Select Committee on Health Care Workforce Innovation

Monday, March 10, 2014
4:00 PM - 6:00 PM
Morris Hall

Will Weatherford
Speaker

Jose R. Oliva
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Select Committee on Health Care Workforce Innovation

Start Date and Time: Monday, March 10, 2014 04:00 pm

End Date and Time: Monday, March 10, 2014 06:00 pm

Location: Morris Hall (17 HOB)

Duration: 2.00 hrs

Consideration of the following proposed committee bill(s):

PCB SCHCWI 14-02 -- Graduate Medical Education

Consideration of the following bill(s):

HB 829 Involuntary Examinations under the Baker Act by Campbell, Rehwinkel Vasilinda

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Friday, March 7, 2014.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Friday, March 7, 2014.

NOTICE FINALIZED on 03/06/2014 16:17 by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB SCHCWI 14-02 Graduate Medical Education
SPONSOR(S): Select Committee on Health Care Workforce Innovation
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Select Committee on Health Care Workforce Innovation		Poche	Calamas

SUMMARY ANALYSIS

Graduate medical education (GME) is the period of training following graduation from medical school when a physician refines the clinical skills necessary to practice in a specific medical field. GME or "residency" programs for allopathic and osteopathic physicians include internships, residency training and fellowships, and can range from three to six years or more in length of time. GME positions are funded primarily through the Medicare and Medicaid programs, but also through other government programs, such as the Department of Defense, U.S Department of Veterans Affairs, and state programs, and private funding.

In order to track and analyze Florida's GME programs, and identify potential areas of investment of state funds to expand or create GME programs to train future physicians in specialties for which there is, or will be, a shortage of physicians, PCB SCHCWI 14-02 requires the Physician Workforce Advisory Council (Council), within the Department of Health, to annually survey the state's medical schools and accredited GME institutions. The survey will include requests for data regarding medical school graduates, number of GME positions, funding sources, and any other data necessary to evaluate the physician workforce and develop strategies and policies to create and expand GME programs in the state.

The PCB requires the Council to compile all responses to the survey and create the Statewide Graduate Medical Education Report, which will be made available to the public.

The PCB has an indeterminate fiscal impact on the Department of Health.

The PCB provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

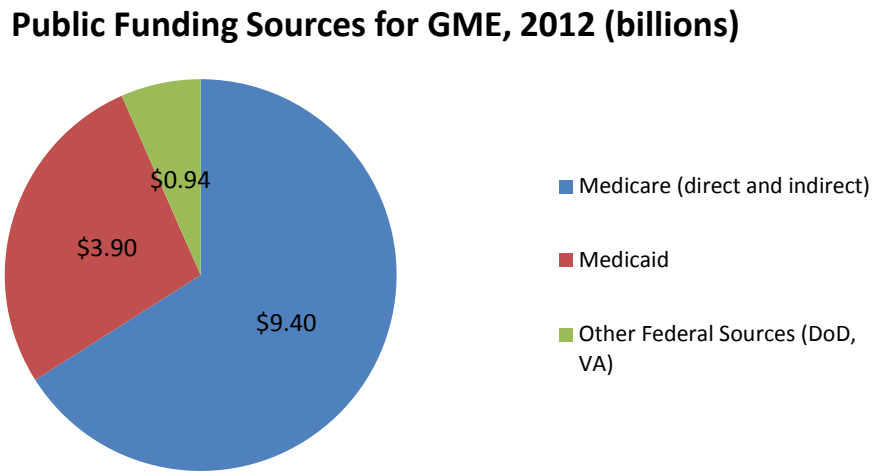
Background

Graduate Medical Education

Graduate medical education (GME) is the period of training following graduation from medical school when a physician refines the clinical skills necessary to practice in a specific medical field. GME or "residency" programs for allopathic and osteopathic physicians include internships, residency training and fellowships, and can range from three to six years or more in length of time.[1] Allopathic GME programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME) and osteopathic GME programs are accredited by the American Osteopathic Association (AOA). During academic year 2012-2013, there were 117,717 residents in GME programs across the country.[2]

Funding

The chart below illustrates the sources of public funding for GME in the United States.[3]



Medicare is the single largest funding source for GME nationwide. There are two types of Medicare GME funding- direct GME and indirect GME. Direct GME payments support "overhead" aspects of residency programs, such as resident salaries and benefits, faculty salaries, and other administrative expenses. The payment amount is determined by a methodology that includes a hospital's "per resident amount," Medicare utilization rate, and number of full-time equivalent residents at the hospital.

[1] Florida Department of Health, *Annual Report on Graduate Medical Education in Florida*, January 2010, page 6, available at: www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/gmereport2010.pdf (last viewed on March 7, 2014).
[2] Accreditation Council for Graduate Medical Education, *GME Data Resource Book-Academic Year 2012-2013*, page 24, available at http://acgme.org/acgmeweb/Portals/0/PFAssets/PublicationsBooks/2012-2013_ACGME_DATABook_DOCUMENT_Final.pdf (last viewed March 7, 2014).
[3] The Florida Legislature, Office of Program Policy Analysis & Government Accountability, *Florida's Graduate Medical Education System*, Report No. 14-08, February 2014, page 4, available at www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1408rpt.pdf (last viewed on March 7, 2014).

Indirect GME, or IME, payments defray the higher costs of patient care associated with teaching hospitals, such as greater resources devoted to sicker and more medically-complex patients, the development and use of emerging technologies, and the decreased efficiencies realized by allowing residents to "learn by doing." The payment amount is determined by a methodology that includes the hospital's teaching intensity, diagnosis related group payments, and IME adjustment factor for the current year.

The estimated annual funding for GME in Florida is approximately $540 million, primarily from Medicare and Medicaid.[4] Other sources of funding for GME in Florida include the Community Health Education Program,[5] U.S. Department of Veterans Affairs, the Department of Defense, and private funding sources.[6]

The number of GME positions funded by Medicare has been stable since 1997, when it was capped by the federal Balanced Budget Act (BBA).[7] The cap was implemented due to the prediction of an oversupply of physicians. The cap limited federal spending on health care and aligned the number of GME positions with the number of U.S. medical graduates at the time. Hospitals that had GME positions existing at the time the BBA was enacted are essentially "frozen," for Medicare reimbursement purposes, at the number of positions that existed in 1997. Several Florida accredited GME institutions have self-funded additional GME positions since 1997.

