HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 977 Behavioral Health Workforce
SPONSOR(S): Health Quality Subcommittee; Peters
TIED BILLS: **IDEN./SIM. BILLS:** SB 1250

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N, As CS	Siples	O'Callaghan
2) Health & Human Services Committee	11 Y, 0 N	Siples	Calamas

SUMMARY ANALYSIS

The bill authorizes physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) to prescribe controlled substances, but includes certain limitations on such prescribing authority. Specifically, the bill allows the Council on Physician Assistants and the Board of Nursing (BON) to each adopt a formulary to limit the types and amounts of controlled substances that may be prescribed by PAs and ARNPs, respectively. The bill requires the BON to form a committee, comprised of members recommended by the Board of Medicine, the BON, and the Board of Pharmacy, to establish and recommend the formulary that limits ARNP controlled substance prescribing authority, which the BON must adopt in rule.

The bill amends s. 456.44, F.S., to require a PA or an ARNP, who prescribes any controlled substance for the treatment of chronic nonmalignant pain to register with the Department of Health (DOH) as a controlled substance prescribing practitioner. This new requirement also subjects PAs and ARNPs who are registered as controlled substance prescribing practitioners to meet the statutory practice standards for such prescribing practitioners. Additionally, the bill provides that only a physician may dispense medication or prescribe a controlled substance on the premises of a registered pain-management clinic.

The bill requires certain continuing education to be completed by PAs and ARNPs relating to the safe and effective prescribing of controlled substances. The bill also subjects PAs and ARNPs to additional disciplinary actions related to the prescribing of controlled substances.

The bill makes the process of retaining a patient in a receiving facility, or placing a patient in a treatment facility, after an involuntary examination under the Baker Act more efficient by allowing the psychiatrist providing the first opinion and the psychiatrist or clinical psychologist providing a second opinion to examine the patient electronically. Currently, only the psychiatrist or clinical psychologist providing a second opinion may perform an examination electronically.

The bill corrects current law to exempt persons employed with the Department of Corrections in an inmate substance abuse program are exempt from a fingerprinting and background check requirement, unless they have direct contact with unmarried inmates under the age of 18 or with inmates who are developmentally disabled. The current law erroneously states the inverse.

The bill expands who is eligible to be a service provider in a substance abuse program by allowing those persons who have had a disqualifying offense that occurred 5 or more years ago and who have requested an exemption from disqualification to work with adults with substance use disorders. These individuals must work under the supervision of a qualified psychologist, clinical social worker, marriage and family therapist, mental health counselor, or a master's level certified addiction professional until the agency makes a final determination regarding the request for an exemption from disqualification.

The bill may have an insignificant, negative fiscal impact on the DOH, and appears to have no fiscal impact on local governments.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Behavioral Health Workforce Shortage

The Institute of Medicine (IOM) has chronicled efforts, beginning as early as the 1970s, which have attempted to deal with some of the workforce issues regarding mental and substance use disorders, but notes that most have not been sustained long enough or been comprehensive enough to remedy the problems.[1] Shortages of qualified workers, recruitment and retention of staff, and an aging workforce have long been cited as problems.[2] Lack of workers in rural areas and the need for a workforce more reflective of the racial and ethnic composition of the U.S. population create additional barriers to accessing care for many.[3] Recruitment and retention efforts are hampered by inadequate compensation, which discourages many from entering or remaining in the field.[4] In addition, the misperceptions and prejudice surrounding mental and substance use disorders and those who experience them are imputed to those who work in the field.[5]

Of additional concern, a 2012 IOM[6] report notes that the workforce is unprepared to meet the mental and substance use disorder treatment needs of the rapidly growing population of older adults. The IOM report's data indicate that 5.6 to 8 million older adults, about one in five, have one or more mental health and substance use conditions which compound the care they need. However, there is a dearth of mental health or substance abuse practitioners who are trained to deal with this population.

The 2012 IOM report projects that by 2020, there will be 12,624 child and adolescent psychologists needed, but a supply of only 8,312 is anticipated.[7] In 2010, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that more than two-thirds of primary care physicians who tried to obtain outpatient mental health services for their patients reported they were unsuccessful because of shortages in mental health care providers, health plan barriers, and lack of coverage or inadequate coverage.

As of January 2016, the Health Resources and Services Administration has designated 4,362 Mental Health Professional Shortage Areas, including one or more in each state, the District of Columbia, and each of the territories.[8]

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[1] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*, January 24, 2013, pg. 4, citing the following Institute of Medicine reports: Institute of Medicine, (2006), *Improving the quality of health care for mental and substance-use conditions.,* Washington, DC, National Academies Press; Institute of Medicine, (2003), Greiner, A., & Knebel, E. (Eds.), *Health professions education: A bridge to quality.*, Washington, DC, National Academies Press; Institute of Medicine, (2004), Smedley, B. D., Butler, A. S., Bristow, L. R. (Eds.), *In the nation's compelling interest: Ensuring diversity in the health-care workforce.*, Washington, DC, National Academies Press; and Institute of Medicine, & Eden, J., (2012), *The mental health and substance use workforce for older adults: In whose hands?*, Washington, DC, National Academies Press; *available at* https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjK9-voubzKAhVCVyYKHYx5DHYQFggdMAA&url=https%3A%2F%2Fstore.samhsa.gov%2Fshin%2Fcontent%2FPEP13-RTC-BHWORK%2FPEP13-RTC-BHWORK.pdf&usg=AFQjCNGxewm3bHzmpsqu5zeWfUdqYhVpiw&sig2=WC81nKPjgNdMdm00jN20fw (last accessed on January 30, 2016).

[2] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*, January 24, 2013, pg. 4, *available at* https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjK9-voubzKAhVCVyYKHYx5DHYQFggdMAA&url=https%3A%2F%2Fstore.samhsa.gov%2Fshin%2Fcontent%2FPEP13-RTC-BHWORK%2FPEP13-RTC-BHWORK.pdf&usg=AFQjCNGxewm3bHzmpsqu5zeWfUdqYhVpiw&sig2=WC81nKPjgNdMdm00jN20fw (last accessed on January 30, 2016).

[3] *Id*.

[4] *Id*.

[5] *Id*.

[6] *Id.*

[7] *Id*. at 10.

