The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 1756
INTRODUCER:	Senator Garcia
SUBJECT:	Examination and Treatment of Individuals with Mental Illness
DATE:	March 31, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Crosier	Hendon	CF	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 1756 provides responsibilities to the Department of Children and Families (DCF) for a comprehensive statewide mental health and substance abuse program. The bill revises the rights of individuals receiving mental health services to use surrogates or proxies to act as decisionmakers. Additionally, the definition of a service provider's employee is expanded to include contractors and volunteers for the purpose of reporting sexual misconduct.

The bill revises the list of people eligible for designation as representative for an individual admitted to a facility for involuntary examination or services to include a guardian advocate, health care surrogate or proxy. Persons ineligible for designation as representative of an individual admitted to a facility for involuntary examination or services include nonclinical people providing substantial professional services to the individual. A designated representative is give certain rights, authority and responsibility concerning the individual.

Reporting requirements for facilities designated as public receiving or treatment facilities are revised to include individual-level encounter data and aggregate data.

The bill allows that upon the filing of a petition for involuntary services the clinical records of the individual that is the subject of the petition are available to the state attorney, if needed, for the prosecution of such petition. However, such clinical records cannot be used by the state attorney for the purpose of a criminal investigation or prosecution.

The criteria for an individual to be subject to an involuntary examination is revised to provide that the individual is likely to suffer from neglect or refuse to care for himself or herself and that such neglect presents a threat of substantial physical or mental harm to his or her well-being.

The professionals allowed to execute a certificate to initiate an involuntary examination is expanded to include a school psychologist and a physician assistant. The professionals allowed

to discharge an individual if an involuntary examination occurred in a hospital removes psychiatric nurses performing within a framework of an established protocol with a psychiatrist and an emergency department physician with experience in the diagnosis and treatment of mental illness and limits such discharge responsibilities to an attending emergency department physician.

The bill provides that hearings on involuntary services must be held within 5 court working days after the petition is filed and the hearing must be held in the receiving or treatment facility where the individual is located unless certain conditions apply. The court may not enter an order for involuntary inpatient services in a state treatment facility for an individual with dementia, Alzheimer's disease, or traumatic brain-injury who lacks a co-occurring mental illness.

The court may order involuntary outpatient services if an individual meets the criteria provided in the bill. The court cannot order outpatient services that are unavailable. If an individual ordered to outpatient services is found non-compliant, the individual may be brought to receiving facility for examination.

The United States Department of Veterans' Affairs that provides mental health services is provided the authority to initiate and conduct involuntary examinations, provide voluntary admission and treatment and petition for involuntary services.

II. Present Situation:

Mental Health and Substance Abuse

Mental illness creates enormous social and economic costs.[1] Unemployment rates for persons with mental disorders are high relative to the overall population.[2] People with severe mental illness have exceptionally high rates of unemployment, between 60 percent and 100 percent.[3] Mental illness increases a person's risk of homelessness in America threefold.[4] Studies show that approximately 33 percent of our nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are not receiving treatment.[5] Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future re-offenses.[6]

According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse.[7] NAMI also

[1] Mental Illness: The Invisible Menace, *Economic Impact* http://www.mentalmenace.com/economicimpact.php
[2] Mental Illness: The Invisible Menace, *More impacts and facts* http://www.mentalmenace.com/impactsfacts.php
[3] *Id.*
[4] Family Guidance Center, *How does Mental Illness Impact Rates of Homelessness?* (February 4, 2014) *available at* http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/
[5] *Id.*
[6] *Id.*
[7] Donna M. White, LPCI, CACP, Psych Central.com, *Living with Co-Occurring Mental & Substance Abuse Disorders,* (October 2, 2013) *available at* http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occurring-mental-substance-abuse-disorders/

estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.[8] When mental health disorders are left untreated, substance abuse is likely to increase. When substance abuse increases, mental health symptoms often increase as well or new symptoms may be triggered. This could also be due to discontinuation of taking prescribed medications or the contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.[9]

Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[10] The Act authorized treatment programs for mental, emotional, and behavioral disorders. The Baker Act required programs to include comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment to facilitate recovery. Additionally, the Baker Act provides protections and rights to individuals examined or treated for mental illness. Legal procedures are addressed for mental health examination and treatment, including voluntary admission, involuntary admission, involuntary inpatient treatment, and involuntary outpatient treatment.

