Date of Hearing: June 27, 2023
Counsel: Andrew Ironside

ASSEMBLY COMMITTEE ON PUBLIC SAFETY
Reginald Byron Jones-Sawyer, Sr., Chair

SB 67 (Seyarto) – As Amended April 24, 2023

SUMMARY: Requires coroners and medical examiners to report actual or suspected overdoses to the Emergency Medical Services Agency (EMSA), which is then required to submit this data to the Overdose Detection Mapping Application Program (ODMAP). Specifically, **this bill**:

1) Requires a coroner or medical examiner who evaluates an individual who, in their opinion, died as the result of an overdose as a contributing factor, to report the incident to the ODMAP managed by the Washington/Baltimore High Intensity Drug Trafficking Area program.

2) Requires the coroner or medical examiner to make the report as soon as possible, but not later than 72 hours after examining the individual who died as the result of an overdose.

3) Requires, if the cause of death is still preliminary and pending toxicology screens, the coroner or medical examiner to report the overdose as a preliminary report, and to update the report when the cause of death is confirmed.

4) Prohibits overdose information reported to ODMAP by a coroner or medical examiner, or shared with ODMAP by EMSA, from being used for a criminal investigation or prosecution.

5) Provides that a person who in good faith makes a report to ODMAP is immune from civil or criminal liability for making the report.

6) Defines "overdose" as "a condition, including extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death, resulting from the consumption or use of any controlled dangerous substance that requires medical attention, assistance, or treatment, and clinical suspicion for drug overdose, including respiratory depression, unconsciousness, or altered mental state, without other conditions to explain the clinical condition."

7) Provides that it is the intent of the Legislature that the overdose information gathered be used for the purpose of making decisions regarding the allocation of public health and educational resources to communities adversely impacted by the use of drugs that lead to overdoses.

EXISTING LAW:

1) Requires coroners to determine the manner, circumstances and cause of death in the following circumstances, among others:

a) Violent, sudden or unusual deaths;

b) Known or suspected homicide, suicide or accidental poisoning;

c) Drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, aspiration, or sudden infant death syndrome;

d) Deaths known or suspected as due to contagious disease and constituting a public hazard;

e) Deaths from occupational diseases or occupational hazards; and,

f) Deaths reported for inquiry by physicians and other persons having knowledge of the death. (Gov. Code, § 27491.)

2) Requires the coroner or medical examiner to sign the certificate of death if they perform a mandatory inquiry. (Gov. Code, § 27491, subd. (a).)

3) States that the content of a death certificate must include, among other things, personal data of the decedent, date of death, place of death, disease or conditions leading directly to death and antecedent causes, accident and injury information, and information regarding pregnancy. (Health & Saf. Code, § 102875.)

4) Allows the medical and health section data and time of death to be filled out in certain circumstances by the physician or surgeon last in attendance or by a supervised licensed physician assistant, unless the coroner is required to certify the medical and health section data. (Health & Saf. Code, § 102795.)

5) Requires a physician and surgeon, physician assistant, funeral director, or other person to notify the coroner when they have knowledge that a death occurred, or if they have charge of a body in which death occurred under any of the following, among others:

a) Without medical attendance;

b) During continued absence of attending physician and surgeon;

c) Where attending physician and surgeon, or physician assistant is unable to state cause of death; and,

d) Reasonable suspicion to suspect death was caused by criminal act. (Health & Saf. Code, § 102850.)

6) Requires an attending physician's certificate be completed within 15 hours of death, or, if a coroner examined the body, within three days after examination of the body. (Health & Saf. Code, § 102800.)

7) Requires each death to be registered with the local registrar of births and deaths in the district in which the death was found or officially pronounced. (Health & Saf. Code, § 102775.)

8) Requires a funeral director, or person acting in lieu thereof, to prepare the certificate, other than the medical and health section data, and register it with the local registrar. (Health & Saf. Code, §§ 102780, 102790.)

9) States that the local registrar of deaths must carefully examine each certificate before acceptance for registration, and if any incomplete or incorrect certificates are submitted, to require further information as needed to make the certificate consistent with established policies. (Health & Saf. Code, § 102305.)