[8] Health Resources and Services Administration, *Data Warehouse, Health Professional Shortage Areas (HPSA) and*

Behavioral Health Practice

In the U.S., states generally require a person to achieve higher levels of education to become a mental health counselor compared to that of a substance abuse counselor. As of 2011, almost all states (98 percent) required a master's degree to qualify as a mental health counselor, but 45 percent of states did not require any college degree to qualify as a substance abuse counselor. For behavioral health care disciplines, independent practice requires a master's degree in most states; however, for addiction counselors, data available a decade ago indicated that about 50-55 percent of those certified or practicing in the field held at least a master's degree, 75 percent held a bachelor's degree, and the reminder had either completed some college or held a high school diploma or equivalent degree.[9]

Because of major changes to the field of behavioral health, including the integration of behavioral health and primary care, a push to accelerate the adoption of evidence-based practices, and a model of care that is recovery-oriented, person-centered, integrated, and utilizes multi-disciplinary teams, behavioral health workers are in need of additional pre-service training and continuing education.[10] Behavioral health has moved to a chronic care, public health model to define needed services. This model recognizes the importance of prevention, the primacy of long-term recovery as its key construct, and is shaped by those with lived experience of recovery.[11] This new care model will require a diverse, skilled, and trained workforce that employs a range of workers, including people in recovery, recovery specialists, case workers, and highly trained specialists.[12] In fact, the movement to include primary care providers into the field of behavioral health has meant that there is currently no consensus as to which health care provider types make up the workforce.[13] Generally, however, the workforce is made up of professionals practicing psychiatry, clinical psychology, clinical social work, advanced practice psychiatric nursing, marriage and family therapy, substance abuse counseling, and counseling.[14]

Involuntary Examination and Inpatient Placement under the Baker Act

In 1971, the Legislature passed the Florida Mental Health Act (also known as the Baker Act[15]), codified in part I of ch. 394, F.S., to address mental health needs in the state.[16] The Baker Act provides the authority and process for the voluntary and involuntary examination of persons with evidence of a mental illness and the subsequent inpatient or outpatient placement of such individuals for treatment.

The Department of Children and Families (DCF) administers the Baker Act through receiving facilities that examine persons with evidence of mental illness. Receiving facilities are designated by the DCF and may be public or private facilities that provide the examination and short-term treatment of persons who meet the criteria under the Baker Act.[17] Subsequent to examination at a receiving facility, a person who requires further treatment may be transported to a treatment facility. Treatment facilities

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Medically Underserved Areas / Populations (MUA/P), *available at* http://datawarehouse.hrsa.gov/topics/shortageAreas.aspx#chart (last accessed on January 30, 2016).

[9] *Supra* note 2.

[10] *Id*. at 4-5.

[11] *Id*. at 6.

[12] *Id*.

[13] Congressional Research Service, *The Mental Health Workforce: A Primer*, April 16, 2015, *available at* http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0ahUKEwjK9-voubzKAhVCVyYKHYx5DHYQFgguMAI&url=http%3A%2F%2Ffas.org%2Fsgp%2Fcrs%2Fmisc%2FR43255.pdf&usg=AFQjCNHkmHp_4SMtmCWS7gImwEWxhPGI1g&sig2=5JBwSXTV1PHBeGZJGig0Xw(last accessed on January 30, 2016).

[14] *Id*. at 2 (using the Substance Abuse and Mental Health Services Administration definition).

[15] "The Baker Act" is named for its sponsor, Representative Maxine E. Baker, one of the first two women from Dade County elected to office in the Florida Legislature. As chair of the House Committee on Mental Health, she championed the treatment of mental illness in a manner that would not sacrifice a patient's rights and dignity. Baker served five terms as a member of the Florida House of Representatives from 1963-1972 and was instrumental in the passage of the Florida Mental Health Act. *See* University of Florida Smathers Libraries, *A Guide to the Maxine E. Baker Papers*, *available at* http://www.library.ufl.edu/spec/pkyonge/baker.htm (last accessed January 21, 2016), and Department of Children and Families and University of South Florida, Department of Mental Health and Law, *Baker Act Handbook and User Reference Guide 2014 (2014)*, *available at* http://myflfamilies.com/service-programs/mental-health/baker-act (select "2014 Baker Act Manual) (last accessed January 30, 2016).

[16] Chapter 71-131, s. 1, Laws of Fla.

[17] Section 394.455(26), F.S.

designated by the DCF are state hospitals (e.g. Florida State Hospital) which provide extended treatment and hospitalization beyond what is provided in a receiving facility.[18]

Current law provides that an involuntary examination may be initiated if there is reason to believe a person has a mental illness and because of the illness:[19]

- The person has refused a voluntary examination after explanation of the purpose of the exam or is unable to determine for himself or herself that an examination is needed; and
- The person is likely to suffer from self-neglect or substantial harm to her or his well-being, or be a danger to himself or herself or others.

Courts, law enforcement officers, and certain health care practitioners are authorized to initiate such involuntary examinations.[20] A circuit court may enter an *ex parte* order stating a person meets the criteria for involuntary examination. A law enforcement officer[21] may take a person into custody who appears to meet the criteria for involuntary examination and transport them to a receiving facility for examination. Health care practitioners may initiate an involuntary examination by executing the *Certificate of a Professional Initiating an Involuntary Examination*, an official form adopted in rule by the DCF.[22] The health care practitioner must have examined the person within the preceding 48 hours and state that the person meets the criteria for involuntary examination.[23] The Baker Act currently authorizes the following health care practitioners to initiate an involuntary examination by certificate:[24]

- A physician licensed under ch. 458, F.S., or ch. 459, F.S., who has experience in the diagnosis and treatment of mental and nervous disorders.
- A clinical psychologist, as defined in s. 490.003(7), F.S., with three years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure.
- A physician or psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility.
- A psychiatric nurse licensed under part I of ch. 464, F.S., who has a master's degree or a doctorate in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advance practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.
- A mental health counselor licensed under ch. 491, F.S.
- A marriage and family therapist licensed under ch. 491, F.S.
- A clinical social worker licensed under ch. 491, F.S.

