HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 61 Emergency Services for an Unintentional Drug Overdose
SPONSOR(S): Lee, Jr.
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Royal	Poche
2) Criminal Justice Subcommittee			
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

Section 395.1041, F.S. requires all hospitals offering emergency services to provide care to every person seeking emergency care regardless of the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services. Hospitals cannot refuse to accept a person with an emergency medical condition if the service is within that hospital's capability and capacity. Persons requiring care beyond the hospital's capability or capacity must be transferred to another facility that can provide the needed services.

HB 61 amends s. 395.1041, F.S., to require a hospital providing emergency services to a person that has experienced an unintentional drug overdose to arrange for certain health care professionals to assess the patient's need for further treatment. The bill also requires the disclosure of the patient's personal health information to certain parties, including the patient's other health care providers and the patient's relatives or emergency contact, related to the unintentional drug overdose. The patient's attending physician must attempt to encourage the patient to voluntarily seek treatment for substance abuse and establish face-to-face contact between the patient and a substance abuse treatment provider.

Finally, the bill immunizes a person who has experienced an unintentional drug overdose and is need of emergency services from being charged, prosecuted, or penalized for possession of a controlled substance if the evidence for such possession was obtained as a result of the overdose and need for emergency services and care.

The bill does not appear to have a fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Substance Abuse

Substance abuse affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[1] Substance abuse disorders occur when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[2] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.[3] Brain imaging studies of persons with substance abuse disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.[4]

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance abuse disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.[5] The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[6]

Opioid Epidemic

Drug overdose is now the leading cause of injury-related death in the United States.[7] Florida is in the midst of an opioid crisis.[8] In 2015, Florida ranked fourth in the nation with 3,228 deaths from drug overdoses[9], and at least one opioid caused 2,530 of those deaths.[10] Statewide, in 2015, heroin caused 733 deaths, fentanyl caused 705, oxycodone caused 565, and hydrocodone caused 236. Deaths caused by heroin and fentanyl increased more than 75% statewide when compared with 2014.[11]

Drug overdose deaths doubled in Florida from 1999 to 2012.[12] Over the same time period, drug overdose deaths occurred at a rate 13.2 deaths per 100,000 persons.[13] The crackdown on "pill mills" dispensing prescription opioid drugs, such as oxycodone and hydrocodone, has contributed to the rise in heroin addiction.[14] With the introduction of synthetic opiates such as fentanyl, which is 100 times

