THE MONTHLY PUBLICATION FOR CAP MEMBERS

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COOPERATIVE OF AMERICAN PHYSICIANS

Case of the Month

Court Explains 'Implied Malice' in Upholding Physician's Murder Convictions

This month, we feature a popular "Case of the Month" from the archives written by CAP's former General Counsel Gordon Ownby

The Court of Appeal has found a substantial basis for a physician's second-degree murder convictions arising out of the doctor's drug prescriptions to three patients. By articulating the "implied malice" required for the convictions, the appellate court explained how circumstantial evidence of the physician's state of mind could be accepted by a jury to convict the physician of murder.

As a licensed physician, Hsiu Ying Lisa Tseng operated a general medical practice with her husband. According to the facts accepted by the Court of Appeal, after Dr. Tseng joined the clinic in 2007, the Advance Care AAA Medical Clinic in Rowland Heights went from serving predominantly local Hispanic and Asians who paid through insurance to serving a clientele of mostly young, largely cash-paying white males from outside the area seeking pain and anxiety management medications.

In July 2012, Dr. Tseng was arrested and charged with three counts of second-degree murder in the deaths of patients Vu Nguyen, Steven Ogle, and Joseph Rovero. The convictions involved treatment by Dr. Tseng of three years for Mr. Nguyen, several weeks for Mr. Ogle, and a single visit with Mr. Rovero.

Mr. Nguyen's treatment by Dr. Tseng included prescriptions for Xanax, Norco, Vicodin, and Opana for back and neck pain, plus Adderall on the patient's claim that he had been diagnosed with attention deficit disorder. Following Mr. Nguyen's death, Dr. Tseng told the coroner's investigator that Mr. Nguyen was always seeking more medication and stronger doses.

At trial, the prosecution presented evidence that Tseng had no treatment plan for Mr. Nguyen, did not obtain information to corroborate her patient's pain and anxiety, did not complete an adequate physical examination, and did not contact Mr. Nguyen's other physicians.

When Mr. Ogle sought treatment from Dr. Tseng, he told her he was taking six to eight tablets of OxyContin daily, using heroin, and that he wanted to take methadone to treat his addiction. Though not a licensed addiction specialist, Dr. Tseng prescribed Mr. Ogle Xanax and methadone, for which he returned

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twice over four weeks to obtain refill prescriptions. Mr. Ogle died two days after the third prescription and near his body were nearly empty bottles of the Xanax and methadone, plus a third bottle containing OxyContin that had been prescribed three months earlier by another physician. The coroner's opinion was that Mr. Ogle died of "methadone intoxication."

At trial, the prosecution presented evidence that Dr. Tseng's treatment of Mr. Ogle represented an extreme departure from the standard of care in various ways, including that she was not a licensed addiction specialist and did not have training to monitor Mr. Ogle's methadone use.

Treatment of Mr. Rovero, a college student from Arizona, involved just one visit for his complaints of back pain, wrist pain, and anxiety. Mr. Rovero told Dr. Tseng that he had been using high doses of OxyContin and Xanax daily, plus the muscle relaxant Soma, and requested the same prescriptions. Dr. Tseng prescribed Roxicodone, Soma, and Xanax. Mr. Rovero died nine days later with empty bottles near his body for the medications prescribed by Dr. Tseng. After his death, Dr. Tseng told investigators that her goal had been to wean Mr. Rovero from opioids and that she had reduced the doses of the drugs he had been taking by 80 percent. At trial, prosecutors presented evidence that such a drastic reduction would cause Mr. Rovero to suffer from withdrawals and that her prescriptions likely increased his potential for overdose because Dr. Tseng failed to verify the doses of the earlier prescriptions from other physicians.

Also at trial, the prosecution presented evidence on six additional patients—all in their 20s and early 30s—who died shortly after filling prescriptions for controlled substances that Dr. Tseng had written for them.