In 2014, there were 181,471 involuntary examinations initiated in the state. Law enforcement initiated half of the involuntary examinations (50.18 percent), followed closely by mental health professionals (47.86 percent), with the remaining initiated pursuant to *ex parte* orders by judges (1.96 percent).[25]

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[18] Section 394.455(32), F.S.
[19] Section 394.463(1), F.S.
[20] Section 394.463(2)(a)1.-3., F.S.
[21] "Law enforcement officer" means any person who is elected, appointed, or employed full time by any municipality or the state or any political subdivision thereof; who is vested with authority to bear arms and make arrests; and whose primary responsibility is the prevention and detection of crime or the enforcement of the penal, criminal, traffic, or highway laws of the state. This definition includes all certified supervisory and command personnel whose duties include, in whole or in part, the supervision, training, guidance, and management responsibilities of full-time law enforcement officers, part-time law enforcement officers, or auxiliary law enforcement officers but does not include support personnel employed by the employing agency. s. 943.10(1), F.S.
[22] The Certificate of a Professional Initiating an Involuntary Examination is a form created by the DCF which must be executed by health care practitioners initiating an involuntary examination under the Baker Act. The form contains information related to the person's diagnosis and the health care practitioner's personal observations of statements and behaviors that support the involuntary examination of such person. See Florida Department of Children and Families, CF-MH 3052b, incorporated by reference in Rule 65E-5.280, F.A.C., and available at http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/3052b.pdf. (last visited January 30, 2016).
[23] Section 394.463(2)(a)3., F.S.
[24] *Id*.
[25] Annette Christy & Christina Guenther, Baker Act Reporting Center, College of Behavioral & Community Sciences, University of South Florida, *Annual Report of Baker Act Data: Summary of 2014 Data*, available at http://bakeract.fmhi.usf.edu/document/BA_Annual_2014.pdf (last visited January 30, 2016).

Background Screening

Substance abuse treatment programs are licensed by the DCF Substance Abuse Program Office under authority granted in s. 397.401, F.S., which states, "It is unlawful for any person to act as a substance abuse service provider unless it (sic) is licensed or exempt from licensure under this chapter." In order to obtain a license, a provider must apply to the DCF and submit "sufficient information to conduct background screening as provided in s. 397.451, F.S."[26] According to the administrative rule implementing this section, the required documentation is verification that fingerprinting and background checks have been completed as required by ch. 397, F.S., and ch. 435, F.S.[27]

Section 397.451, F.S., requires that "all owners, directors, and chief financial officers of service providers are subject to level 2 background screening as provided under chapter 435. . . . All service provider personnel who have direct contact with children receiving services or with adults who are developmentally disabled receiving services are subject to level 2 background screening as provided under chapter 435." Members of a foster family and persons who live in the foster home who are between 12 and 18 years of age are not required to be fingerprinted, but these youth must have background checks for delinquency records. All other members of a foster family and any other persons residing with a foster family who are over 18 years of age must have complete background checks. Church or nonprofit religious organizations that are exempt from licensure as substance abuse treatment programs must also comply with personnel screening requirements.

Exemptions from personnel screening requirements include:

- Persons who volunteer at a program for less than 40 hours per month and who are under direct and constant supervision by persons who meet all screening requirements;
- Service providers who are exempt from licensing; and
- Persons employed by the DCF of Corrections in a substance abuse service program who have direct contact with unmarried inmates under the age of 18 or with inmates who are developmentally disabled.[28]

The requirements for level 1 and level 2 screening are found in ch. 435, F.S. Level 1 screening includes, at a minimum, employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement (FDLE),a check of the Dru Sjodin National Sex Offender Public Website,[29] and may include criminal records checks through local law enforcement agencies. Level 2 screening is required for all employees in positions designated by law as positions of trust or responsibility, and it includes security background investigations, which consist of at least fingerprinting, statewide criminal and juvenile records checks through the FDLE, and federal criminal records checks through the Federal Bureau of Investigation (FBI) and may include local criminal records checks through local law enforcement agencies.[30]

Within five working days after starting to work, it is incumbent upon an employee who is in a position for which employment screening is required to submit a complete set of information necessary to conduct a screening to the employer. For level 1 screening, the employer then submits the information to the FDLE within five working days after receiving it. The FDLE conducts a search of its records and responds to the employer who then informs the employee whether screening has revealed any disqualifying information. For level 2 screening, the employer or the licensing agency submits the screening information to the FDLE within five working days after receiving it; the FDLE conducts its search of criminal and juvenile records and requests that the FBI conduct a search. The employee must supply any missing criminal or other necessary information to the employer within 30 days after the employer requests the information or they are subject to automatic disqualification. After the

[26] Section 397.403, F.S.
[27] Rule 65D-30.003(6)(s), F.A.C.
[28] Section 397.451(2)(c), F.S.
[29] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. The website is available at https://www.nsopw.gov/ (last visited January 30, 2016).
[30] Section 435.04(1), F.S.

background screening is complete, the FDLE responds to the employer or licensing agency who informs the employee whether screening has revealed disqualifying information.[31]

Under certain circumstances, the DCF may grant an exemption from disqualification as provided in s. 435.07, F.S. These circumstances include:

- Felonies committed more than three years prior to the date of disqualification;
- Misdemeanors prohibited under any of the Florida Statutes cited in the chapter or under similar statutes of other jurisdictions;
- Offenses that were felonies when committed but are now misdemeanors;
- Findings of delinquency; or
- Commissions of acts of domestic violence as defined in s. 741.30, F.S.

Under s. 435.07, F.S., employees bear the burden of proving, by clear and convincing evidence, they should not be disqualified,[32] and have administrative hearing rights under ch. 120, F.S., for denials. However, the DCF may not remove a disqualification for or grant an exemption to an individual who is found guilty of, regardless of adjudication, or who has entered a plea of nolo contendere or guilty to any felony covered by s. 435.03, F.S., solely by pardon, executive clemency, or restoration of civil rights.[33]

Substance Abuse Treatment Provider Staff

Since many substance abuse treatment programs employ persons who are themselves in recovery, the DCF is authorized to grant additional exemptions from disqualification for employees of substance abuse treatment programs.[34] Employees must submit a request for an exemption from disqualification within 30 days after being notified of a pending disqualification. Pending disposition of the exemption request, an employee's employment may not be adversely affect. However, upon disapproval of a request for an exemption the service provider must immediately dismiss the employee from employment.[35]

Physician Assistants

Licensure and Regulation

A physician assistant (PA) is a person who has completed an approved medical training program and is licensed to perform medical services, as delegated by a supervising physician.[36] PAs licensure is governed by ss. 458.347(7) and 459.022(7), F.S. The Department of Health (DOH) licenses PAs, and the Florida Council on Physician Assistants (Council) regulates the practice of PAs in conjunction with either the Florida Board of Medicine (Board of Medicine) for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine (Osteopathic Board) for PAs licensed under ch. 459, F.S. Currently, 7,987 PAs hold active licenses in Florida.[37]