Teaching hospitals that started residency programs after 1997 are also eligible for Medicare reimbursement for GME positions. These hospitals have a five-year window to establish the largest number of FTE residents in any residency program measured during the fifth program year.[8] The window opens when the hospital begins training residents in its first residency program.[9] The number of FTE residents determined by the methodology will be the hospital's permanent cap on residents.[10]

Medicaid GME Funding in Florida

In 2013, Senate Bill 1520 created the Statewide Medicaid Residency Program (Program) in the AHCA.[11] Through the Program, Medicaid GME dollars are removed from regular hospital reimbursement payments and are subject to a formula-based redistribution. Each hospital participating in the Program receives an annual allocation determined by a calculation of its percentage of total residents statewide and its percentage of total Medicaid inpatient reimbursement among participating hospitals. The law defines the primary factors that are used in each hospital's annual allocation as follows:

- A "resident" is defined as a medical intern, fellow, or resident enrolled in a program accredited by the ACGME, the American Association of Colleges of Osteopathic Medicine, or the AOA.[12]
- "Full-time equivalent" (FTE) is defined as a resident who is in his or her initial residency period (IRP), not to exceed five years. A resident training beyond the IRP is counted as one-half of one FTE, unless his or her chosen specialty is in general surgery or primary care, in which case the resident is counted as one FTE. For purposes of the Program, primary care specialties include:

[4] Id. at page 12.
[5] The Community Health Education Program (CHEP) was established in s. 381.0403, F.S., and was repealed in 2013 in s.1, ch. 2013-48, Laws of Fla. Some funding issued by the CHEP continues.
[6] See supra, FN 3.
[7] Pub. L. 105-33.
[8] Association of American Medical Colleges, *Becoming a New Teaching Hospital-A Guide to the Medicare Requirements*, January 2013, page 10 (on file with Select Committee for Health Care Workforce Innovation staff).
[9] Id.
[10] Id.
[11] S. 5, ch. 2013-48, Laws of Fla.; *see also* s. 409.909, F.S.
[12] S. 409.909(2)(c), F.S.

- Family medicine;
- General internal medicine;
- General pediatrics;
- Preventive medicine;
- Geriatric medicine;
- Osteopathic general practice;
- Obstetrics and gynecology; and
- Emergency medicine.[13]

- "Medicaid payments" are defined as payments made to reimburse a hospital for direct inpatient services, as determined by the AHCA, during the fiscal year preceding the date on which calculations for the Program's allocations take place for any fiscal year.[14]

The AHCA, on or before September 15, calculates an allocation fraction for each hospital participating in the Program, using the following formula:[15]

HAF = [0.9 x (HFTE/TFTE)] + [0.1 x (HMP/TMP)][16]

Where:

HAF = A hospital's total allocation fraction.
HFTE = A hospital's total number of full-time equivalent residents.
TFTE = The total full-time equivalent residents for all participating hospitals.
HMP = A hospital's Medicaid payments.
TMP = The total Medicaid payments for all participating hospitals.[17]

A hospital's annual allocation equals the funds appropriated for the Program in the General Appropriations Act multiplied by its allocation fraction.[18] If the annual allocation calculation exceeds $50,000 per FTE resident, the allocation will be reduced to equal $50,000 per FTE resident.[19] The excess funds will be redistributed to participating hospitals whose annual allocation does not exceed $50,000 per FTE resident.[20]

The AHCA is required to distribute to each participating hospital one-fourth of that hospital's annual allocation on the final business day of each quarter of a state fiscal year.[21] Total quarterly distribution under the methodology for FY 2013-2014 is $19,995,161, which has been distributed in two payments, on September 17, 2013, and December 11, 2013.[22]

OPPAGA Study on Florida's GME System

In addition to establishing the Program described above, SB 1520 (2013) also required the Office of Program Policy Analysis and Government Accountability (OPPAGA) examine Florida's GME system and produce a report on their findings to the Legislature, which was provided in February 2014. The following are pertinent findings of GME programs during the 2013-2014 academic year, except where otherwise indicated:

[13] S. 409.909(2)(a), F.S.
[14] S. 409.909(2)(b), F.S.
[15] S. 409.909(2), F.S.
[16] S. 409.909(3), F.S.
[17] Id.
[18] S. 409.909(4), F.S.
[19] Id.
[20] Id.
[21] See supra, FN 15.
[22] Agency for Health Care Administration, *Graduate Medical Education/Statewide Residency Program Overview*, *Reimbursement under Statewide Residency Program* (on file with Select Committee on Health Care Workforce Innovation staff).

- There are 53 accredited GME institutions in Florida, of which 44 are administering 407 residency programs with a total of 5,157 positions.[23]
- 21 GME programs are accredited by ACGME, 16 by AOA, and 7 programs are accredited by both.[24]
- Approximately 89 percent of the residency positions were filled.[25]
- Of the 407 residency programs, 24 percent are in primary care specialties, such as family medicine, internal medicine, and general surgery, 25 percent are non-primary care specialties, such as dermatology and neurology, and 51 percent are subspecialties, such as cardiology and nephrology.[26]
- Over 73 percent of GME positions were filled by graduates of out-of-state medical schools.[27]
- Overall, 94 percent of residents who started a GME position in 2006-07 completed the program by 2012-13.[28]
- GME institutions reported a 100 percent completion rate for the following GME programs:
    - Dermatology;
    - Geriatric medicine;
    - Neurology;
    - Obstetrics and gynecology; and
    - Psychiatry.
- Four other specialties had completion rates greater than 90 percent:
    - Pediatrics (99 percent)
    - Emergency medicine (98 percent)
    - Family medicine (93 percent)
    - Internal medicine (91 percent)
- From 2000 through 2013, 9,294 students graduated from Florida medical schools. 3,073 students, or 38 percent, matched to a Florida residency program and 5,094, or 62 percent, matched to an out-of-state residency program.[29]
- From 2000 through 2013, 72 percent of Florida medical school graduates who matched with a Florida-based residency program went to a primary care specialty.[30]

In order to maximize the state's return on its investment in educating and training the next generation of physicians and to stem any shortage of competent physicians in the areas of critical need, such as primary care specialties, it is essential to keep the residents who trained in Florida in the state when their residency is complete. A study cited in the OPPAGA report estimated that 47 percent of physicians stayed or returned to the state where they completed their most recent GME and 66 percent of physicians who completed undergraduate education and GME in the same state remained in that state.[31]

No systemic annual reporting or tracking of the data compiled by OPPAGA is currently in place. In its report, OPPAGA recommended collecting institution- and physician-level data, such as residency program type, size, and rotation sites; approved and filled residency positions; use of Medicare FTEs;

[23] See supra, FN 3 at page 5.
[24] Id.
[25] Id. at page 7.
[26] Id. at page 6.
[27] See supra, FN 25.
[28] Id. at page 8.
[29] Id. at page 9.
[30] Id. at page 10.
[31] Association of American Medical Colleges, *2013 State Physician Workforce Data Book*, pages 46-47, available at https://members.aamc.org/eweb/upload/State%20Physician%20Workforce%20Data%20Book%202013%20(PDF).pdf (last viewed on March 8, 2014).

and GME institution residency completion lengths and rates, to track and analyze GME programs and positions statewide.[32]

OPPAGA also suggested that the information be reported on an annual basis.[33] The data, according to OPPAGA, could help assess GME priorities and challenges and inform decisions about programs and positions and funding opportunities.[34]