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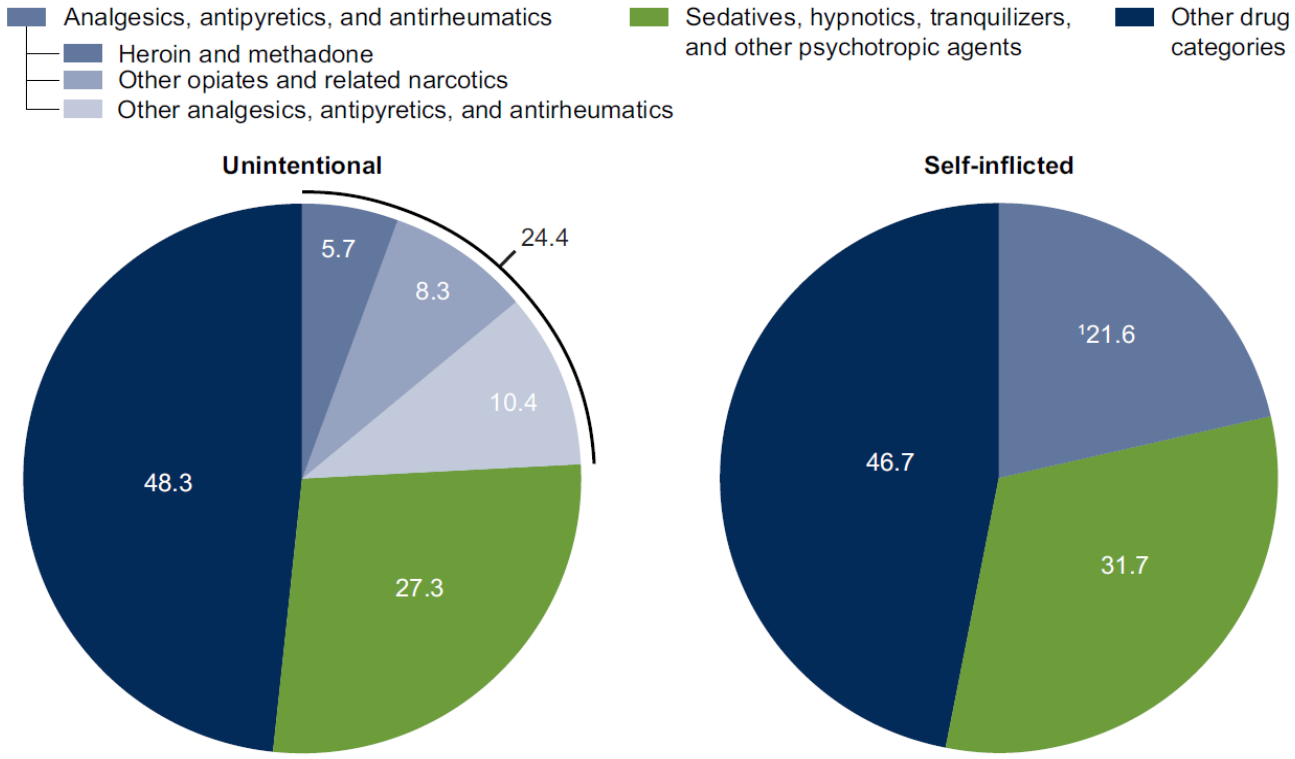
[1] World Health Organization. *Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited March 1, 2017).
[2] Substance Abuse and Mental Health Services Administration, *Substance Use Disorders,* available at: http://www.samhsa.gov/disorders/substance-use (last visited March 1, 2017).
[3] National Institute on Drug Abuse*, Drugs, Brains, and Behavior: The Science of Addiction*, available at: https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited March 1, 2017).
[4] Id.
[5] Supra, FN 2.
[6] Id.
[7] Trust for America's Health, *The Facts Hurt: A State-by-State Injury Prevention Policy Report 2015,* available at: http://healthyamericans.org/reports/injuryprevention15/ (last visited March 11, 2017).
[8] *Palm Beach County Sober Homes Task Force Report 2017*, Jan. 1, 2017, available at: http://www.sa15.state.fl.us/stateattorney/SoberHomes/_content/SHTFReport2017.pdf (last visited March 1, 2017).
[9] Centers for Disease Control and Prevention. *Drug Overdose Death Data*, available at: https://www.cdc.gov/drugoverdose/data/statedeaths.html (last visited March 11, 2017).
[10] Florida Department of Law Enforcement. *Drugs Identified in Deceased Persons by Florida Medical Examiners-2015 Annual Report,* available at: https://www.fdle.state.fl.us/cms/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2015-Annual-Drug-Report.aspx (last visited on March 11, 2017).
[11] Id. at pg. 3.
[12] Florida Department of Health, *Special Emphasis Report: Drug Poisoning (Overdose) Deaths, 1999-2012*, available at: http://www.floridahealth.gov/statistics-and-data/florida-injury-surveillance-system/_documents/CDC-Special-Emphasis-Drug-poisoning-overdose-1999-2012-B-Poston-FINAL.pdf (last visited on March 11,2017).
[13] Id.
[14] Supra, FN 8, at pg. 1.

more potent than morphine, and carfentanil, which is 1,000 times more potent than morphine, Florida is on pace to double the number of overdose deaths from 2016.[15]

Between 2004 and 2009, emergency department visits nationally involving the nonmedical use of pharmaceuticals increased 98.4%, from 627,291 visits to 1,244,679 visits.[16] In 2009, almost one million emergency room visits nationally involved illicit drugs, either alone or in combination with other drugs.[17] From 2008 to 2011, about half of all emergency department visits nationally for both unintentional and self-inflicted drug poisoning involved drugs in the categories of analgesics[18], antipyretics[19], and antirheumatics[20] or sedatives, hypnotics, tranquilizers, and other psychotropic agents.[21] Opiates or related narcotics, including heroin and methadone, accounted for 14% of emergency department visits nationally for unintentional drug poisoning from 2008 to 2011.[22] In Florida, there were approximately 21,700 opioid-related emergency department visits in 2014.[23]

Percentage of Emergency Department Visits for Drug Poisoning, By Intent and Drug Category:

United States, 2008–2011



SOURCE: CDC/NCHS, National Hospital Ambulatory Medical Care Survey, 2008–2011.[24]

[15] Id.
[16] National Institute on Drug Abuse, *Drug-Related Hospital Emergency Room Visits,* available at: https://www.drugabuse.gov/publications/drugfacts/drug-related-hospital-emergency-room-visits (last visited March 9, 2017).
[17] Id.
[18] Analgesics are drugs that produce insensibility to pain.
[19] Antipyretics are drugs that reduce fever.
[20] Antirheumatics are drugs that alleviate or prevent inflammation or pain in muscles, joints, or fibrous tissue.
[21] Albert, M. et al. *Emergency Department Visits for Drug Poisoning: United States, 2008–2011*, NCHS Data Brief No. 196, April 2015, available at: https://www.cdc.gov/nchs/data/databriefs/db196.htm
[22] Id.
[23] Weiss, A.J., et al., *Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009-20014*, HCUP Statistical Brief #219, January 2017, available at: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb219-Opioid-Hospital-Stays-ED-Visits-by-State.pdf
[24] Id.

