SENATE BILL NO. 680

November 09, 2023, Introduced by Senators KLINEFELT, CAVANAGH, HERTEL, SINGH, MOSS, GEISS, CHANG, POLEHANKI, MCCANN, IRWIN, BAYER and WOJNO and referred to the Committee on Health Policy.

A bill to amend 1978 PA 368, entitled "Public health code," by amending sections 17752 and 20175 (MCL 333.17752 and 333.20175), section 17752 as amended by 2020 PA 4 and section 20175 as amended by 2023 PA 62, and by adding section 16221c.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 16221c. A licensee's or registrant's participation in good-faith compliance with the death with dignity act is not grounds for the department to investigate under section 16221 or
for disciplinary action against the licensee or registrant under section 16226.

Sec. 17752. (1) A licensee or dispensing prescriber shall preserve a prescription, or an equivalent record of the prescription approved by the board, for not less than 5 years.

(2) A prescription or equivalent record on file in a pharmacy is not a public record. A person having custody of or access to prescriptions shall not disclose their contents or provide copies without the patient's authorization, to any person except to any of the following:

(a) The patient for whom the prescription was issued, or another pharmacist acting on behalf of the patient.

(b) The authorized prescriber who issued the prescription, or a licensed health professional who is currently treating the patient.

(c) An agency or agent of government responsible for the enforcement of laws relating to drugs and devices.

(d) A person authorized by a court order.

(e) A person engaged in research projects or studies with protocols approved by the board.

(f) The department of health and human services for purposes of section 15 of the death with dignity act.

(3) A pharmacist may refill a copy of a prescription from another pharmacy if the original prescription has remaining authorized refills, and the copy is issued according to the following procedure:

(a) The pharmacist issuing a written or oral copy of a prescription shall cancel the original prescription and record the cancellation. The record of cancellation must include the date the
copy was issued, to whom issued, and the identification of the pharmacist who issued the copy.

(b) The written or oral copy issued must be a duplicate of the original prescription except that it must also include the prescription number, the name of the pharmacy issuing the copy, the date the copy was issued, and the number of authorized refills remaining available to the patient.

(c) The pharmacist receiving a written or oral copy of the prescription shall exercise reasonable diligence to determine whether it is a valid copy, and having done so may treat the copy as an original prescription.

(d) Except as described in this part, all other copies furnished must be used for information purposes only and clearly marked "for informational or reference purposes only".

(4) Subsection (3) does not apply to any of the following:

(a) Pharmacies that share a real-time, online database or other equivalent means of communication.

(b) Pharmacies that transfer prescriptions pursuant to a written contract for centralized prescription processing services as provided under section 17753.

(c) A parent pharmacy if the parent pharmacy receives a copy of a prescription from a remote pharmacy that it operates.

(d) A remote pharmacy if the remote pharmacy receives a copy of a prescription from a parent pharmacy.

(5) For purposes of this section, "equivalent record of the prescription approved by the board" or "equivalent record" includes a digital image described in section 17751(1).

Sec. 20175. (1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete
record of tests and examinations performed, observations made,
treatments provided, and in the case of a hospital, the purpose of
hospitalization. If a medical service provided to a patient on or
after the effective date of the amendatory act that added this
sentence involves the vaginal or anal penetration of the patient, a
health facility or agency shall ensure that the patient's medical
record expressly states that vaginal or anal penetration was
performed unless the medical service meets any of the circumstances
described in subsection (2)(b)(i)(A), (B), (C), or (D).

(2) Unless a longer retention period is otherwise required
under federal or state laws or regulations or by generally accepted
standards of medical practice, a health facility or agency shall
keep and retain each record required under subsection (1) as
follows:

(a) Except as otherwise provided in subdivision (b), for a
minimum of 7 years from the date of service to which the record
pertains.

(b) For a minimum of 15 years from the date of service to
which the record pertains if the service is performed on or after
the effective date of the amendatory act that added this
subdivision October 10, 2023 and 1 of the following applies:

(i) The record includes a medical service involving the vaginal
or anal penetration of a patient. This subparagraph does not apply
to a record for any of the following:

(A) A medical service that primarily relates to the patient's
urological, gastrointestinal, reproductive, gynecological, or
sexual health.

(B) A medical service that is necessary and associated with or
incident to a medical emergency. As used in this sub-subparagraph,
"medical emergency" means a circumstance that, in the good-faith medical judgment of a health professional who is licensed under article 15, creates an immediate threat of serious risk to the life or physical health of the patient.

(C) A medical service performed for the purpose of rectally administering a drug or medicine.

(D) A medical service performed to measure a patient's temperature.

(ii) The patient has filed a complaint with the health facility or agency alleging sexual misconduct by an individual who is employed by, under contract to, or granted privileges by the health facility or agency. As used in this subparagraph, "sexual misconduct" means the conduct described in section 90, 136, 145a, 145b, 145c, 520b, 520c, 520d, 520e, or 520g of the Michigan penal code, 1931 PA 328, MCL 750.90, 750.136, 750.145a, 750.145b, 750.145c, 750.520b, 750.520c, 750.520d, 750.520e, or 750.520g, regardless of whether the conduct resulted in a criminal conviction.