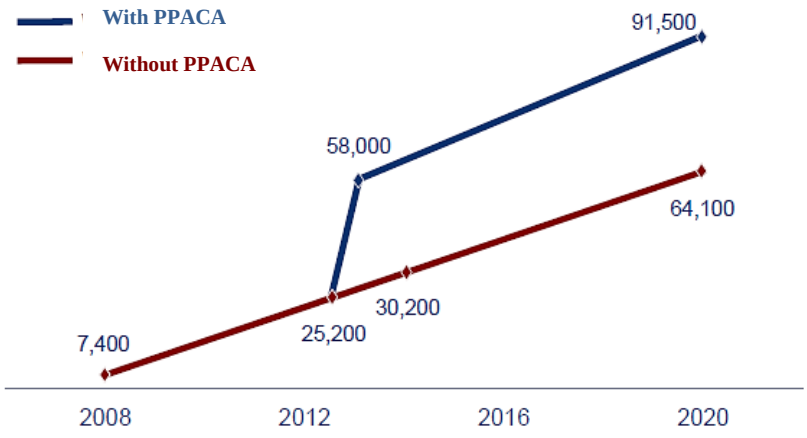
Physician Workforce Data

The Association of American Medical Colleges Center for Workforce Studies estimates that, in 2015, the U.S. will face a physician shortage of 62,900 that will increase to 130,000 across all specialties by 2025.[35]

In 2012, there were 260.5 physicians[36] actively practicing per 100,000 population in the U.S., ranging from a high of 421.5 in Massachusetts to a low of 180.8 in Mississippi. The states with the highest number of physicians per 100,000 population are concentrated in the northeastern states.[37] Regarding primary care physicians, there were 90.1 per 100,000 population.[38]

The following chart illustrates the projected physician shortage, nationally, with and without full implementation of the Patient Protection and Affordable Care Act.

National projected physician shortages



Source: Kirch DG, Henderson MK, Dill MJ (2011). "Physician Workforce Projections in an Era of Health Care Reform." *Annual Review of Medicine.*

Florida had 252.9 actively practicing physicians per 100,000 population in 2012. Although Florida is the fourth most populous state in the nation,[39] it ranks as having the 23rd highest physician to population

[32] Id. at page 15.
[33] Id.
[34] Id.
[35] American Medical Association, "Reducing medical student debt strengthens the physician workforce," available at: http://www.ama-assn.org/resources/doc/mss/student-debt-mss-advocacy.pdf (last visited on February 14, 2014).
[36] These totals include allopathic and osteopathic doctors.
[37] AAMC, "2013 State Physician Workforce Data Book," November 2013, pg. 4, available at: https://www.aamc.org/download/362168/data/2013statephysicianworkforcedatabook.pdf (last visited on February 11, 2014).
[38] Id. at pg. 5.
[39] The U.S. Census Bureau estimated Florida to have 19,552,860 residents in 2013, behind California (38,332,521), Texas (26,448,193), and New York (19,651,127). U.S. Census Bureau, "Annual Estimates of the Resident Population: 2013 Population

ratio.[40] In 2012, Florida had a ratio of 84.8 primary care physicians per 100,000 population, ranking Florida 30th compared to other states.[41] In 2013, 13.2 percent of Florida's physicians reported that they were planning to retire within the next five years, which will exacerbate Florida's shortage of physicians.[42]

As of November 2013, the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services designated approximately 5,800 locations in the U.S. as primary care Health Professional Shortage Areas (HPSAs).[43] Primary care HPSAs are based on a physician to population ratio of 1:3,500. In other words, when there are 3,500 or more people per primary care physician, an area is eligible to be designated as a primary care HPSA. Applying this formula, it would take approximately 7,500 additional primary care physicians to eliminate the current primary care HPSA designations, nationally.[44]

As of November 2014, there were 327 primary care HPSAs in Florida. Those HPSAs would need at least 890 primary care physicians to remove the HPSA designation. In addition to Florida's primary care HPSAs, the state has 275 dental HPSAs and 306 mental health care HPSAs, which would require 870 dentists and 155 psychiatrists, respectively, to remove the HPSA designation.[45]

A different analysis measured current primary care utilization (office visits) and projected the impact of population increases, aging, and insured status changes. The study found that the total number of office visits to primary care physicians will increase from 462 million in 2008 to 565 million in 2025, and (because of aging) the average number of visits will increase from 1.60 to 1.66. The study concluded that the U.S. will require 51,880 *additional* primary care physicians by 2025.[46] The table below illustrates the study's findings.

Estimates," available at: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk (last visited on February 11, 2014).

[40] See supra, FN 37, at pg. 9.

[41] See supra, FN 37, at pg. 13.

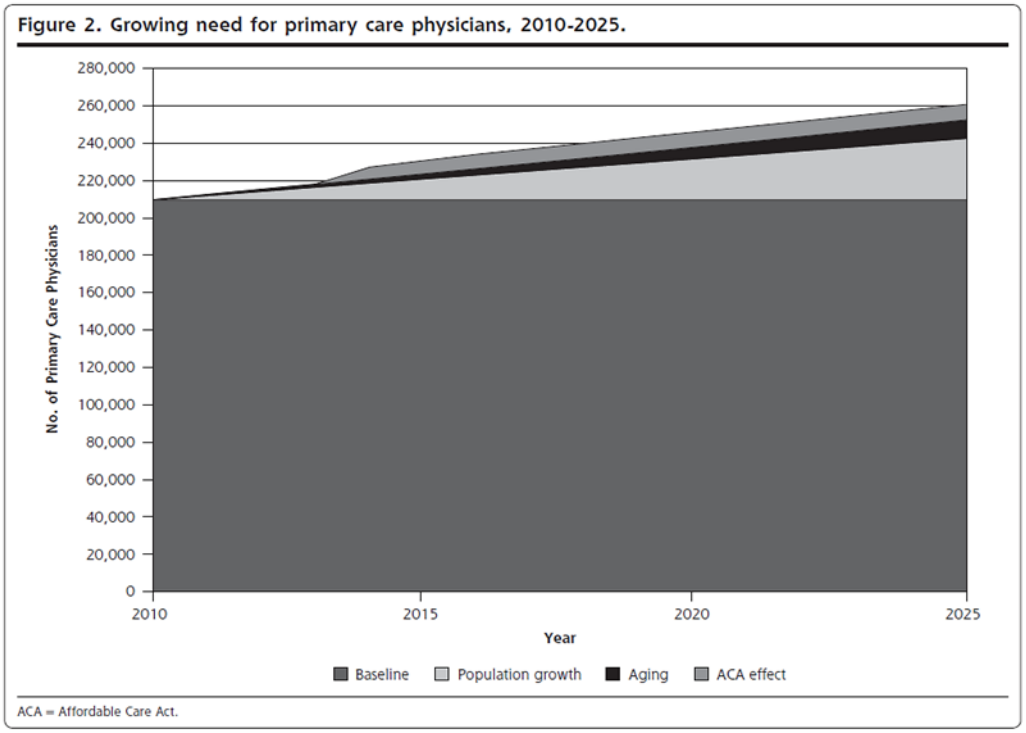
[42] Florida Department of Health, "2013 Physician Workforce Annual Report," available at: http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/physicianworkforce13final.pdf (last visited on February 11, 2014).

[43] U.S. Department of Health and Human Services, Health Resources and Services Administration, "Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations," available at: http://www.hrsa.gov/shortage/ (last visited on February 11, 2014).

[44] While the 1:3,500 ratio has been a long-standing ratio used to identify high need areas, it is important to note that there is no generally accepted ratio of physician to population ratio. Furthermore, primary care needs of an individual community will vary by a number of factors such as the age of the community's population. Additionally, the formula used to designate primary care HPSAs does not take into account the availability of additional primary care services provided by Nurse Practitioners and Physician Assistants in an area. U.S. Department of Health and Human Services, Health Resources and Services Administration, "Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations," available at: http://www.hrsa.gov/shortage/ (last visited on February 11, 2014).