Substance Abuse Treatment in Florida

In the early 1970s, the federal government created formula grants for states to a develop continuum of care for individuals and families affected by substance abuse.[25] The grants provided separate funding streams and requirements for alcoholism and drug abuse. In response, the Florida Legislature enacted Chapters 396, F.S., (alcohol) and 397, F.S. (drug abuse).[26] In 1993, legislation combined Chapters 396 and 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act ("the Marchman Act").[27] The Marchman Act supports the prevention and remediation of substance abuse through a comprehensive system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

Licensed Service Components

The Department of Children and Families (DCF) regulates substance abuse treatment through licensure. Licensed service components include a comprehensive continuum of accessible and quality substance abuse prevention, intervention, and clinical treatment services.[28] Clinical treatment is a professionally directed, deliberate, and planned regimen of services and interventions that are designed to reduce or eliminate the misuse of drugs and alcohol and promote a healthy, drug-free lifestyle. "Clinical treatment services" include, but are not limited to, the following service components:

- Addictions receiving facility,
- Day or night treatment, with or without community housing,
- Detoxification,
- Intensive inpatient treatment or outpatient treatment,
- Medication-assisted treatment for opiate addiction,
- Non-intensive outpatient treatment, and
- Residential treatment.[29]

All private and publicly-funded entities providing substance abuse services must be licensed, unless exempt. Exemptions are available for:

- Hospitals or hospital-based components licensed under Chapter 395, F.S.;
- Nursing home facilities, as defined in s. 400.021, F.S.;
- Substance abuse education programs established pursuant to s. 1003.42, F.S.;
- Facilities or institutions operated by the federal government;
- Physicians or physician assistants licensed under Chapter 458 or Chapter 459, F.S.;
- Psychologists licensed under Chapter 490, F.S.;
- Social workers, marriage and family therapists, or mental health counselors licensed under Chapter 491, F.S.;
- Facilities licensed under Chapter 393, F.S., which, in addition to providing services to persons with developmental disabilities, also provide services to persons developmentally at risk as a consequence of exposure to alcohol or other legal or illegal drugs while in utero; and
- Facilities licensed under s. 394.875, F.S., as crisis stabilization units.[30]

[25] Department of Children and Families, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5 (on file with the Health Innovation Subcommittee).
[26] Id.
[27] S. 2, ch. 93-39, Laws of Fla., codified in ch. 397, F.S.
[28] S. 397.311(25), F.S.
[29] S. 397.311(25)(a), F.S.
[30] S. 397.405, F.S.

Rights of Individuals Receiving Substance Abuse Treatment

Section 397.501, F.S., establishes statutory rights of individuals receiving substance abuse services, including the right to dignity, non-discriminatory services, quality services, confidentiality, counsel and habeas corpus. In particular, s. 397.501(7) prohibits service providers from disclosing records containing the identity, diagnosis, and prognosis of and services provided to any individual without written consent of the individual. The law provides certain exceptions to the disclosure of such information without consent.[31] The law makes service providers who violate these rights liable for damages, unless acting in good faith, reasonably, and without negligence.

Access to Emergency Services and Care

Section 395.1041, F.S., requires all hospitals offering emergency services to provide care to every person presenting to the hospital requesting emergency care regardless of the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services. A hospital is prohibited from refusing to render emergency services unless a determination is made after screening, examining and evaluating the patient that he or she is not suffering from an emergency or the hospital does not have the capability or capacity to render emergency services. A hospital must transfer persons requiring care beyond the hospital's capability or capacity to another facility that can provide the needed services.

In addition, hospitals participating in the Medicare program must comply with the requirements of the federal Emergency Medical Treatment and Labor Act (EMTALA) to provide emergency services to anyone regardless of their insurance status or ability to pay.[32] EMTALA also requires hospitals that do not have the capability to treat the patient's medical condition to transfer the patient to a hospital with the capability to treat the patient. Florida's state law regarding access to emergency services and care is closely aligned with EMTALA.

Federal Protections of Personal Health Information

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. Privacy rules were initially issued in 2000 by the U.S. Department of Health and Human Services and later modified in 2002.[33] The rules address the use and disclosure of an individual's personal health information and create standards for information security. Only certain entities, "covered entities", are subject to HIPAA's provisions. Covered entities are obligated to meet HIPAA's requirements to ensure privacy and confidentiality personal health information. These "covered entities" include[34]:

- Health plans;
- Health care providers;

[31] Disclosure is permitted to:
- Health service providers in cases of medical emergency if the information is necessary to provide services to the individual;
- DCF for the purposes of scientific research;
- Comply with state-mandated child abuse and neglect reporting;
- Comply with a valid court order;
- Report crimes that occur on program premises or against staff;
- Federal, state or local governments for audit purposes; or
- Third party payors providing financial assistance or reimbursement.