(3) A health facility or agency shall maintain the records required under subsection (1) in such a manner as to protect their integrity, to ensure their confidentiality and proper use, and to ensure their accessibility and availability to each patient or the patient's authorized representative as required by law.

(4) Except as otherwise provided in subsection (6), a health facility or agency may destroy a record required under subsection (1) that is less than 7 years old only if both of the following are satisfied:

(a) The health facility or agency sends a written notice to the patient at the last known address of that patient informing the
patient that the record is about to be destroyed, offering the
patient the opportunity to request a copy of that record, and
requesting the patient's written authorization to destroy the
record.

(b) The health facility or agency receives written
authorization from the patient or the patient's authorized
representative agreeing to the destruction of the record.

(5) Except as otherwise provided under federal or state laws
and regulations, records required to be maintained under subsection
(1), other than a record described in subsection (2)(b), may be
destroyed or otherwise disposed of after being maintained for 7
years, and records described in subsection (2)(b) may be destroyed
or otherwise disposed of after being maintained for 15 years. If
records maintained in accordance with this section are subsequently
destroyed or otherwise disposed of, those records must be shredded,
incinerated, electronically deleted, or otherwise disposed of in a
manner that ensures continued confidentiality of the patient's
health care information and any other personal information relating
to the patient. If records are not destroyed or otherwise disposed
of as provided under this subsection or subsection (4), the
department may take action, including, but not limited to,
contracting for or making other arrangements to ensure that those
records and any other confidential identifying information related
to the patient are properly destroyed or disposed of to protect the
confidentiality of patient's health care information and any other
personal information relating to the patient. Before the department
takes action in accordance with this subsection, the department, if
able to identify the health facility or agency responsible for the
improper destruction or disposal of the medical records at issue,
shall send a written notice to that health facility or agency at
the last known address on file with the department and provide the
health facility or agency with an opportunity to properly destroy
or dispose of those medical records as required under this
subsection or subsection (4), unless a delay in the proper
destruction or disposal may compromise the patient's
confidentiality. The department may assess the health facility or
agency with the costs incurred by the department to enforce this
subsection. In addition to the sanctions set forth in section
20165, a hospital that fails to comply with this subsection or
subsection (4) is subject to an administrative fine of $10,000.00.

(6) A health facility or agency shall only destroy a record
described in subsection (2)(b) in accordance with subsection (5).

(7) A hospital shall take precautions to ensure that the
records required under subsection (1) are not wrongfully altered or
destroyed. A hospital that fails to comply with this subsection is
subject to an administrative fine of $10,000.00.

(8) Unless otherwise provided by law, the licensing and
certification records required by this article are public records.

(9) Departmental officers and employees shall respect the
confidentiality of patient clinical records and shall not divulge
or disclose the contents of records in a manner that identifies an
individual except pursuant to court order or as otherwise
authorized by law.

(10) A—Except as otherwise provided in section 19 of the death
with dignity act, a health facility or agency that employs,
contracts with, or grants privileges to a health professional
licensed or registered under article 15 shall report the following
to the department not more than 30 days after it occurs:
(a) Disciplinary action taken by the health facility or agency against a health professional licensed or registered under article 15 based on the licensee's or registrant's professional competence, disciplinary action that results in a change of employment status, or disciplinary action based on conduct that adversely affects the licensee's or registrant's clinical privileges for a period of more than 15 days. As used in this subdivision, "adversely affects" means the reduction, restriction, suspension, revocation, denial, or failure to renew the clinical privileges of a licensee or registrant by a health facility or agency.

(b) Restriction or acceptance of the surrender of the clinical privileges of a licensee or registrant under either of the following circumstances:

(i) The licensee or registrant is under investigation by the health facility or agency.

(ii) There is an agreement in which the health facility or agency agrees not to conduct an investigation into the licensee's or registrant's alleged professional incompetence or improper professional conduct.

(c) A case in which a health professional resigns or terminates a contract or whose contract is not renewed instead of the health facility or agency taking disciplinary action against the health professional.

(11) Upon request by another health facility or agency seeking a reference for purposes of changing or granting staff privileges, credentials, or employment, a health facility or agency that employs, contracts with, or grants privileges to health professionals licensed or registered under article 15 shall notify the requesting health facility or agency of any disciplinary or
other action reportable under subsection (10) that it has taken
against a health professional licensed or registered under article
15 and employed by, under contract to, or granted privileges by the
health facility or agency.

(12) For the purpose of reporting disciplinary actions under
this section, a health facility or agency shall include only the
following in the information provided:
(a) The name of the licensee or registrant against whom
disciplinary action has been taken.
(b) A description of the disciplinary action taken.
(c) The specific grounds for the disciplinary action taken.
(d) The date of the incident that is the basis for the
disciplinary action.

(13) The records, data, and knowledge collected for or by
individuals or committees assigned a professional review function
in a health facility or agency, or an institution of higher
education in this state that has colleges of osteopathic and human
medicine, are confidential, must be used only for the purposes
provided in this article, are not public records, and are not
subject to court subpoena.

(14) This section does not apply to a health facility or
agency that is a health maintenance organization.

Enacting section 1. This amendatory act takes effect 90 days
after the date it is enacted into law.

Enacting section 2. This amendatory act does not take effect
unless Senate Bill No. 681 of the 102nd Legislature is enacted into
law.