To be licensed as a PA , an applicant must demonstrate to the Council that he or she has met the following requirements:

- Satisfactory passage of the proficiency examination administered by the National Commission on Certification of Physician Assistants;

[31] Section 435.05, F.S.
[32] The employee must set forth sufficient evidence of rehabilitation, such as the circumstances surrounding the criminal incident, the time period that has elapsed since the incident, the nature of the harm to the victim, and the history of the employee since the incident.
[33] Section 435.07(4), F.S.
[34] Section 397.451(4)(b), F.S., provides exemptions for crimes under ss. 817.563, 893.13, and 893.147, F.S. These exemptions only apply to providers who treat adolescents age 13 and older; as well as personnel who work exclusively with adults.
[35] Section 397.451(1)(f), F.S.
[36] Sections 458.347(2)(e) and 459.022(2)(e), F.S.
[37] Email correspondence with the Department of Health on November 9, 2015. The number of active-licensed PAs include both in-state and out-of-state licensees, as of November 9, 2015.

- Completion of an application and remittance of the applicable fees to the DOH; [38]
- Completion of an approved PA training program;
- Submission of a sworn statement of any prior felony convictions;
- Submission of a sworn statement of any revocation or denial of licensure or certification in any state;
- Submission of two letters of recommendation; and
- If the applicant is seeking prescribing authority, a submission of a copy of course transcripts and the course description from a PA training program describing the course content in pharmacotherapy.[39]

Licenses are renewed biennially.[40] At the time of renewal, a PA must demonstrate that he or she has met the continuing medical education requirements of 100 hours and must submit a sworn statement that he or she has not been convicted of any felony in the previous two years.[41] If a PA is licensed as a prescribing PA, an additional 10 hours of continuing medical education in the specialty areas of his or her supervising physician must be completed.[42]

Education of PAs

According to the American Academy of Physician Assistants, all accredited PA educational programs include pharmacology courses, and the average amount of formal classroom instruction in pharmacology is 75 hours.[43] Course topics, include pharmacokintetics, drug interactions, adverse effects, contraindications, indications, and dosage, generally by doctoral-level pharmacologists or clinical pharmacists.[44] Additionally, pharmacology education occurs on all clinical clerkships or rotations.[45]

Supervision of PAs

A PA may only practice under the delegated authority of a supervising physician. A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[46] Supervision is defined as responsible supervision and control that requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.[47] A physician may not supervise more than four PAs at any time.[48]

The Board of Medicine and the Osteopathic Board have prescribed by rule what constitutes adequate responsible supervision. Responsible supervision is the ability of a supervising physician to reasonably exercise control and provide direction over the services or tasks performed by the PA.[49] Whether the supervision of the PA is adequate is dependent on the:

- Complexity of the task;
- Risk to the patient;
- Background, training, and skill of the PA;
- Adequacy of the direction in terms of its form;

[38] The application fee is $100 and the initial license fee is $200. Applicants must also pay an unlicensed activity fee of $5. See Rules 64B8-30.019 and 64B15-6.013, F.A.C.
[39] Sections 458.347(7) and 459.022(7), F.S.
[40] For timely renewed licenses, the renewal fee is $275 and the prescribing registration fee is $150. Additionally, at the time of renewal, the PA must pay an unlicensed activity fee of $5. See Rules 64B8-30.019 and 64B15-6.013, F.A.C.
[41] Sections 458.347(7)(c)-(d) and 459.022(7)(c)-(d), F.S.
[42] Rules 64B8-30.005(6) and 64B15-6.0035(6), F.A.C.
[43] American Academy of Physician Assistants, *PAs as Prescribers of Controlled Medications, Professional Issues – Issue Brief* (December 2013), (on file with the staff of the Health and Human Services committee).
[44] *Id.*
[45] *Id.*
[46] Rules 64B8-30.012(1) and 64B15-6.010(1), F.A.C. The term "scope of practice" refers to those tasks and procedures that the supervising physician is qualified by training or experience to support.
[47] Sections 458.347(2)(f) and 459.022(2)(f), F.S.
[48] Sections 458.347(3) and 459.022(3), F.S.
[49] Rules 64B8-30.001(3) and 64B15-6.001(3), F.A.C.

- Setting in which the tasks are performed;
- Availability of the supervising physician;
- Necessity for immediate attention; and
- Number of other persons that the supervising physician must supervise.[50]

Direct supervision refers to the physical presence of the supervising physician so that the physician is immediately available to the PA when needed.[51] Indirect supervision refers to the reasonable physical proximity of the supervising physician to the PA or availability by telecommunication.[52] The decision to permit a PA to perform a task or procedure under direct or indirect supervision is made by the supervising physician based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.[53]

Delegable Tasks

Rules of both the Board of Medicine and the Osteopathic Board place limitations on a supervising physician's ability to delegate certain tasks. Prescribing, dispensing, or compounding medicinal drugs and making a final diagnosis are not permitted to be delegated to a PA, except when specifically authorized by statute.[54]

A supervising physician may delegate authority to a PA the authority to:

- Prescribe or dispense any medicinal drug used in the supervising physician's practice;[55]
- Order medicinal drugs for a hospitalized patient of the supervising physician;[56] and
- Administer a medicinal drug under the direction and supervision of the physician.

Currently, PAs are prohibited from prescribing controlled substances, anesthetics, and radiographic contrast materials.[57] However, physicians may delegate the authority to order controlled substances in facilities licensed under ch. 395, F.S.[58]

Advanced Registered Nurse Practitioners

Licensure and Regulation

Part I of ch. 464, F.S., governs the licensure and regulation of advanced registered nurse practitioners (ARNPs) in Florida. Nurses are licensed by the DOH and are regulated by the Board of Nursing.[59] There are 22,003 actively licensed ARNPs in Florida.[60]

In Florida, an ARNP is a licensed nurse who is certified in advanced or specialized nursing practice and may practice as a certified registered nurse anesthetist, a certified nurse midwife, or a nurse

