A bill to be entitled

An act relating to behavioral health workforce; amending s. 394.453, F.S.; revising legislative intent; amending s. 394.463, F.S.; expanding the authority of a psychiatric nurse to approve the release of a patient from a receiving facility; amending s. 394.467, F.S.; authorizing procedures for recommending admission of a patient to a treatment facility; amending s. 397.451, F.S.; revising provisions relating to exemptions from disqualification for certain service provider personnel; amending s. 409.909, F.S.; adding psychiatry to a list of primary care specialties under the Statewide Medicaid Residency Program; amending s. 456.44, F.S.; deleting an obsolete date; requiring advanced registered nurse practitioners and physician assistants who prescribe controlled substances for pain management to make a certain designation, comply with registration requirements, and follow specified standards of practice; providing applicability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 394.453, Florida Statutes, is amended to read:

394.453 Legislative intent.—It is the intent of the Legislature to authorize and direct the Department of Children and Families to evaluate, research, plan, and recommend to the Governor and the Legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders. It is the intent of the Legislature that treatment programs for such disorders shall include, but not be limited to, comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment in order to encourage them to assume responsibility for their treatment and recovery. It is intended that such persons be provided with emergency service and temporary detention for evaluation when required; that they be admitted to treatment facilities on a voluntary basis when extended or continuing care is needed and unavailable in the community; that involuntary placement be provided only when expert evaluation determines that it is necessary; that any involuntary treatment or examination be accomplished in a setting which is clinically appropriate and most likely to facilitate the person's return to the community as soon as possible; and that individual dignity and human rights be guaranteed to all persons who are admitted to mental health facilities or who are being held under s. 394.463. It is the further intent of the Legislature that the least restrictive means of intervention be employed based on the individual needs of each person, within the scope of available services. It is

the policy of this state that the use of restraint and seclusion on clients is justified only as an emergency safety measure to be used in response to imminent danger to the client or others. It is, therefore, the intent of the Legislature to achieve an ongoing reduction in the use of restraint and seclusion in programs and facilities serving persons with mental illness. The Legislature further finds the need for additional psychiatrists to be of critical state concern and recommends the establishment of an additional psychiatry program to be offered by one of Florida's schools of medicine currently not offering psychiatry. The program shall seek to integrate primary care and psychiatry and other evolving models of care for persons with mental health and substance use disorders. Additionally, the Legislature finds that the use of telemedicine for patient evaluation, case management, and ongoing care will improve management of patient care and reduce costs of transportation.

Section 2. Paragraph (f) of subsection (2) of section 394.463, Florida Statutes, is amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(f) A patient shall be examined by a physician, a clinical psychologist, or a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of

the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, ~~or~~ a clinical psychologist, or~~, if the receiving facility is owned or operated by a hospital or health system, the release may also be approved by~~ a psychiatric nurse performing within the framework of an established protocol with a psychiatrist or an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

Section 3. Subsection (2) of section 394.467, Florida Statutes, is amended to read:

394.467 Involuntary inpatient placement.—

(2) ADMISSION TO A TREATMENT FACILITY.—A patient may be retained by a receiving facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of the receiving facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have

personally examined the patient within the preceding 72 hours, that the criteria for involuntary inpatient placement are met. However, in a county that has a population of fewer than 50,000, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse. Any ~~second~~ opinion authorized in this subsection may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation shall be entered on an involuntary inpatient placement certificate that authorizes the receiving facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

Section 4. Paragraphs (e) and (f) of subsection (1) and paragraph (b) of subsection (4) of section 397.451, Florida Statutes, are amended to read:

397.451 Background checks of service provider personnel.—

(1) PERSONNEL BACKGROUND CHECKS; REQUIREMENTS AND EXCEPTIONS.—

(e) Personnel employed directly or under contract with the Department of Corrections in an inmate substance abuse program ~~who have direct contact with unmarried inmates under the age of 18 or with inmates who are developmentally disabled~~ are exempt from the fingerprinting and background check requirements of this section unless they have direct contact with unmarried

inmates under the age of 18 or with inmates who are developmentally disabled.