[45] Florida Department of Health, Presentation on Health Care Workforce: Physician Workforce and Florida CHARTS Data, November 6, 2013, available at: http://myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2786&Session=2014&DocumentType=Meeting Packets&FileName=schcwi 11-6-13.pdf (last visited on February 11, 2014).

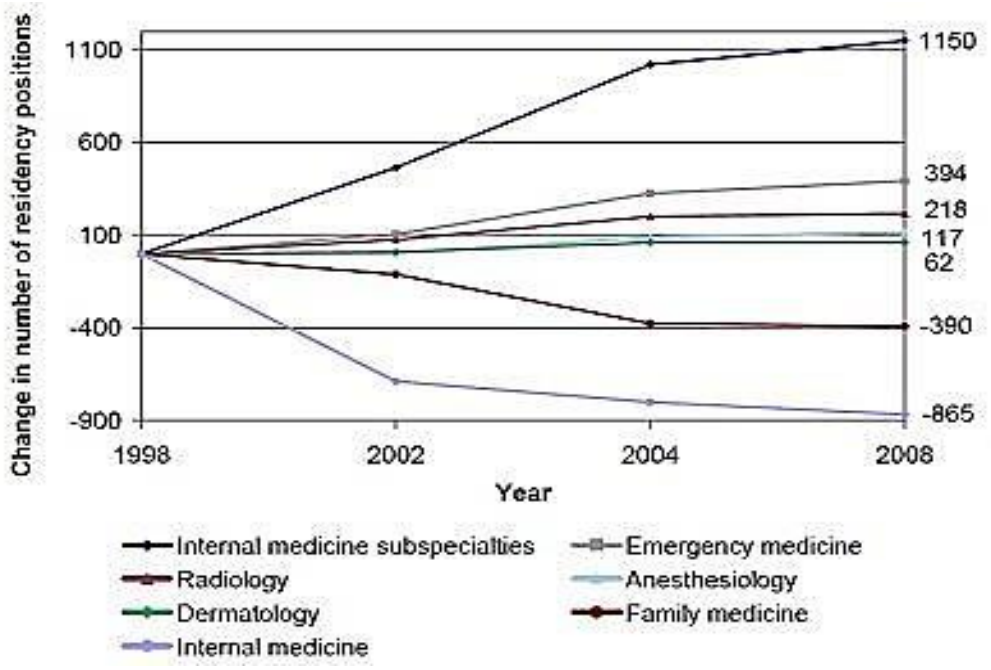
[46] Petterson, Stephen M., et al., "Projecting U.S. Primary Care Physician Workforce Needs: 2010-2025", Annals of Family Medicine, vol. 10, No. 6, Nov./Dec. 2012, available at: http://www.annfammed.org/content/10/6/503.full.pdf+html (last visited on February 24, 2014).



One factor contributing to the shortage of primary care physicians is that medical students are choosing to go into specialty practice to pay off large student loans that they have accumulated.[47] Physicians in 12 specialties, such as radiology, psychiatry and anesthesiology, may earn up to twice the income (from $191,000 to >$400,000 per year) of primary care physicians (from $183,000 to $201,000 per year).[48] It is estimated that 86% of the medical school graduating class of 2013 will have education-related debt.[49] With an average medical student debt of $169,901, debt plays a major role in medical students' career decisions.[50]

The type of residencies that are available to medical school graduates also has a role in those career decisions. Data on residencies funded by Medicare (1998-2008) indicates program growth is predominantly in subspecialty training and non-primary-care core specialties.[51] For example, 133 internal medicine subspecialty programs opened in that time. Conversely, there was a net loss of 390 first-year family medicine resident positions. Similarly, 865 general internal medicine positions were lost, converted to preliminary year positions, or offset by opportunities to subspecialize. Primary care also lost 40 family medicine and 25 internal medicine programs during this time. The chart below indicates the change in the number of first-year residency programs by specialty in that time.[52]

[47] A study conducted by the Robert Graham Center found that the income gap between primary care and subspecialists has an impressively negative impact on choice of primary care specialties and of practicing in rural or underserved settings. Robert Graham Center, "What Influences Medical Student & Resident Choices?", March 2, 2009, available at: http://www.graham-center.org/online/etc/medialib/graham/documents/publications/mongraphs-books/2009/rgcmo-specialty-geographic.Par.0001.File.tmp/Specialty-geography-compressed.pdf (last visited on February 14, 2014).
[48] Grayson, M., Newton, D., Thompson, L., "Payback time: the associations of debt and income with medical student career choice," *Medical Education*, Vol. 46, Issue 10, pg. 984, October 2012, on file with committee staff.
[49] Association of American Medical Colleges, "Medical Student Education: Debt, Costs, and Loan Repayment Fact Card," October 2013, available at: https://www.aamc.org/download/152968/data/debtfactcard.pdf (last visited on February 14, 2014).
[50] Id.
[51] Weida NA, Phillips RL Jr, Bazemore AW, Dodoo MS, Petterson SM, Xierali I, Teevan B., "Loss of Primary Care Residency Positions Amidst Growth in other Specialties. *Am Fam Physician*, 2010 Jul 15;82(2):121, available at: http://www.graham-center.org/online/graham/home/publications/onepagers/2010/op66-loss-primary.html (last visited on February 25, 2014).
[52] Id.



Several researchers have advocated the position that GME is a public good that should be supported by and held accountable to the public for the purpose of developing the number and specialty mix of physicians to meet public need.[53]

Physician Workforce Advisory Council

The Physician Workforce Advisory Council (Council) was created within the Department of Health (DOH) in 2010.[54] The Council consists of 19 members, including the State Surgeon General, who serves as its chair.[55] The remaining members are appointed by the State Surgeon General and include individuals from the medical community and the academic community.[56] The Council is required to meet at least twice a year[57], and must:

- Advise the State Surgeon General and the DOH on matters concerning current and future physician workforce needs;
- Review survey materials and the compilation of survey information;
- Annually review the number, location, cost, and reimbursement of graduate medical education programs and positions;
- Provide recommendations to the DOH regarding the survey completed by physicians licensed under chapter 458 or chapter 459;
- Assist the DOH in preparing the annual report to the Legislature pursuant to ss. 458.3192[58] and 459.0082, F.S.;[59]

[53] Josiah Macy Jr. Foundation, *Creating an Accountable Graduate Medical Education System-2011 Annual Report*, page 8, available at http://macyfoundation.org/docs/annual_reports/JMF_11_AnnualReport_WEBPDF.pdf (last viewed on March 8, 2014); see also Carnegie Foundation for the Advancement of Teaching, *News Release-Educating Physicians: A Call for Reform of Medical School and Residency*, June 2010, available at www.carnegiefoundation.org/newsroom/press-releases/educating-physicians-call-reform-medical-school-and-residency (last viewed on March 8, 2014).
[54] S. 29, ch. 2010-161, Laws of Fla.
[55] S. 381.4018(4)(c), F.S.
[56] S. 381.4018(4)(a), F.S.
[57] S. 381.4018(4)(e), F.S.
[58] The report referenced in this subparagraph contains information gathered from the Physician Surveys concerning the number of physicians who are delivering children in the state, reading mammograms, and performing on-call emergency care for a hospital ER department, and other physician-specific data.
[59] See supra, FN 58.