Mental illness creates enormous social and economic costs.[11] Unemployment rates for persons having mental disorders are high relative to the overall population.[12] Rates of unemployment for people having a severe mental illness range between 60 percent and 100 percent.[13] Mental illness increases a person's risk of homelessness in America threefold.[14] Approximately 33 percent of the nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are untreated.[15] Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future recidivism.[16]

Involuntary Examination to under the Baker Act

Criteria for Involuntary Examination

The Baker Act provides that a person meets the criteria for involuntary examination if a court finds by clear and convincing evidence that:

- He or she has a mental illness and because of his or her mental illness:
- Has refused voluntary inpatient placement for treatment after sufficient and conscientious explanation and disclosure of the purposes of inpatient placement for treatment; or

[8] *Id.*
[9] *Id.*
[10] Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.
[11] MentalMenace.com, *Mental Illness: The Invisible Menace; Economic Impact,* http://www.mentalmenace.com/economicimpact.php (last visited Jan. 11, 2016).
[12] MentalMenace.com, *Mental Illness: The Invisible Menace: More impacts and facts,* http://www.mentalmenace.com/impactsfacts.php (last visited Jan. 11, 2016).
[13] *Id.*
[14] Family Guidance Center for Behavioral Health Care, *How does Mental Illness Impact Rates of Homelessness?,* (February 4, 2014), http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/.
[15] *Id.*
[16] *Id.*

- He or she is unable to determine for himself or herself whether inpatient placement is necessary; and
- He or she is incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
- There is substantial likelihood that in the near future he or she will inflict serious bodily harm on self or others, as evidenced by recent behavior causing, attempting, or threatening such harm; and
- All available less restrictive treatment alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.[17]

Initiation of involuntary examinations

Courts, law enforcement officers, and certain health care practitioners are authorized to initiate such involuntary examinations.[18] A circuit court may enter an *ex parte* order stating a person meets the criteria for involuntary examination. A law enforcement officer may take a person into custody who appears to meet the criteria and transport them to a receiving facility for examination. Health care practitioners may initiate an involuntary examination by executing the *Certificate of Professional Initiating an Involuntary Examination*, an official form adopted in rule by DCF. 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.[19] The Baker Act currently authorizes the following health care practitioners to initiate an involuntary examination by certificate:

- 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 or the United States Department of Defense that qualifies as a receiving or treatment facility.
- A psychiatric nurse who is certified as an advanced registered nurse practitioner under s. 464.012, 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.[20]

[17] Section 394.467(1), F.S.
[18] Section 394.463(2)(a), F.S.
[19] Section 394.463(2)(a)3., F.S.
[20] *Id.*

Time Limits

A critical 72-hour period applies under the Baker Act. The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.[21] Within that 72-hour examination period, or, if the 72 hours ends on a weekend or holiday, no later than the next working day, one of the following must happen:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will resume custody;
- The patient must be released into voluntary outpatient treatment;
- The patient must be asked to give consent to be placed as a voluntary patient if placement is recommended; or
- A petition for involuntary placement must be filed in circuit court for outpatient or inpatient treatment.[22]

Physician Assistants

Physician assistant (PA) licensure in Florida 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 them.[23] Pas are also regulated by either the Flordia Board of Medicine for Pas licensed under ch. 458, F.S., or the Florida Board of Osteopathic Medicine for Pas liensed under ch. 459, F.S. The duty of the board and its members is to make disciplinary decisions concerning whether a doctor or PA has violated the provisions of his or her practice act.[24]

Pas may only practice under the direct or indirect supervision of a medical doctor or doctor of osteopathic medicine with whom they have a clinical relationship.[25] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[26] The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than four Pas at any time.[27]

To be licensed as a PA in Florida, an applicant must demonstrate to the Council:

- Satisfactory passage of the National Commission on Certification of Physician Assistant exam;
- Completion of the application and remittance of the application fee;[28]
- Completion of an approved PA training program;
- Acknowledgement of any prior felony convictions;
- Acknowledgement of any previous revocation or denial of licensure in any state;
- Two letters of recommendation; and

[21] Section 394.463(2)(f), F.S.
[22] Section 394.463(2)(i)4., F.S.
[23] The Council consists of three physicians who are members of the Board of Medicine; one member who is a member of the Board of Osteopathic Mediciane, and a physician assistant appointed by the State Surgeon General. (Sections 458.347(9) and 459.022(8), F.S.)
[24] Sections 458.347(12) and 459.022(12), F.S.
[25] Sections 485.347(2)(f) and 459.022(2)(f), F.S.
[26] Rules 64B8-30.012 and 64B15-6.010, F.A.C.
[27] Sections 458.347(15) and 459.022(15), F.S.
[28] The application fee is $100 and the initial license fee is $205. *See* http://flboardofmedicine.gov/licesning/physician-assistant-licensure/ (last visited March 31, 2017).

- If the applicant wishes to apply for prescribing authority, a copy of course transcripts and a copy of the course description from a PA training program describing the course content in pharmacotherapy.[29]

Licenses are renewed biennially. At the time of renewal, a PA must demonstrate that he or she has met the continuing education requirements and must submit an acknowledgement that he or she has not been convicted of any felony in the previous two years.[30]

Current Florida law does not expressly allow PAs to refer for or initiate involuntary examinations under the Baker Act; however, in 2008, Attorney General Bill McCollum issued an opinion stating:

A physician assistant pursuant to Chapter 458 or 459, Florida Statutes, may refer a patient for involuntary evaluation pursuant to section 394.463, Florida Statutes, provided that the physician assistant has experience regarding the diagnosis and treatment of mental and nervous disorders and such tasks are within the supervising physician's scope of practice.[31]

Pas are not required by law to have experience in the diagnosis and treatment of mental and nervous disorders.

Advanced Registered Nurse Practitioners

Nurse licensure is governed by part I of ch. 464, F.S. Nurses are licensed by the DOH and regulated by the Board of Nursing. Licensure requirements to practice nursing include completion of an approved educational course of study, passage of an examination approved by the DOH, acceptable criminal background screening results, and payment of applicable fees.[32]

A nurse who holds a current license to practice professional nursing may apply to be certified as an Advanced Registered Nurse Practitioner (ARNP), under s. 464.012, F.S., if the nurse meets one or more of the following requirements:
- Satisfactory completion of a formal postbasic educational program of at least one academic year that prepares nurses for advanced or specialized practice;
- Certification by a specialty board; or
- Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills.

Current law defines three categories of ARNPs: certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners.[33] All ARNPs, regardless of practice category, may only practice within the framework of an established protocol and under the supervision of an

[29] Sections 458.347(7) and 459.022(7), F.S.
[30] Sections 458.347(7)(b)-(c) and 459.022(7)(b)-(c), F.S.
[31] Op. Att'y Gen. Fla. 08-31 (2008), available at http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/agopinion.pdf (last visited March 31, 2017).
[32] Sections 464.008 and 424.009, F.S.
[33] Section 464.012(2), F.S.

allopathic or osteopathic physician or dentist.[34] ARNPs may carry out treatments as specified in statute, including:[35]

- Prescribing, dispensing, administering, or ordering any drug;[36]
- Initiating appropriate therapies for certain conditions;
- Ordering diagnostic tests and physical and occupational therapy;
- Ordering any medication for administration patients in certain facilities; and
- Performing additional functions as maybe determined by rule in accordance with s. 464.003(2), F.S.[37]

In addition to the above-allowed acts, an ARNP may also perform other acts as authorized by statute and within his or her specialty.[38] Further, if it is within an ARNP's established protocol, the ARNP may establish behavioral problems and diagnosis and make treatment recommendations.[39]

Currently, only ARNPs who are "psychiatric nurses" may initate involuntary examinations under the Baker Act.[40] To qualify as a psychiatric nurse, an ARNP must have a master's or doctoral degree in psychiatric nursing, hold a national advance practice certification as a psychiatric mental health advanced practice nurse, and two years post-master's clinical experience.