(f) Service provider personnel who request an exemption from disqualification must submit the request within 30 days after being notified of the disqualification. If 5 years or more have elapsed since the most recent disqualifying offense, service provider personnel may work with adults with substance use disorders under the supervision of a qualified professional licensed under chapter 490 or chapter 491 or a master's level certified addiction professional until the agency makes a final determination regarding the request for an exemption from disqualification ~~Upon notification of the disqualification, the service provider shall comply with requirements regarding exclusion from employment in s. 435.06~~.

(4) EXEMPTIONS FROM DISQUALIFICATION.—

(b) Since rehabilitated substance abuse impaired persons are effective in the successful treatment and rehabilitation of individuals with substance use disorders ~~substance abuse impaired adolescents~~, for service providers which treat adolescents 13 years of age and older, service provider personnel whose background checks indicate crimes under s. 817.563, s. 893.13, or s. 893.147 may be exempted from disqualification from employment pursuant to this paragraph.

Section 5. Paragraph (a) of subsection (2) of section 409.909, Florida Statutes, is amended to read:

409.909 Statewide Medicaid Residency Program.—

(2) On or before September 15 of each year, the agency shall calculate an allocation fraction to be used for distributing funds to participating hospitals. On or before the final business day of each quarter of a state fiscal year, the agency shall distribute to each participating hospital one-fourth of that hospital's annual allocation calculated under subsection (4). The allocation fraction for each participating hospital is based on the hospital's number of full-time equivalent residents and the amount of its Medicaid payments. As used in this section, the term:

(a) "Full-time equivalent," or "FTE," means a resident who is in his or her residency period, with the initial residency period defined as the minimum number of years of training required before the resident may become eligible for board certification by the American Osteopathic Association Bureau of Osteopathic Specialists or the American Board of Medical Specialties in the specialty in which he or she first began training, not to exceed 5 years. The residency specialty is defined as reported using the current residency type codes in the Intern and Resident Information System (IRIS), required by Medicare. A resident training beyond the initial residency period is counted as 0.5 FTE, unless his or her chosen specialty is in primary care, in which case the resident is counted as 1.0 FTE. For the purposes of this section, primary care specialties include:

1. Family medicine;

2. General internal medicine;

3. General pediatrics;

4. Preventive medicine;

5. Geriatric medicine;

6. Osteopathic general practice;

7. Obstetrics and gynecology;

8. Emergency medicine; and

9. General surgery.

10. Psychiatry.

Section 6. Subsections (2) and (3) of section 456.44, Florida Statutes, are amended to read:

456.44 Controlled substance prescribing.—

(2) REGISTRATION.—~~Effective January 1, 2012,~~ A physician licensed under chapter 458, chapter 459, chapter 461, or chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner certified under part I of chapter 464 who prescribes any controlled substance, listed in Schedule II, Schedule III, or Schedule IV as defined in s. 893.03, for the treatment of chronic nonmalignant pain, must:

(a) Designate himself or herself as a controlled substance prescribing practitioner on his or her ~~the physician's~~ practitioner profile.

(b) Comply with the requirements of this section and applicable board rules.

(3) STANDARDS OF PRACTICE.—The standards of practice in

this section do not supersede the level of care, skill, and treatment recognized in general law related to health care licensure.

(a) A complete medical history and a physical examination must be conducted before beginning any treatment and must be documented in the medical record. The exact components of the physical examination shall be left to the judgment of the registrant ~~clinician~~ who is expected to perform a physical examination proportionate to the diagnosis that justifies a treatment. The medical record must, at a minimum, document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, a review of previous medical records, previous diagnostic studies, and history of alcohol and substance abuse. The medical record shall also document the presence of one or more recognized medical indications for the use of a controlled substance. Each registrant must develop a written plan for assessing each patient's risk of aberrant drug-related behavior, which may include patient drug testing. Registrants must assess each patient's risk for aberrant drug-related behavior and monitor that risk on an ongoing basis in accordance with the plan.

(b) Each registrant must develop a written individualized treatment plan for each patient. The treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial

function, and shall indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the registrant ~~physician~~ shall adjust drug therapy to the individual medical needs of each patient. Other treatment modalities, including a rehabilitation program, shall be considered depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. The interdisciplinary nature of the treatment plan shall be documented.