10) Requires the California Department of Public Health (DPH) to establish an Internet-based electronic death registration system for the creation, storage, and transfer of death registration information. (Health & Saf. Code, § 102778.)

11) Requires the DPH to access data within the electronic death registration system to compile reports on veteran suicide that include information on age, sex, race, county of residence, and method of suicide. (Health & Saf. Code, § 102791.)

12) Requires DPH to track data on pregnancy-related deaths and publish such data at least once every three years, as specified. (Health & Saf. Code, § 123630.4.)

FISCAL EFFECT: Unknown.

COMMENTS:

1) **Author's Statement**: According to the author, "Californians are falling victim to drug dealers who prey on the potency and availability of illicit drugs and opioids, like fentanyl. While each state, local, and federal departments [sic] uses its own program to track and report overdose incidents, currently, there is no uniform sharing of overdoses that include emergency medical services agencies, coroners, and fire departments. Limited to only authorized personnel and eliminating all personal identifiable information, ODMAP provides an essential tool for first responders on the frontlines of the opioid epidemic to effectively track and address live patterns of overdoses."

2) **Background on ODMAP:** In 1988, Congress created the High Intensity Drug Trafficking Areas (HIDTA) program to provide assistance to federal, state, local, and tribal law enforcement agencies operating in areas determined to be critical drug-trafficking regions of the United States. There are currently 33 HIDTAs, including four in California: Central Valley, Northern California, Los Angeles, and San Diego/Imperial Valley. In January of 2017, the Washington/Baltimore HIDTA launched ODMAP as a response to the lack of a consistent methodology to track overdoses, which limited the ability to understand and mobilize against the crisis. According to the Washington/Baltimore HIDTA, ODMAP is an overdose mapping tool that allows first responders to log an overdose in real time into a centralized database in order to support public safety and public health efforts to mobilize an immediate response to a sudden increase, or spike, in overdose events. ODMAP is only available to government agencies serving the interest of public safety and health, and each agency wishing to use the system must sign a participation agreement designed to protect the data within the system. The system currently serves more than 3,700 agencies with more than 28,000 users in all 50 states, and has logged 850,000 overdose events. According to the Washington/Baltimore HIDTA, there are seventeen states with statewide implementation

strategies, including several with legislation requiring reporting to ODMAP. (https://www.hidta.org/odmap/)

3) **Reporting Drug Overdoses:** California is taking a multi-pronged, collaborative approach to comprehensively address the drug epidemic in the state. (DPH, *Overdose Prevention Initiative*, (Last updated Dec. 6, 2022) <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/PrescriptionDrugOverdoseProgram.aspx> [as of June 22, 2023].) California's Overdose Prevention Initiative (OPI) collects and shares data on fatal and non-fatal drug related overdoses, overdose risk factors, prescriptions, and substance use. (DPH, *Overdose Prevention Initiative* (last updated June, 2023) <https://www.cdph.ca.gov/Programs/CCDPHP/sapb/Pages/OPI-landing.aspx> [as of June 22, 2023].) The OPI works with local and state partners to address the complex and evolving nature of the drug overdose epidemic by data collection and analysis, prevention programs, public awareness and education campaigns, and safe prescribing and treatment practices. (DPH. *Drug Overdose Response Partner Recommendations*. (Last updated Feb. 16, 2023].) <https://www.cdph.ca.gov/Programs/CCDPHP/sapb/Pages/Drug-Overdose-Response.aspx> [as of Mar. 22, 2023].) One of the five recommendations it makes to local and statewide partners is to improve rapid identification of drug overdose outbreaks partnering with coroner and medical examiner offices, healthcare facilities, and emergency medical services to obtain overdose data to form a timely response. (*Ibid*.)