[50] *Id.*
[51] Rules 64B8-30.001(4) and 64B15-6.001(4), F.A.C.
[52] Rules 64B8-30.001(5) and 64B15-6.001(5), F.A.C.
[53] Rules 64B8-30.012(2) and 64B15-6.010(2), F.A.C.
[54] *Supra* note 48.
[55] Sections 458.347(4)(f)1., F.S., and 459.022(4)(e), F.S., directs the Council to establish a formulary listing the medical drugs that a PA may not prescribe. The formulary in Rules 64B8-30.008 and 64B15-6.0038, F.A.C., prohibits PAs from prescribing controlled substances, as defined in Chapter 893, F.S., general, spinal, or epidural anesthetics, and radiographic contrast materials.
[56] Sections 458.347(4)(g), and 459.022(4)(f), F.S., provides that an order is not a prescription.
[57] Rules 64B8-30.008, F.A.C., and 64B15-6.0038, F.A.C.
[58] Sections 458.347(4)(g), F.S., and 459.022(4)(f), F.S.; the facilities licensed in ch. 395, F.S., include hospitals, ambulatory surgical centers, and mobile surgical facilities.
[59] Pursuant to s. 464.004, F.S., the Board of Nursing is comprised of 13 members appointed by the Governor and confirmed by the Senate who serve 4-year terms. The Board is comprised of three licensed practical nurses who have practiced for at least four years, seven members who are registered numbers who have practiced for at least 4 years; three Florida residents who have never been licensed as nurses, are not connected to the practice of nursing, and have no financial interest in any health care facility, agency, or insurer; and seven members who are registered nurses who have practiced at least four years. Among the seven members who are registered nurses, there must be at least one must be an ARNP, one nurse educator of an approved program, and one nurse executive.
[60] E-mail correspondence with the Department of Health (Nov. 9, 2015) (on file with the staff of the Health and Human Services Committee). This number includes all active licenses, including out of state practitioners.

practitioner.[61] Section 464.003(2), F.S., defines "advanced or specialized nursing practice" to include the performance of advanced-level nursing acts approved by the Board of Nursing, which by virtue of postbasic specialized education, training, and experience are appropriately performed by an ARNP.[62]

Florida recognizes three types of ARNPs: nurse anesthetist, certified nurse midwife, and nurse practitioner. The Board of Nursing, created by s. 464.004, F.S., establishes the eligibility criteria for an applicant to be certified as an ARNP and the applicable regulatory standards for ARNP nursing practices.[63] To be certified as an ARNP, the applicant must:

- Have a registered nurse license;
- Have earned, at least, a master's degree; and
- Submit proof to the Board of Nursing of holding a current national advanced practice certification obtained from a board-approved nursing specialty board.[64]

All ARNPs must carry malpractice insurance or demonstrate proof of financial responsibility.[65] An applicant for certification is required to submit proof of coverage or financial responsibility within sixty days of certification and with each biennial renewal.[66] An ARNP must have professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000, or an unexpired irrevocable letter of credit, which is payable to the ARNP as beneficiary, in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000.[67]

Supervision of ARNPs

Pursuant to s. 464.012(3), F.S., ARNPs may only perform nursing practices delineated in an established protocol filed with the Board of Nursing that is filed within 30 days of entering into a supervisory relationship with a physician and upon biennial license renewal.[68] Florida law allows a primary care physician to supervise ARNPs in up to four offices, in addition to the physician's primary practice location.[69] If the physician provides specialty health care services, then only two medical offices, in addition to the physician's primary practice location, may be supervised.

The supervision limitations do not apply in the following facilities:

- Hospitals;
- Colleges of medicine or nursing;
- Nonprofit family-planning clinics;
- Rural and federally qualified health centers;
- Nursing homes;
- Assisted living facilities;
- Student health care centers or school health clinics; and
- Other government facilities.[70]

To ensure appropriate medical care, the number of ARNPs a supervising physician may supervise is limited based on consideration of the following factors:

[61] Section 464.003(3), F.S.
[62] Section 464.003(2), F.S.
[63] Section 464.012(2), F.S.
[64] Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C. A nursing specialty board must attest to the competency of nurses in a clinical specialty area, require nurses to take a written examination prior to certification, require nurses to complete a formal program prior to eligibility of examination, maintain program accreditation, and identify standards or scope of practice statements appropriate for each nursing specialty.
[65] Section 456.048, F.S.
[66] Rule 64B9-4.002(5), F.A.C.
[67] *Id*.
[68] Physicians are also required to provide notice of the written protocol and the supervisory relationship to the Board of Medicine or Board of Osteopathic Medicine, respectively. See ss. 458.348 and 459.025, F.S.
[69] Sections 458.348(4) and 459.025(3), F.S.
[70] Sections 458.348(4)(e), and 459.025(3)(e), F.S.

- Risk to the patient;
- Educational preparation, specialty, and experience in relation to the supervising physician's protocol;
- Complexity and risk of the procedures;
- Practice setting; and
- Availability of the supervising physician or dentist.[71]

Delegable Tasks

Within the framework of a written physician protocol, an ARNP may:

- Monitor and alter drug therapies;
- Initiate appropriate therapies for certain conditions;
- Order diagnostic tests and physical and occupational therapy;
- Perform certain acts within his or her specialty;
- Perform medical acts authorized by a joint committee; and
- Perform additional functions determined by rule.[72]

Florida law does not authorize ARNPs to prescribe, independently administer, or dispense controlled substances.[73]

Controlled Substances

Controlled substances are drugs with the potential for abuse. Chapter 893, F.S., sets forth the Florida Comprehensive Drug Abuse Prevention and Control Act (Act) and classifies controlled substances into five categories, known as schedules.[74] The distinguishing factors between the different drug schedules are the "potential for abuse" of the substance and whether there is a currently accepted medical use for the substance. Schedules are used to regulate the manufacture, distribution, preparation and dispensing of the substances. The Act provides requirements for the prescribing and administering of controlled substances by health care practitioners and proper dispensing by pharmacists and health care practitioners.[75]

Controlled Substance Prescribing for Chronic Nonmalignant Pain in Florida

As of January 1, 2012, every physician, podiatrist, or dentist, who prescribes controlled substances in the state for the treatment of chronic nonmalignant pain,[76] must register as a controlled substance prescribing practitioner and comply with certain practice standards specified in statute and rule.[77] Before prescribing controlled substances for the treatment of chronic nonmalignant pain, a practitioner must:

- Document certain characteristics about the nature of the patient's pain, success of past treatments, and a history of alcohol and substance abuse;
- Develop a written plan for assessing the patient's risk for aberrant drug-related behavior and monitor such behavior throughout the course of controlled substance treatment;
- Develop an written individualized treatment plan for each patient stating the objectives that will be used to determine treatment success; and

[71] Rule 64B9-4.010, F.A.C.
[72] Section 464.012(3), F.S. Pursuant to s. 464.012(4), F.S., certified registered nurse anesthetists, certified nurse midwives, and certified nurse practitioners are authorized to perform additional acts that are within their specialty and authorized under an established supervisory protocol.
[73] Sections 893.02(21) and 893.05(1), F.S. The definition of practitioner does not include ARNPs.
[74] *See* s. 893.03, F.S.
[75] Sections 893.04 and 893.05, F.S.
[76] "Chronic nonmalignant pain" is defined as pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery. Section 456.44(1)(e), F.S.
[77] Chapter 2011-141, s. 3, Laws of Fla. (creating ss. 456.44, F.S., effective July 1, 2011).