(c) The registrant ~~physician~~ shall discuss the risks and benefits of the use of controlled substances, including the risks of abuse and addiction, as well as physical dependence and its consequences, with the patient, persons designated by the patient, or the patient's surrogate or guardian if the patient is incompetent. The registrant ~~physician~~ shall use a written controlled substance agreement between the registrant ~~physician~~ and the patient outlining the patient's responsibilities, including, but not limited to:

1. Number and frequency of controlled substance prescriptions and refills.

2. Patient compliance and reasons for which drug therapy may be discontinued, such as a violation of the agreement.

3. An agreement that controlled substances for the treatment of chronic nonmalignant pain shall be prescribed by a single treating registrant ~~physician~~ unless otherwise authorized by the treating registrant ~~physician~~ and documented in the

medical record.

(d) The patient shall be seen by the registrant ~~physician~~ at regular intervals, not to exceed 3 months, to assess the efficacy of treatment, ensure that controlled substance therapy remains indicated, evaluate the patient's progress toward treatment objectives, consider adverse drug effects, and review the etiology of the pain. Continuation or modification of therapy shall depend on the registrant's ~~physician's~~ evaluation of the patient's progress. If treatment goals are not being achieved, despite medication adjustments, the registrant ~~physician~~ shall reevaluate the appropriateness of continued treatment. The registrant ~~physician~~ shall monitor patient compliance in medication usage, related treatment plans, controlled substance agreements, and indications of substance abuse or diversion at a minimum of 3-month intervals.

(e) The registrant ~~physician~~ shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention shall be given to those patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation and requires consultation with or referral to an addiction medicine specialist or psychiatrist.

(f) A registrant ~~physician~~ registered under this section

must maintain accurate, current, and complete records that are accessible and readily available for review and comply with the requirements of this section, the applicable practice act, and applicable board rules. The medical records must include, but are not limited to:

1. The complete medical history and a physical examination, including history of drug abuse or dependence.

2. Diagnostic, therapeutic, and laboratory results.

3. Evaluations and consultations.

4. Treatment objectives.

5. Discussion of risks and benefits.

6. Treatments.

7. Medications, including date, type, dosage, and quantity prescribed.

8. Instructions and agreements.

9. Periodic reviews.

10. Results of any drug testing.

11. A photocopy of the patient's government-issued photo identification.

12. If a written prescription for a controlled substance is given to the patient, a duplicate of the prescription.

13. The registrant's ~~physician's~~ full name presented in a legible manner.

(g) Patients with signs or symptoms of substance abuse shall be immediately referred to a board-certified pain management physician, an addiction medicine specialist, or a

mental health addiction facility as it pertains to drug abuse or addiction unless the registrant is a physician who is board-certified or board-eligible in pain management. Throughout the period of time before receiving the consultant's report, a prescribing registrant ~~physician~~ shall clearly and completely document medical justification for continued treatment with controlled substances and those steps taken to ensure medically appropriate use of controlled substances by the patient. Upon receipt of the consultant's written report, the prescribing registrant ~~physician~~ shall incorporate the consultant's recommendations for continuing, modifying, or discontinuing controlled substance therapy. The resulting changes in treatment shall be specifically documented in the patient's medical record. Evidence or behavioral indications of diversion shall be followed by discontinuation of controlled substance therapy, and the patient shall be discharged, and all results of testing and actions taken by the registrant ~~physician~~ shall be documented in the patient's medical record.

This subsection does not apply to a board-eligible or board-certified anesthesiologist, physiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-eligible or board-certified medical specialist who has also completed a fellowship in pain medicine approved by

the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who is board eligible or board certified in pain medicine by the American Board of Pain Medicine, the American Board of Interventional Pain Physicians, the American Association of Physician Specialists, or a board approved by the American Board of Medical Specialties or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes. This subsection does not apply to a registrant, advanced registered nurse practitioner, or physician assistant who prescribes medically necessary controlled substances for a patient during an inpatient stay in a hospital licensed under chapter 395.

Section 7. This act shall take effect July 1, 2016.