- Assist the DOH in preparing an initial strategic plan, conduct ongoing strategic planning in accordance with this section, and provide ongoing advice on implementing the recommendations;
- Monitor and provide recommendations regarding the need for an increased number of primary care or other physician specialties to provide the necessary current and projected health and medical services; and
- Monitor and make recommendations regarding the status of the needs relating to graduate medical education.[60]

Neither the Council nor the DOH collects or studies data on GME in Florida.

Effect of Proposed Changes

The PCB requires the Council to conduct an annual survey of all state public and private allopathic and osteopathic medical schools, hospitals and other entities regarding GME programs in Florida. The collection of this information will allow GME programs, resident retention, and chosen practice areas to be tracked and analyzed statewide. Such analysis may include the performance of existing GME programs and identify the need for additional GME programs in certain specialties and subspecialties.

In developing the content and design of the survey, the PCB requires the Council to consult with the Department of Economic Opportunity, the Board of Governors, and the Council of Florida Medical School Deans. The Council is also required to compile all of the survey responses to create the Statewide Graduate Medical Education Report and make it publicly available by July 1st each year.

The PCB requires each medical school to report annually through the survey the following information for the preceding year:

- The number of students enrolled in the school who graduated from Florida-based programs;
- The number of students enrolled in the school who graduated from out-of-state programs;
- The number of students matched to a Florida residency program;
- The location and setting of each Florida residency program with a graduate from the school and number of graduates in each of those programs;
- The number of students matched to an out-of-state residency program;
- The location and setting of each out-of-state residency program with a graduate from the school and the number of graduates in each of those programs; and
- Any other data necessary to evaluate the physician workforce and develop strategies to increase the existing GME programs and create new GME programs in the state.

The PCB requires each accredited GME institution to report annually through the survey the following information for the preceding year for each hospital or entity that serves as a rotating site for the institution:

- The number of approved GME program positions and the number of filled positions by primary care specialty, non-primary care specialty, and subspecialty;
- The number of Medicare FTE positions in the GME program;
- The location and setting of each GME program position;
- The cost of each GME program position;
- The amounts received and the sources of funding for the GME program, including, but not limited to, Medicare payments, Medicaid payments, Community Hospital Education Program funding, federal Health Resources and Services Administration funding, Department of Defense funding, and U.S. Department of Veterans Affairs funding;
- The GME program budget;

[60] S. 381.4018(4)(f)1, through 8., F.S.

- Completion rates by program for primary care specialties, non-primary care specialties, and subspecialties;
- The licensing test and board certification examination results by specialty and subspecialty, if applicable, for each resident completing her or his residency;
- The location and setting of each medical practice of each new physician who completed her or his residency;
- Any other data necessary to evaluate the physician workforce and develop strategies to increase the existing GME programs and create new GME programs in the state.

Each school and accredited GME institution must report its survey responses to the Council each year by January 1st.

The PCB provides an effective date of July 1, 2014.

B. SECTION DIRECTORY:

Section 1: Amends s. 381.4018, F.S., relating to physician workforce assessment and development.
Section 2: Provides an effective date of July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The DOH is required to create survey forms for all state public and private allopathic and osteopathic medical school and all accredited GME institutions, which will have an indeterminate fiscal impact on the DOH.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Medical schools and accredited GME institutions may see an increase in administrative costs associated with gathering the necessary information to complete the survey, recording the information on the survey form, and submitting the survey to the DOH.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The PCB provides sufficient rule-making authority to the DOH to implement the provisions of the PCB.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to graduate medical education; amending s. 381.4018, F.S.; providing an effective date.

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

Section 1. Paragraph (f) of subsection (4) is amended and subsection (5) is added to section 381.4018, Florida Statutes, to read:

381.4018 Physician workforce assessment and development.—

(4) PHYSICIAN WORKFORCE ADVISORY COUNCIL.—There is created in the department the Physician Workforce Advisory Council, an advisory council as defined in s. 20.03. The council shall comply with the requirements of s. 20.052, except as otherwise provided in this section.

(f) The council shall:

1. Advise the State Surgeon General and the department on matters concerning current and future physician workforce needs in this state;

2. Conduct an annual survey of all state public and private allopathic and osteopathic medical schools, hospitals and other entities regarding graduate medical education programs in the state pursuant to subsection (5).

3.~~2.~~ Review survey materials and the compilation of survey information;

~~3. Annually review the number, location, cost, and reimbursement of graduate medical education programs and positions~~;

4. Provide recommendations to the department regarding the survey completed by physicians licensed under chapter 458 or chapter 459;

5. Assist the department in preparing the annual report to the Legislature pursuant to ss. 458.3192 and 459.0082;

6. Assist the department in preparing an initial strategic plan, conduct ongoing strategic planning in accordance with this section, and provide ongoing advice on implementing the recommendations;

7. Monitor and provide recommendations regarding the need for an increased number of primary care or other physician specialties to provide the necessary current and projected health and medical services for the state; and

8. Monitor and make recommendations regarding the status of the needs relating to graduate medical education in this state.

(5) GRADUATE MEDICAL EDUCATION PROGRAM REPORTING.—(a) Each state public or private allopathic or osteopathic medical school shall report each year to the council by January 1, on a survey form furnished by the department, the following information for the preceding year.

1. The number of students enrolled in the school who matriculated from programs located in Florida.

2. The number of students enrolled in the school who

matriculated from out-of-state programs.

3. The number of students matched to a residency program in Florida, the location and setting of each residency program in Florida with a graduate from the school, and the number of graduates from the school in each residency program.

4. The number of students matched to an out-of-state residency program, the location and setting of each out-of-state residency program with a graduate from the school, and the number of graduates from the school in each residency program.

5. Any other data deemed necessary by the department to evaluate the physician workforce and develop strategies and policies to create and expand graduate medical education programs in this state.

(b) Each accredited graduate medical education institution shall report each year to the council by January 1, on a form furnished by the department, the following information for the preceding year for each hospital or entity that serves as a rotating site for the institution.

1. The number of approved graduate medical education program positions in the hospital or entity by primary care specialty, non-primary care specialty, and subspecialty and the number of filled positions.

2. The number of Medicare full-time equivalent positions in the graduate medical education program at the hospital or entity.

3. The location and setting of each graduate medical

education program position.

4. The cost to the hospital or entity of each graduate medical education program position.

5. The amounts received and sources of funding for the hospital or entity graduate medical education program, including, but not limited to, Medicare payments, Medicaid Disproportionate Share Hospital payments, Statewide Medicaid Residency Program funding, Community Hospital Education program funding, Health Resources and Services Administration funds, Department of Defense funds, and United States Department of Veteran Affairs funds.

6. The graduate medical education program budget for the hospital or entity.

7. Completion rates by program for primary care specialty, non-primary care specialty, and subspecialty.

8. The licensing test and board certification examination results by specialty and subspecialty, if applicable, for each resident completing her or his residency.

9. The location and setting of each medical practice of each new physician who completed her or his residency.

10. Any other data deemed necessary by the department to evaluate the physician workforce and develop strategies and policies to create and expand graduate medical education programs in this state.

(c) The council shall compile all information received pursuant to paragraphs (a) and (b) to create the Statewide

Graduate Medical Education Report, which shall be made available to the public by July 1 of each year.

(d) The department shall by rule create a survey form for the purpose of this section. The department shall consult with the Department of Economic Opportunity, the Board of Governors, and the Council of Florida Medical School Deans to develop survey content and design.

Section 2. This act shall take effect July 1, 2014.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 829 Involuntary Examinations under the Baker Act
SPONSOR(S): Campbell
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Care Workforce Innovation		Guzzo	Calamas
2) Civil Justice Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In 1971, the legislature passed the Florida Mental Health Act (also known as "The Baker Act") to address mental health needs of individuals in the state. The Baker Act allows for voluntary and involuntary examination of an individual and establishes procedures for the court, law enforcement and the medical community that ensure the preservation of an individual's rights relating to medical services.

The Baker Act authorizes involuntary examination of an individual who appears to have a mental illness and who, because of mental illness, presents a substantial threat of harm to themselves or others. Involuntary examination may be initiated by courts, law enforcement officers, physicians, clinical psychologists, psychiatric nurses, mental health counselors, marriage and family therapists, and clinical social workers.

The bill adds advanced registered nurse practitioners and physician assistants to the list of medical professionals who may execute a certificate for involuntary examination of a person.

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

The bill provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Involuntary Examination Under the Baker Act

In 1971, the legislature passed the Florida Mental Health Act (also known as "The Baker Act") to address mental health needs in the state.[1] Part I of Chapter 394, F.S., provides 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 individuals for treatment. The Department of Children and Families (DCF) administers this law through receiving facilities which provide for the examination of persons with evidence of a mental illness. Receiving facilities are designated by DCF and may be public or private facilities which provide the examination and short-term treatment of persons who meet criteria under The Baker Act.[2] Subsequent to examination at a receiving facility, a person who requires further treatment may be transported to a treatment facility. Treatment facilities designated by DCF are state hospitals (e.g., Florida State Hospital) which provide extended treatment and hospitalization beyond what is provided in a receiving facility.[3]

Current law provides that an involuntary examination may be initiated for a person if there is reason to believe the person has a mental illness and because of the illness:[4]

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

An involuntary examination may be initiated by a circuit court or a law enforcement officer.[5] A circuit court may enter an *ex parte* order stating a person meets the criteria for involuntary examination. A law enforcement officer, as defined in s. 943.10, F.S., may take a person into custody who appears to meet the criteria for involuntary examination and transport them to a receiving facility for examination.

In addition, the following professionals, when they have examined a person within the preceding 48 hours, may issue a certificate stating that the person meets the criteria for involuntary examination:[6]

- A physician licensed under ch. 458, F.S., or an osteopathic physician licensed under ch. 459, F.S., who has experience in the diagnosis and treatment of mental and nervous disorders.
- A physician employed by a facility operated by the United States Department of Veterans Affairs which qualifies as a receiving or treatment facility.
- A clinical psychologist, as defined in s. 490.003(7), F.S., with 3 years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a 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 and 2 years of post-master's clinical experience under the supervision of a physician.

[1] Section 1, ch. 71-131, L.O.F.
[2] Section 394.455(26), F.S.
[3] Section 394.455(32), F.S.
[4] Section 394.463(1), F.S.
[5] Section 394.463(2)(a), F.S.
[6] *Id.*

- A mental health counselor licensed under ch. 491, F.S.
- A marriage and family therapist licensed under ch. 491, F.S.[7]
- A clinical social worker licensed under ch. 491, F.S.[8]

In 2011, there were 150,466 involuntary examinations initiated in the state. Law enforcement initiated almost half of the involuntary exams (49.21 percent) followed by mental health professionals and physicians (48.73 percent) and then *ex parte* orders by judges (2.06 percent).[9]

Physician Assistants

Sections 458.347(7) and 459.022(7), F.S., govern the licensure of physician assistants (PAs) in Florida. PAs are licensed by the Department of Health (DOH) and are regulated by the Florida Council on Physician Assistants (Council) and either the Florida Board of Medicine (Board of Medicine) for PAs licensed under ch. 458, F.S., or the Florida Board of Osteopathic Medicine (Osteopathic Board) for PAs licensed under ch. 459, F.S. Currently, there are 5,874 active licensed PAs in Florida.[10]

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. A supervising physician may only delegate tasks and procedures to the physician assistant that are within the supervising physician's scope of practice.[11] The supervising physician is responsible and liable for any and all acts of the PA and may not supervise more than four PAs at any time.[12]

PAs are regulated through the respective physician practice acts.[13] Each of the medical practice acts has a corresponding board (i.e., the Board of Medicine and Osteopathic Board). The duty of a Board and its members is to make disciplinary decisions concerning whether a doctor or PA was practicing medicine within the confines of their practice act.[14]

To become licensed as a PA in Florida, an applicant must demonstrate to the Council:[15] passage of the National Commission on Certification of Physician Assistant exam; completion of the application; completion of a PA training program; a sworn, notarized statement of felony convictions; a sworn statement of denial or revocation of licensure in any state; letters of recommendation from physicians;[16] payment of a licensure fee; and completion of a two hour course on the prevention of medical errors, error reduction and prevention, and patient safety.[17] Licensure renewal occurs biennially.[18]

In 2008 Attorney General Bill McCollum issued an opinion stating that:

> *A physician assistant licensed pursuant to Chapter 458 or 459, F.S., may refer a patient for involuntary evaluation pursuant to section 394.463, F.S., provided that the physician assistant*

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[7] Marriage and Family Therapists use practice methods of a psychological nature to evaluate, assess, diagnose, treat and prevent emotional and mental disorders or dysfunctions. Section 491.003(8), F.S.
[8] Clinical Social Workers are required by law to have experience in providing psychotherapy and counseling. Section 491.003(3), F.S.
[9] Department of Children and Families, *Florida's Baker Act: 2013 Fact Sheet*, available at http://myflfamilies.com/service-programs/mental-health/baker-act-manual (last visited March 7, 2014).
[10] Florida Department of Health, *Medical Quality Assurance Annual Report 2012-2013*, available at http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/annual-reports.html (last visited March 7, 2014).
[11] Rule 64B8-30.012(1), F.A.C, and Rule 64B15-6.010(1), F.A.C.
[12] Section 458.347(3), F.S., and s. 459.022(3), F.S.
[13] Chapters 458 and 459, F.S.
[14] Section 458.347(12), F.S., and 459.022(12), F.S.
[15] Section 458.347(7), F.S., and s. 459.022(7), F.S.
[16] Rule 64B8-30.003(1), F.A.C., and Rule 64B15-6.003(1), F.A.C.
[17] Rule 64B8-30.003(3), F.A.C., and Rule 64B15-6.003(4), F.A.C.
[18] Section 458.347(7)(c), F.S. Rule 64B8-30.019, F.A.C., establishes the initial licensure and renewal fee schedule. Section 459.022(7)(b), F.S. Rule 64B15-6.013, F.A.C., establishes the initial licensure and renewal fee schedule.

has experience regarding the diagnosis and treatment of mental and nervous disorders and such tasks as are within the supervising physician's scope of practice.[19]

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

Advanced Registered Nurse Practitioners (ARNPs)

Part I of ch. 464, F.S., governs the licensure and regulation of nurses in Florida. Nurses are licensed by DOH and are regulated by the Board of Nursing. Licensure requirements to practice advanced and specialized nursing include completion of education requirements,[20] demonstration of passage of a department approved examination, a clean criminal background screening, and payment of applicable fees.[21] Renewal is biennial and contingent upon completion of certain continuing medical education requirements.