- Enter into a controlled substance agreement with each patient that must be signed by the patient or their legal representative and by the prescribing practitioner. Such agreements must include:
    - The number and frequency of prescriptions and refills;
    - A statement outlining expectations for patience compliance and reasons for which the drug therapy may be discontinued, such as violation of the agreement; and
    - An agreement that the patient's chronic nonmalignant pain only be treated by a single treating practitioner unless otherwise authorized and documented in the medical record.[78]

Patients being treated with controlled substances for chronic nonmalignant pain must be seen by their prescribing practitioners at least once every three months to monitor progress and compliance, and detailed medical records relating to such treatment must be maintained.[79] Patients at special risk for drug abuse or diversion may require consultation with or a referral to an addiction medicine physician or a psychiatrist.[80] Anyone with signs or symptoms of substance abuse must be immediately referred to a pain-management physician, an addiction medicine specialist, or an addiction medicine facility.[81]

Drug Enforcement Administration

The Drug Enforcement Administration (DEA), housed within the U.S. Department of Justice, enforces the controlled substances laws and regulations of the United States, including preventing and investigating the diversion of controlled pharmaceuticals.[82]

Any health care professional wishing to prescribe controlled substances must apply for a registration number from the DEA. Registration numbers are linked to state licenses and may be suspended or revoked upon any disciplinary action taken against a licensee.[83] The DEA will grant registration numbers to a wide range of health care professionals, including physicians, nurse practitioners, physician assistants, optometrists, dentists, and veterinarians, but such professionals may only prescribe controlled substances as authorized under state law.[84] The DEA provides that a controlled substance prescription may only be issued by a registered practitioner who is:

- Authorized to prescribe controlled substances by the jurisdiction in which the practitioner is licensed to practice; and
- Registered with the DEA, or exempt from registration (e.g., Public Health Service, Federal Bureau of Prisons, or military practitioners); or
- A qualified agent or employee of a hospital or other institution acting in the normal course of business or employment under the DEA registration number of the hospital or other institution which is registered in lieu of the individual practitioner being registered.[85]

The DEA's Practitioner Manual includes requirements for valid prescriptions. The DEA defines "prescription" as an order for medication which is dispensed to or for an ultimate user, but is not an order for a medication dispensed for immediate administration to the user, such as an order to dispense a drug to a patient in a hospital setting.[86]

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[78] Section 465.44(3), F.S.
[79] Section 465.44(3)(d), F.S.
[80] Section 465.44(3)(e), F.S.
[81] Section 456.44(3)(g), F.S.
[82] Drug Enforcement Administration, *About Us*, *available at* http://www.deadiversion.usdoj.gov/Inside.html (last accessed January 30, 2016).
[83] Registration numbers must be renewed every three years. *Drug Enforcement Administration, Practitioners Manual,* 7 (2006), available at http://www.deadiversion.usdoj.gov/pubs/manuals/pract/pract_manual012508.pdf (last accessed January 30, 2016).
[84] *Id*. at 7.
[85] DEA, Practitioner Manual, 18.
[86] *Id*.

Controlled Substance Prescriptive Authority for ARNPs and PAs in Other States

ARNPs

An ARNP's ability to prescribe, dispense, or administer controlled substances is dependent on his or her specific state's law. Forty-nine states authorize ARNPs to prescribe controlled substances.[87] Twenty-one states and the District of Columbia allow an ARNP to practice independently, including evaluating, diagnosing, ordering, and interpreting diagnostic tests, and managing treatment, including prescribing medications, of a patient without physician supervision.[88] Twenty-two states specifically prohibit certified registered nurse anesthetists from prescribing controlled substances.[89]

Some states have specific limitations regarding ARNPs prescribing authority for Schedule II controlled substances.[90] For example, 7 states authorize ARNPs to prescribe all levels of scheduled drugs, except for Schedule II. Some states have specific education requirements for those ARNPs who wish to prescribe Schedule II substances or require additional registration for ARNPs to be authorized to prescribe.[91]

PAs

A PA's ability to prescribe, dispense, or administer controlled substances is dependent on their specific state's law. Forty-eight states authorize PAs to prescribe controlled substances within an agreement with a supervisory physician, with varying limitations on administration, dispensing, and independent prescribing.[92]

Of the 48 states, some have specific restrictions on PAs' prescribing authority for schedule II controlled substances; for example, Texas and Hawaii only authorize PAs to order schedule II controlled substances in an inpatient hospital setting. Some states have medication quantity restrictions on prescriptions for schedule II drugs and some states give PAs' prescriptive authority for all levels of scheduled drugs except for schedule II.[93] Some states also have a formulary determined by the relevant PA licensing board which identifies the controlled substances that PAs are authorized to prescribe.

Effect of Proposed Changes

Behavioral Health Workforce Shortage

The bill seeks to address a behavioral health workforce shortage in the state through several different mechanisms. A legislative intent provision in the bill states that the Legislature finds:

- A need for additional psychiatrists and recommends the establishment of an additional psychiatry program to be offered by one of Florida's schools of medicine, which shall seek to integrate primary care and psychiatry, and other evolving models of care for persons with mental health and substance use disorders.
- The use of telemedicine for patient evaluation, case management, and ongoing care will improve management of patient care and reduce costs of transportation.