III. Effect of Proposed Changes:

Section 1 amends s. 394.453, F.S., to authorize DCF to include substance abuse impairment in its evaluation, research and recommendations of programs designed to reduce occurrence, severity, duration, and disabling aspects of mental, emotional and behavioral disorders.

Section 2 amends s. 394.455, F.S., to add or revise terms to the definitions.

Section 3 amends s. 394.457, F.S., to add substance abuse to DCF's comprehensive statewide program of mental health. Also, DCF is permitted to distribute its information handbook of policies and procedures for mental health and substance abuse online.

Section 4 amends s. 394.4573, F.S., to change the term "patient" to "individual".

Section 5 amends s. 394.4574, F.S. to allow mental health counselors, marriage and family therapists or qualified professionals conduct evaluations of individuals residing in assisted living facilities that hold limited mental health licenses.

[34] Section 464.012(3), F.S.
[35] *Id.*
[36] an ARNP may only prescribe controlled substances if he or she has graduated from a program leading to a master's or doctoral degree in a clinical nursing specialty area with training in specialized practitioner skills. An ARNP is limited to prescribing a 7-day supply of Schedule II controlled substances. Only a psychiatric nurse may prescribe psychotropic controlled substances for the treatment of mental disorders and psychiatric mental health controlled substance for children younger than 18.
[37] Section 464.003(2), F.S.
[38] Section 464.012(4), F.S.
[39] Section 464.012(4)(c)1, F.S.
[40] Section 394.463(2)(a), F.S.

Section 6 amends s. 394.458, F.S., to provide it is unlawful to knowingly and intentionally bring certain items or articles into any facility providing mental health or substance abuse services.

Section 7 amends s. 394.459, F.S., to provide that a person shall be given, in addition to a physical examination, a mental health examination within 24 hours at the facility by a psychiatrist, psychologist, or psychiatric nurse. The examinations must be documented in the clinical record. The facility, within 72 hours after admission of an individual, must provide the individual with an individualized treatment plan in writing.

This section also directs receiving and treatment facilities to have written procedures for reporting events that place individuals receiving services at risk of harm, including, but not limited to, death, injury, unauthorized departure or absence of the individual, a disaster or crisis situation or allegation of sexual battery upon an individual examined or treated in the facility. Facilities are directed to ensure that all staff, including contractors and volunteers receive the written procedures.

This section provides additional individuals who may deny or withdraw consent at any time on behalf of the individual, to receive notices on behalf and to receive custody of personal effects of the individual to include a health care surrogate or proxy.

Additionally, this section directs all service providers to provide information concerning advance directives and assist individuals who are competent and willing to complete advance directives. The directive may include instructions regarding mental health or substance abuse treatment.

Section 8 amends s. 394.4593, F.S., to change the term "patient" to "individual".

Section 9 repeals s. 394.4595, F.S., relating to statewide and local advocacy councils.

Section 10 creates s. 394.4596 to allow the agency designated by the Governor as the federally mandated protection and advocacy system for individuals with disabilities to have specific access under federal law to facilities, individuals, information and records.

Section 11 amends s. 394.4597, F.S., to add the name, address and telephone number of a guardian advocate, health care surrogate or proxy to the list of individuals entered into the patient's clinical record.

Additionally, this section adds volunteers, contractors and persons providing substantial professional nonclinical services to the list of individuals ineligible to serve as a representative of the patient. The person selected as representative by the individual or designated by the facility has the right to receive notices, have immediate access to the individual, receive a copy of the individuals inventory of clothing and person effects, petition on behalf of the individual for a writ of habeas corpus, apply for a change in venue for the involuntary placement hearing, and receive notice of release of the individual from a facility.

Section 12 amends s. 394.4598, F.S., to prohibit a contractor or a volunteer of a facility from being appointed as a guardian advocate of an individual in a facility for involuntary examination.

Section 13 amends s. 394.4599, F.S., to remove the requirement that a notice for the petition for involuntary outpatient services be filed with the criminal county court or the circuit court in the county in which the individual is hospitalized.