Generally, drug overdose deaths require lengthier investigations that can include forensic toxicology analysis before the data can be used even in a preliminary or provisional manner. (Centers for Disease Control and Prevention (CDC) *Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts*. (Last reviewed Mar. 15, 2023) <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#drug_specificity> [as of Mar. 22, 2023].) Provisional data is used to give an approximate, although not completely accurate, depiction of drug overdose deaths. (*Ibid*.) Provisional counts of drug overdose deaths are underestimated relative to final counts, the degree of which is primarily determined by the percentage of records with the manner of death reported as "pending investigation" and tends to vary by a number of factors. (*Ibid.*) At the federal level, provisional estimates of drug overdose deaths were traditionally reported 6 months after the date of death, however, due to recent improvements, the 6-month lag was shortened to 4 months. (*Ibid*.) In California, the latest provisional data that the OPI displays was released on May 31, 2023, and it showed overdose deaths up to January 2023. (OPI. *Preliminary Monthly Fatal Drug-Related Overdose Counts*. (May 31, 2023) <https://www.cdph.ca.gov/Programs/CCDPHP/sapb/CDPH Document Library/Prelim_Monthly_Death_Data_2023_04_FINAL_ADA.pdf> [as of June 22, 2023].) Recent changes in the way overdose deaths are reported are resulting in quicker, although perhaps more tentative, data.

According to ESMA, in July of 2022, the agency entered into a data sharing agreement with ODMAP, including developing an application programming interface to allow data sharing from the California Emergency Medical Services Information System (CEMSIS) reporting system. According to EMSA, the system allows near real-time data sharing: as soon as an EMS provider closes out a call and completes the electronic record, the data is submitted to CEMSIS and if the incident is coded as an overdose, that information is then shared with ODMAP (though without personally identifiable information such as name, exact birth date, and exact address). Generally speaking, the data sharing happens nearly instantaneously;

however, there could be a delay of one to two days, depending on the region of California and internet connectivity. Once the Los Angeles County EMSA starts reporting via CEMSIS in July of this year, overdose data from all EMS providers will be shared with ODMAP if the incident record is correctly coded as an overdose or suspected overdose. According to EMSA, because the agreement with ODMAP is less than a year old, they are still working out some kinks. For instance, if an EMS provider does not enter the keywords associated with an overdose correctly, the application programming interface may not trigger the system to share the overdose information with ODMAP. EMSA states they are continuing to work with local EMSAs to improve the accuracy of the data shared with ODMAP to ensure the overdose reporting is as complete as possible.

To ensure accurate overdose reporting, this bill would require coroners and medical examiners to report actual or suspected overdoses to the EMSA, which is then required to submit this data to ODMAP.

4) **Related Legislation**:

   a) AB 1351 (Haney), would have required all coroners or medical examiners to submit quarterly reports to the DPH on deaths caused by, or involving, overdoses of any drugs. AB 1351 was held by the Assembly Appropriations Committee.

   b) AB 1462 (Jim Patterson), would require the DPH to access existing data within the electronic death registration system to compile a report on veteran drug overdose deaths in California and to report specified data. AB 1462 is pending hearing in the Senate Committee on Military and Veterans Affairs.

5) **Prior Legislation**: SB 1695 (Escutia) Chapter 678, Statutes of 2002, among other things, required DPH to create a webpage on drug overdose trends in California, including death rates, in order to ascertain changes in the cause or rate of fatal and nonfatal drug overdoses.

REGISTERED SUPPORT / OPPOSITION:

Support

Arcadia Police Officers' Association
Burbank Police Officers' Association
California Coalition of School Safety Professionals
California Police Chiefs Association
California Reserve Peace Officers Association
Chino Valley Chamber of Commerce
Claremont Police Officers Association
Corona Police Officers Association
County of Fresno
Culver City Police Officers' Association
Deputy Sheriffs' Association of Monterey County
Drug Induced Homicide
Fullerton Police Officers' Association
Los Angeles School Police Officers Association

Murrieta Police Officers' Association
Newport Beach Police Association
Novato Police Officers Association
Pain Parents & Addicts in Need
Palos Verdes Police Officers Association
Placer County Deputy Sheriffs' Assocation
Pomona Police Officers' Association
Riverside County Sheriff's Office
Riverside Police Officers Association
Riverside Sheriffs' Association
Santa Ana Police Officers Association
Shasta Substance Use Coalition
Upland Police Officers Association

Opposition

None submitted

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