[87] Drug Enforcement Agency, *Mid-Level Practitioners Authorization by State*, *available at* http://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf (last visited January 30, 2016). The Commonwealth of Puerto Rico also prohibits ARNPs from prescribing controlled substances.
[88] Alaska, Arizona, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Iowa, Maine, Maryland, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, Vermont, Washington, and Wyoming allow for independent practice. See American Association of Nurse Practitioners, *State Practice Environment*, *available at* https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment/66-legislation-regulation/state-practice-environment/1380-state-practice-by-type (last visited January 30, 2016).
[89] American Association of Nurse Anesthetists, AANA Journal, June 2011; 79(3):235, on file with committee staff.
[90] *Supra* note 89.
[91] *Id*.
[92] *Id*. Every state, except Florida and Kentucky, has some form of controlled substance prescriptive authority for PAs.
[93] *Id*.

The bill makes the process of retaining a patient in a receiving facility, or placing a patient in a treatment facility, after an involuntary examination under the Baker Act more efficient by allowing the psychiatrist providing the first opinion and the psychiatrist or clinical psychologist providing a second opinion about the patient's placement to examine the patient electronically. Currently, only the psychiatrist or clinical psychologist providing a second opinion may perform an examination electronically.

The bill expands who is eligible to be a service provider under a substance abuse program by allowing those persons who have had a disqualifying offense that occurred 5 or more years ago and who have requested an exemption from disqualification to work with adults with substance use disorders. These individuals must work under the supervision of a qualified psychologist, clinical social worker, marriage and family therapist, mental health counselor, or a master's level certified addiction professional until the agency makes a final determination regarding the request for an exemption from disqualification.

The bill makes a clarification in the law that persons employed with the Department of Corrections in an inmate substance abuse program are exempt from a fingerprinting and background check requirement, unless they have direct contact with unmarried inmates under the age of 18 or with inmates who are developmentally disabled. The current law erroneously states the inverse.

PA and ARNP Controlled Substance Prescribing Authority

The bill seeks to increase access to behavioral health treatment, by allowing physician assistants (PAs) licensed under ch. 458 or 459 F.S., and advanced registered nurse practitioners (ARNPs) certified under part I of ch. 464, F.S., to prescribe controlled substances. However, the bill requires the Council on Physician Assistants and the Board of Nursing to each adopt a formulary to restrict the amounts and types of controlled substances that may be prescribed by PAs and ARNPs, respectively.

Specifically, the Council on Physician Assistants must establish a formulary that limits the prescription of Schedule II controlled substances to a 7-day supply and restricts the prescription of psychiatric mental health controlled substances for children under 18 years of age. The Board of Nursing must adopt a formulary, recommended by a committee established by the BON, which provides the controlled substances that may not be prescribed, the specific uses for which controlled substances may be prescribed, or the quantities of controlled substances that may be prescribed. Additionally, the BON formulary must restrict the prescribing of psychiatric mental health controlled substances for children under 18 years of age to those ARNPs who are psychiatric nurses, and must limit the prescribing of Schedule II controlled substances to a 7-day supply unless a psychiatric nurse is prescribing a psychiatric medication. The bill provides that the formulary does not apply to controlled substances dispensed for administration pursuant to an order.

The bill requires the committee, formed by the BON for the purpose of recommending a formulary, to be comprised of 3 ARNPs recommended by the Board of Nursing, 3 allopathic or osteopathic physicians who have work experience with ARNPs and who are recommended by the Board of Medicine, and a pharmacist who holds a Doctor of Pharmacy degree and who is recommended by the Board of Pharmacy. The bill requires the BON to adopt this committee's formulary recommendation by no later than October 31, 2016.

The bill provides additional restrictions or oversight requirements pertaining to the prescribing authority of PAs and ARNPs. For example, the bill:

- Limits, for ARNPs, acts of medical diagnosis and treatment, prescription, and operation to those authorized within the framework of an established supervisory protocol, and provides controlled substance prescribing authority only to those who have graduated from a program leading to a master's or doctoral degree in a clinical nursing specialty area with training in specialized practitioner skills;

- Requires a PA or ARNP who prescribes any controlled substance for the treatment of chronic nonmalignant pain to register with THE DOH as a controlled substance prescribing practitioner and to meet certain registration and practice requirements; and
- Prohibits a PA or ARNP from dispensing a medication or prescribing a controlled substance on the premises of a registered pain management clinic by limiting such authority to licensed physicians.

The bill requires PAs and ARNPs to complete continuing education pertaining to the safe and effective prescribing of controlled substances. PAs are required to complete 3 hours of such continuing education, which are to be applied to the 10 hours of continuing education required under current law for PAs who have prescriptive privileges. The bill requires the PA continuing education to be offered by a statewide professional association of physicians in Florida that is accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category I Credit or designated by the American Academy of Physician Assistants as a Category 1 Credit.

The bill requires ARNPs to complete 3 hours of continuing education on the safe and effective prescribing of controlled substances, which must be applied to their required 30 hours of continuing education requirements under current law. The bill requires the continuing education courses to be offered to ARNPs by a statewide professional association of physicians in Florida that is accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 Credit, the American Nurses Credentialing Center, the American Association of Nurse Anesthetists, or the American Association of Nurse Practitioners. The courses may be offered in a distance-learning format.

The bill adds acts related to the prescribing of controlled substances into s. 464.018, F.S., which an ARNP is prohibited from performing and which, if performed, constitute grounds for denial of license or disciplinary actions. The bill subjects PAs to administrative disciplinary actions in s. 456.072, F.S., such as fines or license suspensions for violating standards of practice in law relating to prescribing and dispensing controlled substances.[94]

The bill adds PAs and ARNPs to the definition of practitioner in ch. 893, F.S., the Florida Comprehensive Drug Abuse Prevention and Control Act (Act), thus requiring these practitioners to comply with the prescribing and dispensing requirements and limitations under the Act. This definition also requires practitioners to hold a valid federal DEA controlled substance registry number.

The bill provides that it will take effect upon becoming a law, unless otherwise expressly provided within the bill.

B. SECTION DIRECTORY:

Section 1. Amends s. 110.12315, F.S., relating to prescription drug program.
Section 2. Amends s. 310.071, F.S., relating to deputy pilot certification.
Section 3. Amends s. 310.073, F.S., relating to state pilot licensing.
Section 4. Amends s. 310.081, F.S., relating to department examination and licensure of state pilots and certification of deputy pilots; vacancies.
Section 5. Amends. s. 394.453, F.S., relating to legislative intent.
Section 6. Amends s. 394.467, F.S., relating to involuntary inpatient placement.
Section 7. Amends s. 397.451, F.S., relating to background checks of service provider personnel.
Section 8. Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 9. Amends s. 456.44, F.S., relating to controlled substance prescribing.
Section 10. Amends s. 458.3265, F.S., relating to pain-management clinics.
Section 11. Amends s. 459.0137, F.S., relating to pain-management clinics.