Section 14 repeals s. 394.460, F.S., relating to rights of professionals.

Section 15 amends s. 394.461, F.S., to provide that only governmental facilities and facilities designated by DCF may hold or treat individuals on an involuntary basis. Governmental facilities are authorized to provide voluntary and involuntary mental health or substance abuse examination and treatment.

This section adds individual-level encounter data to the data currently being submitted to the Agency for Health Care Administration (AHCA) by DCF. The individual-level encounter data must be submitted to DCF by the 15th day of the month following the month in which the data is collected. The data is to include number of licensed beds available by payor class, contracted bed day unit cost and total revenue by payor class.

Section 16 amends s. 394.4615, F.S., to add certain individuals that may allow for the release and/or inspection of an individual's clinical record to include the individual's guardian advocate, health care surrogate or proxy.

This section also allows that clinical records may be released to a state attorney if a petition for involuntary services is filed and the state attorney needs the records to evaluate the sufficiency of the petition; however, the records may not be used for the purpose of a criminal investigation or prosecution.

Section 17 amends s. 394.462, F.S., to allow law enforcement to transport an individual eligible for services provided by the United States Department of Veterans' Affairs to a facility operated by the United States Department of Veterans' Affairs.

This section allows a law enforcement officer who has custody of an individual based on a misdemeanor or a felony, other than a forcible felony as defined in s. 776.08, F.S. to transport the individual to an appropriate facility. The facility is not required to admit an individual charged with a forcible felony as defined in s. 766.08, F.S. if it determines it cannot provide adequate security.

This section allows a law enforcement officer to transport an individual who appears to meet the criteria for voluntary admission to a receiving facility upon the individual's request.

This section removes the provision that disallows exceptions to transportation plans after June 30, 2017.

Section 18 amends s. 394.4625, F.S., to provide criteria for examination and treatment of voluntary admissions of individuals to facilities. A minor may only be admitted on the basis of express and informed consent of the minor's guardian in conjunction with the assent of the minor. Unless the minor's assent is verified a petition for involuntary services must be filed with the court within 24 hours or the minor must be released to his or her guardian.

This section provides that a facility may not admit an individual on voluntary status or transfer an individual to voluntary status who has been adjudicated incapacitated except when a court provides authorization to a legal guardian.

This section also provides that an individual on voluntary status charged with a crime is to be discharged into the custody of law enforcement unless the individual has been released from law enforcement custody by posting a bond, pretrial conditional release or other judicial release.

An individual on voluntary status right to receive notice of discharge is revised to include notice at admission and at least every 3 months thereafter instead of every 6 months thereafter.

Section 19 amends s. 394.463, F.S., to include physical or mental harm to the criteria for involuntary examination of an individual. Also, a school psychologist and a physician assistant are added to the list of professionals that may complete a certificate to initiate involuntary examination of an individual. A law enforcement officer or professional who initiates an involuntary examination of an individual may notify the individual's guardian, representative, health care surrogate or proxy of such examination.

This section also provides that an individual may not be held for more than 72 hours for involuntary examination unless certain actions are taken.

Section 20 repeals s. 394.4655, F.S., relating to involuntary out-patient services.

Section 21 amends s. 394.467, F.S., to rename involuntary "inpatient placement" with involuntary "services", to add physical or mental harm to the criteria for involuntary examination of an individual, to require petitions for involuntary services filed by facilities to be provided to AHCA the next workday and to allow the state attorney to have access to the individual's clinical record and witnesses in order to independently evaluate the sufficiency and appropriateness of the petition for involuntary services. The state attorney must not use the clinical records for the purpose of criminal investigation or prosecution.

This section revises the circumstances in which continuances of the hearing on the petition for involuntary services may be requested, that the hearing must be held at the receiving or treatment facility where the individual is located or at a location convenient to the individual. The court is directed to allow testimony from family members deemed relevant by the court to the individual's prior history and how that history relates to the individual's current condition.

This section prohibits the court from entering an order of involuntary inpatient services for individuals with Alzheimer's disease, dementia, or traumatic brain injury who lacks a co-occurring mental illness.

Additionally, this section prohibits the court from ordering involuntary services that are not available and, if a material modification of a service plan is necessary, notice shall be provided to the court. If an individual ordered to outpatient services refuses to comply with the court-ordered services, the individual may be brought to a facility for an examination. If the individual does not meet the criteria for involuntary services, the individual must be discharged from the facility.

The Division of Administrative Hearings is directed to ensure that individuals who are the subject of a petition for continued involuntary services or his or her guardian, guardian advocate, health care surrogate or proxy are informed of the individual's right to an independent expert examination. This section provides that hearings for continued involuntary services for individuals placed at a receiving facility or nonstate treatment facility are not administrative hearings. Facilities are required to file a petition in circuit court for continued involuntary services which must include a statement from the individual's physician or psychologist justifying the request. Within 1 court working day the public defender must be appointed to represent the individual. Hearings on continued involuntary services must be before the circuit court. Before the expiration of each additional period of involuntary services, the same procedures must be repeated.

Section 22 amends s. 394.46715, F.S., to clarify the department's rulemaking authority.

Section 23 amends s. 394.4672, F.S., to include a facility owned, operated, or administered by the United States Department of Veterans' Affairs that provides mental health services the authority to initiate and conduct involuntary examinations, provide voluntary services, and provide voluntary admission and treatment.

Section 24 amends s. 394.4685, F.S, to allow a private facility to request an individual be transferred to another private facility upon the acceptance of the transfer by the facility to which the individual is being transferred.

Section 25 amends s. 394.469, F.S., to provide that an individual currently charged with a crime may be discharged to law enforcement under certain conditions.

Section 26 amends s. 394.473, F.S., to clarify that a public defender appointed to represent an indigent individual may not receive compensation for such representation.

Section 27 amends s. 394.475, F.S., to change the term "patient" to "individual".

Section 28 amends s. 394.4785, F.S., to correct cross-references.

Section 29 repeals s. 394.4786, F.S., providing legislative intent.

Section 30 repeals s. 394.47865, F.S., relating to privatization of state hospitals.

Section 31 repeals s. 394.4787, F.S., providing definitions.

Section 32 repeals s. 394.4788, F.S.. relating to the use of certain funds.

Section 33 repeals s. 394.4789, F.S.. relating to referrals.

Section 34 amends s. 20.425, F.S., to correct cross-references.

Section 35 amends s. 39.407, F.S., to replace the term "involuntary placement" with "involuntary services".

Section 36 amends s. 394.492, F.S., to replace the term "involuntary placement" with "involuntary services".

Section 37 amends s. 394.495, F.S., to correct cross-references.

Section 38 amends s. 394.496, F.S,. to correct cross-references.

Section 39 amends s. 394.9082, F.S., to remove the requirement that crisis stabilization units report all admissions and discharges of clients receiving facility services who qualify as indigent. This section also correct cross-references.

Section 40 amends s. 394.9085, F.S., to correct cross-references.

Section 41 amends s. 409.972, F.S., to correct cross-references.

Section 42 amends s. 744.2007, F.S., to correct cross-references.

Section 43 amends s. 790.065, F.S., to correct cross-references.

Section 44 amends s. 945.46, F.S., to replace the term "involuntary placement" with "involuntary services".

Section 45 provides an effective date of July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

DCF's current system is designed to collect individual-level encounter data; however the department would be required to modify its current acute care database to collect and maintain the required aggregate data by payor class as set forth in Section 15 of the proposed legislation.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.453, 394.457, 394.4573, 394.4574, 394.458, 394.459, 394.4593, 394.4595, 394.4597, 394.4598, 394.4599, 394.461, 394.4615, 394.462, 394.4625, 394.463, 394.4655, 394.467, 394.46715, 394.4672, 394.4685, 394.469, 394.473, 394.475, 394.4785, , 20.425, 39.407, 394.492, 394.495, 394.496, 394.9082, 394.9085, 409.972, 744.2007, 790.065, 945.46
This bill creates section 394.4596, of the Florida Statutes.
This bill repeals the following sections of the Florida Statutes: 394.4595, 394.460, 394.4655, 394.4786, 394.47865, 394.4787, 394.4788, 394.4789

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.