[32] 42 U.S. Code § 1395dd

[33] U.S. Department of Health and Human Services, *The Privacy Rule,* available at http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/ (last visited on March 11, 2017).

[34] U.S. Department of Health and Human Services, *For Covered Entities and Business Associates*, available at http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/ (last visited on March 11, 2017).

- Health care clearinghouses; and
- Business associates of any of the above.

Confidentiality of Alcohol and Drug Abuse Patient Records

Federal law restricts the disclosure of alcohol and drug patient records maintained by federally assisted alcohol and drug abuse programs which identify a patient as an alcohol or drug abuser.[35] Disclosure of patient-identifying information is permitted in certain cases and patients may consent in writing to the disclosure of such information.[36]

Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.[37] SBIRT is an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.[38]

SBIRT consists of three major components[39]:

- Screening — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.
- Brief Intervention — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.
- Referral to Treatment — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

Immunity from Prosecution for Drug-related Overdoses

Section 893.21(2), F.S., immunizes a person who experiences a drug-related overdose and is in need of medical assistance from being charged, prosecuted or penalized for possession of a controlled substance if the evidence of possession was obtained as a result of the overdose and the need for medical assistance. The law also immunizes a person, acting in good faith, who seeks medical assistance for a person experiencing a drug-related overdose from being charged, prosecuted or penalized for possession of a controlled substance if the evidence for possession was obtained as a result of seeking medical assistance.[40]

Effect of Proposed Changes

HB 61 requires a hospital providing emergency services to a person who has experienced an unintentional drug overdose to take certain measures to encourage the patient to seek further treatment for substance abuse. The bill requires a hospital to assign a SBIRT-trained health care professional to a person who has received emergency services for an unintentional drug overdose for assessment and determination of the need for further services. If a SBIRT-trained health care professional is unavailable, the attending physician must refer the patient to a physician or a physician assistant, a psychiatrist, a psychologist, or a psychiatric nurse to conduct the assessment.

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[35] 42 CFR Part 2.
[36] Disclosure is allowed to comply with state-mandated child abuse and neglect reporting; to report the cause of death; to comply with a valid court order; in cases of medical emergency; to report crimes that occur on program premises or against staff ; to entities having administrative control; to qualified service organizations and to outside auditors, evaluators, central registries, and researchers.
[37] Substance Abuse and Mental Health Services Administration. http://www.integration.samhsa.gov/clinical-practice/sbirt (last visited on March 9, 2017).
[38] Substance Abuse and Mental Health Services Administration. SBIRT Factsheet. Available at: http://www.integration.samhsa.gov/sbirt/SBIRT_Factsheet_ICN904084.pdf (last visited on March 9,2017).
[39] Supra, FN 29.
[40] S. 893.21(1), F.S.

Before the patient is discharged from the hospital, the bill requires the attending physician to attempt to make contact with the following individuals to inform them of the unintentional overdose and provide additional information or advice, as indicated:

- The patient's primary care physician and any practitioner who prescribed a controlled substance to the patient within the past 12 months.
- If the patient is currently receiving treatment for substance abuse, the patient's primary care physician and the medical director or addiction medicine specialist of the treating facility, to inform them that the patient's treatment plan may need to be reevaluated.
- The patient's adult next of kin or emergency contact to inform them of the patient's location, condition, the nature of the overdose, a list of substance abuse treatment and addiction recovery service providers, and involuntary commitment procedures for mental health or substance abuse treatment.

The attending physician must attempt to encourage the patient to voluntarily seek treatment for substance abuse and establish face-to-face contact between the patient and a substance abuse treatment provider. The bill prohibits the transfer of a patient to a licensed detoxification or addictions receiving facility before the patient is stabilized.

To encourage a person experiencing an unintentional drug overdose to seek medical care, the bill immunizes a person who has experienced an unintentional drug overdose and is in need of emergency services from being charged, prosecuted, or penalized for possession of a controlled substance if the evidence for such possession was obtained as a result of the overdose and need for emergency services and care.

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.1041, F.S., relating to access to emergency services and care.
Section 2: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals may incur costs associated with the assessment of the patient by a SBIRT-trained professional or other health care professional and the requirement to establish face-to-face contact between the patient and a substance abuse treatment provider. The bill may also create more demand for substance abuse treatment services.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill's requirement for a physician to disclose a patient's personal health information without the patient's consent may put the physician at risk of violating state and federal laws regarding the confidentiality of personal health information.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES