, as specified, to provide a patient with care outside of that scope of services, to provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium, or to furnish or order a Schedule II or III controlled substance, as specified. The bill would include care for common gynecologic conditions, as specified, in the scope of services a certified nurse-midwife is authorized to perform without policies and protocols that are mutually agreed upon with a physician and surgeon. The bill would additionally authorize a general acute care hospital, as defined, or a special hospital specified as a maternity hospital, as defined, to grant privileges to a certified nurse-midwife, allowing them to admit and discharge patients upon their own authority if in accordance with organized medical staff bylaws of that facility and within the nurse-midwife's scope of practice.

For more information:

CMA Summary
https://www.cmadocs.org/Portals/CMA/files/public/CMA%20New%20Health%20Laws%202024.pdf?ver=2024-01-04-120828-330

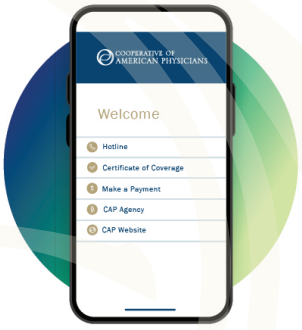
Capitol Advocacy Summary
www.CAPphysicians.com/AdvocacySummary

Gabriela Villanueva is CAP's Government and External Affairs Analyst. Questions or comments related to this article should be directed to GVillanueva@CAPphysicians.com.

PUBLIC POLICY

COOPERATIVE OF
AMERICAN PHYSICIANS

Cooperative of American Physicians, Inc.
333 S. Hope St., 12th Floor
Los Angeles, CA 90071



Manage Your CAP Membership on the Go!

Download CAPMobile Today!

DOWNLOAD ON Google Play

DOWNLOAD ON THE App Store

IN THIS ISSUE

FEBRUARY 2024

333 S. Hope St., 12th Floor, Los Angeles, CA 90071 | 800-252-7706 | www.CAPphysicians.com.

We welcome your comments! Please submit to communications@CAPphysicians.com.

The information in this publication should not be considered legal or medical advice applicable to a specific situation. Legal guidance for individual matters should be obtained from a retained attorney.