On appeal, Dr. Tseng contended that her convictions should be overturned because of a lack of substantial evidence that she acted with the implied malice. She argued that though she acted with negligence sufficient to support convictions for involuntary manslaughter, there was no evidence she acted with "conscious disregard" for her patients' lives.

In the unanimous opinion, the Los Angeles-based Court of Appeal explained in The People v. Hsiu Ying Lisa Tseng that implied malice exists when an intentional act naturally dangerous to human life is committed "by a person who knows that his conduct endangers the life of another and who acts with conscious disregard for life."

The appellate court began its analysis of the convictions by stating its recognition that a departure from the medical standard of care alone is not sufficient to support a finding of implied malice. The court then commented that Dr. Tseng's experience and medical training regarding opioids and other controlled substances "endowed her with special knowledge of [the] dangers" of the drugs she prescribed and that the combination of the prescribed drugs, often with increasing doses, posed a significant risk of death.

The court also noted that after larger pharmacies raised questions with Dr. Tseng over her prescriptions and ultimately stopped filling her prescriptions, the physician sent her patients to small "mom and pop" pharmacies. According to the court's written opinion, Dr. Tseng knew some patients were obtaining similar prescriptions from other doctors, but did not contact those other doctors (or the CURES database) to find out more about those prescriptions. The court also noted that in the course of treating Mr. Nguyen, Mr. Ogle, and Mr. Rovero, she became aware of an increasing number of deaths of other patients with similar drug profiles following her prescriptions of medications for them.

In the case of Mr. Nguyen, the court stated: "A reasonable jury could infer from [the] evidence that Tseng was aware Nguyen was abusing the opioids and

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sedatives she had prescribed, and that by continuing to prescribe the drugs in greater amounts and stronger doses, Tseng acted in conscious disregard for his life."

The court also found substantial evidence that Dr. Tseng acted with implied malice in treating Mr. Ogle. The court noted in particular that though Dr. Tseng observed Mr. Ogle was suffering from drug withdrawal, she did not refer him to an addiction specialist, but "just wrote him refill prescriptions."

Finally, the court found substantial evidence to support implied malice in treating Mr. Rovero.

"By the time she prescribed drugs for Rovero . . . Tseng knew that eight of her patients . . . had died shortly after she had prescribed the types of drugs Rovero sought. Even armed with this knowledge, she continued to prescribe dangerous drugs in conscious disregard for Rovero's life."

The court rejected Dr. Tseng's assertion that because coroner and police investigators never informed her that she was responsible for the deaths of the three victims or the deaths of other patients, her continued prescribing practices did not show the necessary reckless mindset to support a finding of implied malice.

"[E]ven accepting Tseng's claim that investigators did not expressly inform her that she was directly responsible for the deaths of Nguyen, Ogle, Rovero, or other patients, her conduct after learning of these deaths demonstrated she was aware of the lethal consequences of her prescribing practices," the court explained. "For example, Tseng placed 'alerts' in the patient files indicating they died of suspected drug overdoses. She also altered patient records after she learned she was under investigation.

"From this evidence and other circumstantial evidence in the record, a jury could have reasonably found that Tseng knew the cause of Nguyen's, Ogle's, and Rovero's deaths and her role in their demise. In sum, substantial evidence supports the jury's findings of implied malice."

Ask My Practice

by Andie Tena

Compliance Training a Must for Medical Practices: Free Courses for CAP Members

Online Harassment Avoidance Training

The current climate has illuminated the adverse effects that harassment of any kind can have on an organization and highlights the need for quality training to prevent harmful situations from arising.

Current California law requires that employers with five or more employees provide sexual harassment avoidance training for all staff members. The Cooperative of American Physicians (CAP) is pleased to offer its members free courses for this mandated training, which also includes an optional 40-minute diversity, equity, and inclusion (DE&I) training program addressing discrimination in the workplace. Both courses are available for supervisory and non-supervisory employees through Kantola Training Solutions. Training must take place within six months of hire or promotion. Additionally, supervisors and employees are required to complete sexual harassment avoidance training every two years with supervisors attending a two-hour training and staff a one-hour training.

As part of your practice's comprehensive human resources management plan, CAP recommends that your practice train new employees upon hire, as well as existing employees that have not yet completed the training. You and your staff members may follow the instructions below to complete the trainings:

1. Click here: https://online.kantola.com/signup/register/SvFoy1
2. Register for a new account and make a selection for the following course options for “Group”:
    - Harassment Prevention (Employee) AND Diversity Equity and Inclusion
    - Harassment Prevention (Manager) AND Diversity Equity and Inclusion
3. Once you have created the account, you will see a pop-up message. Click “Close” and you will be taken to the course. Click “Play” to get started.
4. Once you complete the program, you will be able to save the certificate of completion as a PDF.

These courses are optimized for the most current versions of internet browsers. You can check whether your browser is up to date by clicking https://www.whatismybrowser.com/

Cyber Security and HIPAA Training

CAP offers members free access to NAS CyberNet, a robust online suite of the most up-to-date training courses to help keep you HIPAA compliant and reduce the

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likelihood that you'll fall victim to a cyberattack. These courses include:

- Introduction to Breaches
- Data Security Basics
- Social Engineering
- HIPAA Training Series
- Safeguarding Information
- Payment Card Industry—Identifying Fraudulent Payment Cards

NAS CyberNet also provides free access to sample policies, incident response plan templates, and one-on-one expert consultations. Free HIPAA training provides each employee who takes the course a certificate of completion to meet annual HIPAA training requirements.

Understanding how to protect your practice is an important component of your risk management plan. CAP recommends that all practice staff participate in HIPAA training annually as a refresher. Training can be accessed at **https://cap.nascybernet.com.** Click on "Need an account? SIGN UP." Follow the steps to set up your practice account. One person can serve as the administrator and assign training to all staff.

As these courses are being offered free as a benefit of CAP membership, we request that you do not share the link with any individuals outside of your member practice. Thank you for understanding.

If you would like more information or assistance on the training mentioned in this article or have practice management questions, contact Andie Tena, Director of Practice Management Services at: ATena@CAPphysicians.com.

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

The Importance of an Advance Directive Cannot be Overlooked

By Bryan Dildy

An advance directive is a document, such as a living will or durable power of attorney, which provides instructions that guide an agent in making healthcare-related decisions on behalf of a patient. Its purpose is to empower patients to ensure their wishes and goals of care are followed.

Studies have shown that advance directives increase patient satisfaction by encouraging physician-patient communication and shared decision-making.[1] It is therefore beneficial for physicians to discuss advance care planning with patients and their families, especially if there are concerns that the patient is at risk for loss of capacity.

Before having a discussion with patients and families, it is important to have a fundamental understanding of the components of an advance directive and how it impacts patient care.

What is an Agent?

An agent is a person appointed by the patient to make medical decisions on their behalf. An agent can be an adult family member, friend, or any trusted person identified by the patient. An agent cannot be the patient's treating physician or any employee at your practice. However, an agent who is related to, or who is a coworker of the patient, is a recognized exception. In such scenarios, that individual can serve as an agent but cannot concurrently participate as a member of the care team.

What Healthcare Decisions Can an Agent Make?

An agent can make all healthcare decisions except those decisions expressly limited in the advance directive. An agent is authorized to:[2]

- Accept or refuse treatment
- Withdraw consent for treatment including nutrition, hydration, and cardiopulmonary resuscitation
- Choose or reject any physician, healthcare provider, or facility
- Receive and consent to release of medical information
- Donate organs and tissues
- Authorize autopsy and dispose of remains

The agent's decisions must be consistent with the patient's wishes, values, and goals of care.

What Makes an Advance Directive Valid?

Although there is no duty to investigate the validity of an advance directive, you should ensure that the following are present in the directive:[3]

- Patient's signature
- Two adult witness' signatures
  Witnesses cannot be the healthcare provider (physician), physician's employee, operator or employee of a community care or residential care facility, or the appointed agent. An acknowledgment by a notary public may be used.

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- Signature of patient advocate or ombudsman for advanced directives executed when an individual is a patient in a skilled nursing facility
- Witness declarations, including one witness who is not related to the patient
- Date that the advance directive was executed

A physician should initiate further review when a newly executed advance directive is presented during the time when the patient's decisional capacity is in question and when family members are disputing the patient's directives.

What if a Patient Presents With an Advance Directive from Another State?

California does not prohibit out-of-state advance directives.[4] The physician should read the advance directive in its entirety and ensure that the signature, date, and witness requirements are met. If these elements are present, the practice must follow the directive.

Revocation of an Advance Directive

There are a variety of reasons why a patient would want to revoke their advance directive. One of the most common reasons is related to changes in goals of care. A patient can revoke their advance directive at any time. However, if the patient wishes to revoke the power of an agent, they must directly express this desire to the attending physician. A revocation should be documented in the patient's medical record. If there are concerns regarding the patient's capacity to revoke, it is recommended the physician seek further guidance, e.g., from a bioethics committee.

Does A Physician Have the Right to Refuse to Comply With an Advance Directive?

A physician has the right to refuse to comply with an advance directive if the requested treatment is medically inappropriate. In these cases, it is important that the physician communicates his concern to the agent. If the physician and agent are unable to resolve the disagreement, the physician can elect to terminate the patient-physician relationship after appropriate notice is given to the agent.

Tips on How to Discuss Advance Directives with a Patient:

Having an advance directive discussion with a patient can be uncomfortable and difficult to approach. However, advance directives promote patient autonomy and provide physicians with clearer guidance on end-of-life decisions. The following are guidelines that can help a physician facilitate the conversation:[5]

- Invite the patient to share their desire regarding future medical care

  Would you like to talk about what might happen in the future, and how we could make sure your wishes are followed?
- Allow the patient to determine whether they want others involved in advanced care planning

  Would you like to talk about this by yourself, or are there others you would like to join us?
- Determine if the patient has thoughts about the medical care that they would like to receive in the future

  Has someone close to you been faced with an end-of-life decision? What would you have wanted in that situation?
- Ask about advance care preferences

  If you were to stop breathing, would you want to be on a machine that breathes for you?
- Have the patient identify someone who will carry out their wishes in case they are unable to in the future

  If you became unable to inform your care team what kind of care they should provide you, who would you want to make medical decisions for you?
- Encourage the patient to complete an advance healthcare directive form

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These are important decisions that will impact your care in the future; we should make sure to get them in writing.

By understanding the components of advance directives and planning, the physician will ultimately improve patient satisfaction and trust. Since January 2016, the Centers for Medicare & Medicaid Services (CMS) approved advanced care planning as a distinct service that allows providers to bill Medicare under Current Procedural Terminology (CPT) codes 99497 and 99498.[6] As a result, providers who document that an advance care planning discussion was completed will likely receive a Medicare reimbursement. Private insurers may also offer reimbursement for advance healthcare; therefore, it is recommended that providers review their contracts.

If there are any concerns regarding an advance directive, members should contact CAP for additional guidance via the Risk Management Hotline at 800-252-0555.

Bryan Dildy is a Senior Risk Management & Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to BDildy@CAPphysicians.com.

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[1]Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomized controlled trial. BMJ 2010; 340:c1345.

[2]California Hospital Association Consent Manual 48th Edition. 2021.

[3]California Probate Code § 4674

[4]California Probate Code § 4676

[5]Childers JW, Back AL, Tulsky JA, Arnold RM. REMAP: A Framework for Goals of Care Conversations. J Oncol Pract. 2017 Oct;13(10):e844-e850. doi: 10.1200/JOP.2016.018796. Epub 2017 Apr 26. PMID: 28445100.

[6]Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services, https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf (last visited Jan. 27, 2023).

A.M. Best Affirms A+ (Superior) Rating of the Cooperative of American Physicians' Mutual Protection Trust for 16th Consecutive Year

As a CAP member, you'll be pleased to know that the Mutual Protection Trust (MPT) has earned a Financial Strength Rating of A+ (Superior) from A.M. Best for the 16th consecutive year.

Among several notable acknowledgments, A.M. Best recognized MPT's "cost-effective medical professional liability services," with a "favorable market position in California as the second-largest provider of physician professional liability coverage in the state."

The rating reflects MPT's ability to meet ongoing coverage and contract obligations for your more than 12,500 fellow physician members. MPT's outlook was reaffirmed as stable and its strong financial flexibility, capital strength, and sound invested asset base were highlighted as part of the rating.

"Since 2006, MPT has received an A+ rating from A.M. Best, a demonstration of our ongoing prudent financial oversight and strength on behalf of our physician members and their practices," said CAP CEO Sarah E. Scher. "As so many California physicians recognize and rely upon MPT's protection, CAP continues to experience significant growth."

A.M. Best is the oldest credit reporting agency, assessing the creditworthiness of over 16,000 companies worldwide; and is renowned for its financial ratings and information in the insurance industry. A.M. Best's internationally recognized Credit Ratings summarize an organization's ability to pay claims and debts and meet other financial obligations. For more information on A.M. Best and its rating criteria, visit www.ambest.com.

Congratulations to all CAP members on another year of prestigious recognition by A.M. Best.

Important Information About CAP Member CyberRisk Insurance Benefits

Providing the best medical malpractice coverage and practice support benefits to protect your professional and personal well-being are a hallmark of CAP membership.

Healthcare facilities and medical groups continue to experience a dramatic increase in the frequency and severity of claims as a result of ransomware and phishing attacks.

As today's risks are more threatening and prevalent, it is important for you to remember the value-added insurance coverages CAP provides as part of your membership, including CyberRisk insurance. This cyberliability policy covers up to $50,000 and 5,000 patient notifications per covered claim should you experience a data breach in your practice.

CAP members should note that their CyberRisk insurance includes a $2,500 deductible per covered claim.

In addition, your CyberRisk insurance benefit is subject to a shared annual aggregate limit of $10,000,000, which means that all amounts paid under CyberRisk on your behalf and on behalf of all other CAP members will reduce and may completely exhaust such shared annual aggregate limit. If the shared annual aggregate limit is exhausted, your individual CyberRisk limits will also be deemed exhausted, and there will be no further CyberRisk insurance benefit available to you or others for the remainder of the year.

To avoid potential claims, CAP encourages all member practices to implement strict cybersecurity measures. As part of the benefits of your CyberRisk insurance, you and your staff can access free HIPAA training courses on how to prevent data breaches, and much more at https://CAP.nascybernet.com. (First-time users will need to sign up for a free account with your CAP member number as your "Sign Up Code." Once you have registered, you will be able to create usernames and passwords for your employees also.)

To report any claim or potential incident, please contact Tokio Marine HCC below, advise that you are a CAP member, and give your CAP member/entity number:

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Encino, CA 91436
Claims Telephone Number: 888-627-8995
Claims Email Address: cpl.claims@tmhcc.com

There are no upfront costs to report a claim or potential claim. Tokio Marine HCC's goal is to get you back up and running while reaching a successful resolution. When it comes to providing expert breach response, Tokio Marine HCC's in-house claims team considers the needs of each member.

Now is a good time to explore purchasing additional CyberRisk insurance available at excellent rates through CAP Physicians Insurance Agency, Inc. (CAP Agency). To learn more, call one of CAP Agency's licensed insurance professionals at **800-819-0061** or email **CAPAgency@CAPphysicians.com**.

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MARCH 2023

Legislature Pivots to the Opioid Crisis

by Gabriela Villanueva

In California, based on data available from the Department of Public Health as of January 4, 2023, there were 7,175 opioid-related overdose deaths in 2021, with 5,961 being fentanyl-related. Amongst those, 236 were teens aged 15 to 19. Another staggering data point on this report is the 21,016 emergency department visits related to opioid overdoses in 2021.[1]

With the state's COVID-19 public health emergency expired as of February 28, 2023, lawmakers have the chance to focus more on legislation addressing the ongoing opioid crisis.

Starting with a special bipartisan committee to investigate fentanyl and opioid deaths, Assembly Speaker Anthony Rendon (Lakewood-D) approved the creation of the Assembly Select Committee on Fentanyl, Opioid Addiction, and Overdose Prevention. According to the committee's designated chair, Matt Haney (San Francisco-D), the bipartisan committee will focus on three areas of the opioid crisis: "public health response to opioid addiction; the response of law enforcement to the sale of opioids and fentanyl; and current medical practices for treating opioids and fentanyl addiction."

Additionally, the committee will hold meetings in impacted communities across the state and will hear from national addiction experts, local and state leaders, and residents.[2]

Committee members include four Republicans and seven Democrats. They are:

Members of the Select Committee on Fentanyl, Overdose Prevention, & Opioids

Assemblymember Matt Haney (D-San Francisco)

Assemblymember Isaac Bryan (D-Los Angeles)

Assemblymember Laurie Davies (R-Laguna Niguel)

Assemblymember Ash Kalra (D-San Jose)

Assemblymember Jim Patterson (R-Fresno)

Assemblymember Cottie Petrie-Norris (D-Laguna Beach)

Assemblymember James Ramos (D-Highland)

Assemblymember Robert Rivas (D-Salinas)

Assemblymember Kelly Seyarto (R-Murrieta)

Assemblymember Marie Waldron (R-Escondido)

Assemblymember Jim Wood (D-Santa Rosa)

Other bills now introduced into the 2023-2024 legislative cycle include:

AB 33 (Bains-D) Fentanyl Task Force

Summary: Would state the intent of the Legislature to enact legislation relating to a fentanyl task force, in order to identify and address the fentanyl crisis as part of the opioid epidemic in this state. The bill would further state the intent of the Legislature that any future appropriation made for the purpose of implementing the fentanyl task force does not exceed a specific dollar amount.

PUBLIC POLICY

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AB 462 (Ramos-D) Overdose Response Teams

Summary: Would authorize the Counties of San Bernardino, Riverside, and Orange, until January 1, 2029, to establish and implement overdose response teams with the sheriff's departments of those counties. The bill would require these teams to only respond to and investigate overdose deaths and nonfatal overdoses involving juveniles and multiple victims, with a focus on overdose deaths related to fentanyl. The bill would require counties participating in these programs to send annual reports to the Assembly Select Committee on Fentanyl, Opioid Addiction, and Overdose Prevention, including the number of arrests of drug dealers in each county, the amount of fentanyl and opioids seized in each county, and the number of units of opioid antagonists found at each overdose scene.

SB 10 (Cortese-D) Pupil Health: Opioid Overdose Prevention and Treatment

Summary: Current law requires the Department of Education to recommend best practices and identify training programs for use by local educational agencies to address youth behavioral health issues. Current law also requires the department to ensure that each identified training program provides instruction on recognizing the signs and symptoms of youth behavioral health disorders, including common psychiatric conditions and substance use disorders, such as opioid and alcohol abuse. This bill would add the requirement that training programs provide instruction to school staff on the use of emergency opioid antagonists for purposes of treating an opioid overdose, with the recommended training following specified standards and criteria.

SB 62 (Nguyen-R) Controlled Substances: Fentanyl

Summary: Current law prohibits a person from possessing for sale or purchasing for purposes of sale, specified controlled substances, including fentanyl, and provides for imprisonment in a county jail for 2 to 4 years for a violation of this provision. Current law also imposes an additional term and authorizes a trial court to impose a specified fine upon a person who is convicted of a violation of, or of a conspiracy to violate, specified provisions of law with respect to a substance containing heroin, cocaine base, and cocaine, if the substance exceeds a specified weight. This bill would impose that additional term upon, and authorize a fine against, a defendant who violates those laws with respect to a substance containing fentanyl. By increasing the penalty for a crime, the bill would impose a state mandated local program.

SB 67 (Seyarto-R) Controlled Substances: Overdose Reporting

Summary: Would require an emergency medical services provider who treats and releases or transports an individual to a medical facility who is experiencing a suspected or an actual overdose to report the incident to the Emergency Medical Services Authority. The bill requires the authority to report the data gathered pursuant to the bill to the Overdose Detection Mapping Application Program managed by the Washington/Baltimore High Intensity Drug Trafficking Area program.

SB 237 (Grove-R) Controlled Substances: Fentanyl

Summary: Current law prohibits a person from possessing for sale or purchasing for purposes of sale specified controlled substances, including fentanyl, and punishes a violation of that prohibition by imprisonment in a county jail for 2 to 4 years. Current law also prohibits transporting, importing into this state, selling, furnishing, administering, or giving away specified controlled substances, including fentanyl, and punishes a violation of that prohibition by imprisonment in a county jail for 3 to 5 years. Current law also prohibits the trafficking of specified controlled substances, including fentanyl, and punishes a violation of that prohibition by

imprisonment in a county jail for anywhere between 3 to 9 years. The bill would punish the possession, sale, or purchase for sale of fentanyl by imprisonment in a county jail for 4 to 6 years, the transportation, importation, sale, furnishing, administering, or giving away of fentanyl by imprisonment in a county jail for 7 to 9 years, and the trafficking of fentanyl by imprisonment in a county jail for anywhere between 7 to 13 years.

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

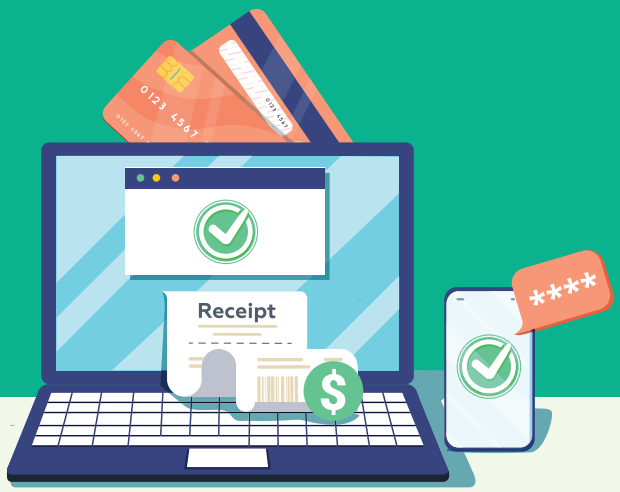
Resources:

California has education and prevention resources, including a program that offers free Naloxone, a life-saving medication used to reverse opioid overdose, for qualified organizations. For more information, go to: https://www.cdph.ca.gov/Programs/OPA/Pages/NR22-148.aspx

References:

[1]California Overdose Surveillance Dashboard. https://skylab.cdph.ca.gov/ODdash/?tab=Home

[2]Press Release. September 29, 2022. Assemblymember Haney Announces Creation of Special Bipartisan Committee to Investigate Fentanyl and Opioid Deaths in California, https://a17.asmdc.org/press-releases/20220929-assemblymember-haney-announces-creation-special-bipartisan-committee



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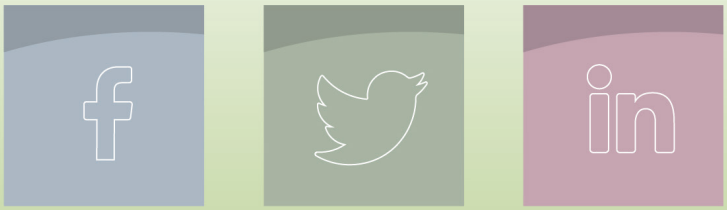

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