[94] Disciplinary sanctions against physicians apply to PAs. Sections 458.347(7)(g) and 459.022(7)(g), F.S., state that the Board of Medicine or the Board of Osteopathic Medicine may impose any penalty authorized under ss. 456.072, 458.332(2), and 459.015(2), F.S., on a PA if the PA or the supervising physician has been found guilty of any prohibited acts. The bill republishes these sections of law to make such disciplinary authority against PAs applicable to PAs' new prescribing authority.

Section 12. Amends s. 458.347, F.S., relating to physician assistants.
Section 13. Amends s. 458.347, F.S., relating to physician assistants.
Section 14. Amends s. 464.003, F.S., relating to definitions.
Section 15. Amends s. 464.012, F.S., relating to certification of advanced registered nurse practitioners; fees.
Section 16. Amends s. 464.012, F.S., relating to certification of advanced registered nurse practitioners; fees.
Section 17. Amends s. 464.013, F.S., renewal of license or certificate.
Section 18. Amends s. 464.018, F.S., relating to disciplinary actions.
Section 19. Amends s. 893.02, F.S., relating to definitions.
Section 20. Amends s. 948.03, F.S., relating to terms and conditions of probation.
Section 21. Amends s. 458.348, F.S., relating to formal supervisory relationships, standing orders, and established protocols; notice; standards.
Section 22. Amends s. 459.025, F.S., relating to formal supervisory relationships, standing orders, and established protocols; notice; standards.
Section 23. Reenacts s. 458.331, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 24. Reenacts s. 458.347, F.S., relating to physician assistants.
Section 25. Reenacts s. 459.015, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 26. Reenacts s. 459.022, F.S., relating to physician assistants.
Section 27. Reenacts s 465.0158, F.S., relating to nonresident sterile compounding permit.
Section 28. Reenacts s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 29. Reenacts s. 466.02751, F.S., relating to establishment of practitioner profile for designation as a controlled substance prescribing practitioner.
Section 30. Reenacts s. 458.303, F.S., relating to provisions not applicable to other practitioners; exceptions, etc.
Section 31. Reenacts s. 458.3475, F.S., relating to anesthesiologist assistants.
Section 32. Reenacts s. 459.022, F.S., relating to physician assistants.
Section 33. Reenacts s. 459.023, F.S., relating to anesthesiologist assistants.
Section 34. Reenacts s. 456.041, F.S., relating to practitioner profile; creation.
Section 35. Reenacts s. 458.348, F.S., relating to formal supervisory relationships, standing orders, and established protocols; notice; standards.
Section 36. Reenacts s. 464.0205, F.S., relating to retired volunteer nurse certificate.
Section 37. Reenacts s. 320.0848, F.S., relating to persons who have disabilities; issuance of disabled parking permits; temporary permits; permits for certain providers of transportation services to persons who have disabilities.
Section 38. Reenacts s. 464.008, F.S., relating to licensure by examination.
Section 39. Reenacts s. 464.009, F.S., relating to licensure by endorsement.
Section 40. Reenacts s. 464.0205, F.S., relating to retired volunteer nurse certificate.
Section 41. Reenacts s. 775.051, F.S., relating to voluntary intoxication; not a defense; evidence not admissible for certain purposes; exceptions.
Section 42. Reenacts s. 944.17, F.S., relating to commitments and classification; transfers.
Section 43. Reenacts s. 948.001, F.S., relating to definitions.
Section 44. Reenacts s. 948.101, F.S., relating to terms and conditions of community control.
Section 45. Provides that the bill will take effect upon becoming a law, unless otherwise specified in the act.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill will have an insignificant, negative fiscal impact on the DOH associated with the creation of practitioner profiles for PAs and the DOH will incur a recurring increase in costs associated with PA profile notification cards. In FY 2014-15 there were 6,744 active-licensed PAs, of which 6,707 are authorized to prescribe. The cost is $0.53 per postcard which equates to $3,555 (6,707 x $0.53). The DOH's current budget authority is adequate to absorb these costs.[95]

The DOH will also experience workload impacts related to potential additional practitioner complaints and investigations. The DOH will also incur costs associated with rulemaking to establish formularies in rule. These costs will be absorbed within current resources and budget authority.[96]

The DOH will experience a recurring cost associated with queries to the National Practitioner Data Bank for PAs. The cost is $3.00 per query. The impact is indeterminate at this time, but the DOH anticipates that its current budget authority is adequate to absorb these costs.[97]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care entities may experience some cost savings associated with the efficiencies of allowing additional practitioners to provide treatment and care, which cost savings may be passed on to patients.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

[95] Department of Health, *2016 Agency Legislative Bill Analysis for HB 977*, December 16, 2015, on file with the Health Quality Subcommittee.
[96] *Id*.
[97] *Id*.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 25, 2016, the Health Quality Subcommittee adopted a strike all amendment and an amendment to the strike all amendment to HB 977. Together, the amendments made the following changes to the bill:

- Removes sections pertaining to psychiatric nurses' authority to release persons from facilities under the Baker Act and psychiatry residency positions under the Statewide Medicaid Residency Program.
- Authorizes physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) to prescribe controlled substances under certain limited conditions.
- Provides that only a physician may dispense medication or prescribe a controlled substance on the premises of a registered pain-management clinic.
- Requires certain continuing education to be completed by PAs and ARNPs relating to the safe and effective prescribing of controlled substances.
- Requires the Council on Physician Assistants to include in its formulary that a PA may only prescribe a 7-day supply of Schedule II controlled substances and must restrict the prescribing of psychiatric mental health controlled substances for children less than 18 years of age.
- Deletes a joint committee under the Nurse Practice Act and creates a new joint committee for the purpose of developing a formulary of controlled substances that an ARNP may not prescribe or limitations on his or her prescribing authority, which must be adopted by the Board of Nursing.
- Provides additional disciplinary actions for ARNPs related to prescribing controlled substances.
- Republishes certain statutes to recognize the aforementioned changes in law and make the republished statutes subject to such changes.

The bill was reported favorably as a committee substitute. This analysis is drafted to the committee substitute.