A nurse who holds a license to practice advanced and specialized nursing may be certified as an ARNP under s. 464.012, F.S., if the nurse meets one or more of the following requirements:

- Completion of a post basic education program of at least one academic year that prepares nurses for advanced or specialized practice;
- Certification by a specialty board, such as a registered nurse anesthetist or nurse midwife; or
- Possession of a master's degree in a nursing clinical specialty area.

Current law defines three categories of ARNPs: certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners.[22] All ARNPs, regardless of practice category, may only practice within the framework of an established protocol and under the supervision of an allopathic or osteopathic physician or a dentist.[23] ARNPs may carry out treatments as specified in statute, including:[24]

- Monitoring and altering drug therapies;
- Initiating appropriate therapies for certain conditions;
- Performing additional functions as may be determined by rule in accordance with s. 464.003(2), F.S.;[25] and
- Ordering diagnostic tests and physical and occupational therapy.

In addition to the above allowed acts, ARNPs may also perform other acts as authorized by statute and within his or her specialty.[26] Further, if it is within the ARNPs established protocol, the ARNP may establish behavioral problems and diagnosis and make treatment recommendations.[27]

There are 15,420 active, licensed ARNPs in Florida.[28]

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[19] *See*, 08-31 Fla. Op. Att'y Gen. (2008). Available at: http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/agopinion.pdf (last visited March 7, 2014).

[20] Rule 64B9-4.003, F.A.C., provides that an Advanced Nursing Program shall be at least one year long and shall include theory in the biological, behavioral, nursing and medical sciences relevant to the area of advanced practice in addition to clinical expertise with a qualified preceptor.

[21] Section 464.009, F.S., provides an alternative to licensure by examination for nurses through licensure by endorsement.

[22] Section 464.012(2), F.S.

[23] Section 464.012(3), F.S.

[24] *Id.*

[25] Section 464.003(2), F.S., defines "Advanced or Specialized Nursing Practice" to include additional activities that an ARNP may perform as approved by the Board of Nursing.

[26] Section 464.012(4), F.S.

[27] Section 464.012(4)(c)5, F.S.

[28] Florida Department of Health, *Medical Quality Assurance Annual Report 2012-2013*, available at http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/annual-reports.html (last visited March 7, 2014).

Effect of Proposed Changes

The bill amends s. 394.463, F.S., to add that a PA or an ARNP may execute a certificate stating that a person who the ARNP or PA has examined within the preceding 48 hours appears to meet the criteria for involuntary examination for mental illness.

The bill also amends s. 394.455, F.S., to add definitions of PAs and ARNPs to the terms associated with the provision of services and care under the Florida Mental Health Act.

Finally, the bill makes several necessary conforming changes due to the statutory changes made by the bill.

B. SECTION DIRECTORY:

Section 1: Amends s. 39.407, F.S., relating to medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.
Section 2: Amends s. 394.455, F.S., relating to definitions.
Section 3: Amends s. 394.463, F.S., relating to involuntary examination.
Section 4: Amends s. 394.495, F.S., relating to child and adolescent mental health system of care; programs and services.
Section 5: Amends s. 394.496, F.S., relating to service planning.
Section 6: Amends s. 394.9085, F.S., relating to behavioral provider liability.
Section 7: Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment.
Section 8: Amends s. 744.704, F.S., relating to powers and duties.
Section 9: Provides an effective date of July 1, 2014.

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:

None.

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:

No additional rule-making is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to involuntary examinations under the Baker Act; reordering and amending s. 394.455, F.S.; providing definitions; updating references to the Department of Children and Families; amending s. 394.463, F.S.; authorizing physician assistants and advanced registered nurse practitioners to initiate involuntary examinations under the Baker Act of persons believed to have mental illness; amending ss. 39.407, 394.495, 394.496, 394.9085, 409.972, and 744.704, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) of section 39.407, Florida Statutes, is amended to read:

39.407 Medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.—

(3)(a)1. Except as otherwise provided in subparagraph (b)1. or paragraph (e), before the department provides psychotropic medications to a child in its custody, the prescribing physician shall attempt to obtain express and informed consent, as defined in s. 394.455 ~~394.455(9)~~ and as described in s. 394.459(3)(a), from the child's parent or legal

guardian. The department must take steps necessary to facilitate the inclusion of the parent in the child's consultation with the physician. However, if the parental rights of the parent have been terminated, the parent's location or identity is unknown or cannot reasonably be ascertained, or the parent declines to give express and informed consent, the department may, after consultation with the prescribing physician, seek court authorization to provide the psychotropic medications to the child. Unless parental rights have been terminated and if it is possible to do so, the department shall continue to involve the parent in the decisionmaking process regarding the provision of psychotropic medications. If, at any time, a parent whose parental rights have not been terminated provides express and informed consent to the provision of a psychotropic medication, the requirements of this section that the department seek court authorization do not apply to that medication until such time as the parent no longer consents.

2. Any time the department seeks a medical evaluation to determine the need to initiate or continue a psychotropic medication for a child, the department must provide to the evaluating physician all pertinent medical information known to the department concerning that child.

Section 2. Section 394.455, Florida Statutes, is reordered and amended to read:

394.455 Definitions.—As used in this part, ~~unless the context clearly requires otherwise,~~ the term:

(1) "Administrator" means the chief administrative officer of a receiving or treatment facility or his or her designee.

(2) "Advanced registered nurse practitioner" means a practitioner licensed under part I of chapter 464 who is authorized to perform the functions listed in s. 464.012(4)(c).

(3) ~~(2)~~ "Clinical psychologist" means a psychologist as defined in s. 490.003(7) with 3 years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility under this part.

(4) ~~(3)~~ "Clinical record" means all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by a facility which pertains to the patient's hospitalization or treatment.

(5) ~~(4)~~ "Clinical social worker" means a person licensed as a clinical social worker under chapter 491.

(6) ~~(5)~~ "Community facility" means any community service provider contracting with the department to furnish substance abuse or mental health services under part IV of this chapter.

(7) ~~(6)~~ "Community mental health center or clinic" means a publicly funded, not-for-profit center which contracts with the department for the provision of inpatient, outpatient, day treatment, or emergency services.

(8)~~(7)~~ "Court," unless otherwise specified, means the circuit court.

(9)~~(8)~~ "Department" means the Department of Children and Families ~~Family Services~~.

(10)~~(38)~~ "Electronic means" means a form of telecommunication that requires all parties to maintain visual as well as audio communication.

(11)~~(9)~~ "Express and informed consent" means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

(12)~~(10)~~ "Facility" means any hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness. The term ~~"Facility"~~ does not include any program or entity licensed pursuant to chapter 400 or chapter 429.

(13)~~(11)~~ "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated.

(14)~~(12)~~ "Guardian advocate" means a person appointed by a court to make decisions regarding mental health treatment on

behalf of a patient who has been found incompetent to consent to treatment pursuant to this part. The guardian advocate may be granted specific additional powers by written order of the court, as provided in this part.

(15) ~~(13)~~ "Hospital" means a facility as defined in s. 395.002 and licensed under chapter 395 and part II of chapter 408.

(16) ~~(14)~~ "Incapacitated" means that a person has been adjudicated incapacitated pursuant to part V of chapter 744 and a guardian of the person has been appointed.

(17) ~~(15)~~ "Incompetent to consent to treatment" means that a person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

(18) ~~(34)~~ "Involuntary examination" means an examination performed under s. 394.463 to determine if an individual qualifies for involuntary inpatient treatment under s. 394.467(1) or involuntary outpatient treatment under s. 394.4655(1).

(19) ~~(35)~~ "Involuntary placement" means either involuntary outpatient treatment pursuant to s. 394.4655 or involuntary inpatient treatment pursuant to s. 394.467.

(20) ~~(16)~~ "Law enforcement officer" means a law enforcement officer as defined in s. 943.10.

(21) ~~(36)~~ "Marriage and family therapist" means a person

licensed as a marriage and family therapist under chapter 491.

(22) ~~(37)~~ "Mental health counselor" means a person licensed as a mental health counselor under chapter 491.

(23) ~~(17)~~ "Mental health overlay program" means a mobile service which provides an independent examination for voluntary admissions and a range of supplemental onsite services to persons with a mental illness in a residential setting such as a nursing home, assisted living facility, adult family-care home, or nonresidential setting such as an adult day care center. Independent examinations provided pursuant to this part through a mental health overlay program must only be provided under contract with the department for this service or be attached to a public receiving facility that is also a community mental health center.

(24) ~~(18)~~ "Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

(25) ~~(19)~~ "Mobile crisis response service" means a nonresidential crisis service attached to a public receiving facility and available 24 hours a day, 7 days a week, through

which immediate intensive assessments and interventions, including screening for admission into a receiving facility, take place for the purpose of identifying appropriate treatment services.

(26)~~(20)~~ "Patient" means any person who is held or accepted for mental health treatment.

(27)~~(21)~~ "Physician" means a medical practitioner licensed under chapter 458 or chapter 459 who has experience in the diagnosis and treatment of mental and nervous disorders or a physician employed by a facility operated by the United States Department of Veterans Affairs which qualifies as a receiving or treatment facility under this part.

(28) "Physician assistant" means a physician assistant licensed under chapter 458 or chapter 459 who has experience regarding the diagnosis and treatment of mental and nervous disorders and such tasks as are within the supervising physician's scope of practice.

(29)~~(22)~~ "Private facility" means any hospital or facility operated by a for-profit or not-for-profit corporation or association that provides mental health services and is not a public facility.

(30)~~(23)~~ "Psychiatric nurse" means a registered nurse licensed under part I of chapter 464 who has a master's degree or a doctorate in psychiatric nursing and 2 years of post-master's clinical experience under the supervision of a physician.

(31)~~(24)~~ "Psychiatrist" means a medical practitioner licensed under chapter 458 or chapter 459 who has primarily diagnosed and treated mental and nervous disorders for a period of not less than 3 years, inclusive of psychiatric residency.

(32)~~(25)~~ "Public facility" means any facility that has contracted with the department to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.

(33)~~(26)~~ "Receiving facility" means any public or private facility designated by the department to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. The term does not include a county jail.

(34)~~(27)~~ "Representative" means a person selected to receive notice of proceedings during the time a patient is held in or admitted to a receiving or treatment facility.

(35)~~(28)~~(a) "Restraint" means a physical device, method, or drug used to control behavior. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual's body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one's body.

(b) A drug used as a restraint is a medication used to control the person's behavior or to restrict his or her freedom of movement and is not part of the standard treatment regimen of a person with a diagnosed mental illness who is a client of the

department. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.

(c) Restraint does not include physical devices, such as orthopedically prescribed appliances, surgical dressings and bandages, supportive body bands, or other physical holding when necessary for routine physical examinations and tests; or for purposes of orthopedic, surgical, or other similar medical treatment; when used to provide support for the achievement of functional body position or proper balance; or when used to protect a person from falling out of bed.

(36) ~~(29)~~ "Seclusion" means the physical segregation of a person in any fashion or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area. For purposes of this chapter, the term does not mean isolation due to a person's medical condition or symptoms.

(37) ~~(30)~~ "Secretary" means the Secretary of Children and Families ~~Family Services~~.

(38) ~~(33)~~ "Service provider" means any public or private receiving facility, an entity under contract with the Department of Children and Families ~~Family Services~~ to provide mental health services, a clinical psychologist, a clinical social worker, a marriage and family therapist, a mental health

counselor, a physician, a psychiatric nurse as defined in subsection (30) ~~(23)~~, or a community mental health center or clinic as defined in this part.

(39)~~(31)~~ "Transfer evaluation" means the process, as approved by the appropriate district office of the department, whereby a person who is being considered for placement in a state treatment facility is first evaluated for appropriateness of admission to the facility by a community-based public receiving facility or by a community mental health center or clinic if the public receiving facility is not a community mental health center or clinic.

(40)~~(32)~~ "Treatment facility" means any state-owned, state-operated, or state-supported hospital, center, or clinic designated by the department for extended treatment and hospitalization, beyond that provided for by a receiving facility, of persons who have a mental illness, including facilities of the United States Government, and any private facility designated by the department when rendering such services to a person pursuant to the provisions of this part. Patients treated in facilities of the United States Government shall be solely those whose care is the responsibility of the United States Department of Veterans Affairs.

Section 3. Paragraph (a) of subsection (2) of section 394.463, Florida Statutes, is amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination, giving the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on sworn testimony, written or oral. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to the nearest receiving facility for involuntary examination. The order of the court shall be made a part of the patient's clinical record. No fee shall be charged for the filing of an order under this subsection. Any receiving facility accepting the patient based on this order must send a copy of the order to the Agency for Health Care Administration on the next working day. The order shall be valid only until executed or, if not executed, for the period specified in the order itself. If no time limit is specified in the order, the order shall be valid for 7 days after the date that the order was signed.

2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to the nearest receiving facility for examination. The officer shall execute a written report detailing the circumstances under

which the person was taken into custody, and the report shall be made a part of the patient's clinical record. Any receiving facility accepting the patient based on this report must send a copy of the report to the Agency for Health Care Administration on the next working day.

3. A physician, physician assistant, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, ~~or~~ clinical social worker, or advanced registered nurse practitioner may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer shall take the person named in the certificate into custody and deliver him or her to the nearest receiving facility for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record. Any receiving facility accepting the patient based on this certificate must send a copy of the certificate to the Agency for Health Care Administration on the next working day.

Section 4. Paragraphs (a) and (c) of subsection (3) of section 394.495, Florida Statutes, are amended to read:

394.495 Child and adolescent mental health system of care; programs and services.—

(3) Assessments must be performed by:

(a) A professional as defined in s. 394.455(3), (5), (27), (30), or (31) ~~394.455(2), (4), (21), (23), or (24)~~;

(c) A person who is under the direct supervision of a professional as defined in s. 394.455(3), (5), (27), (30), or (31) ~~394.455(2), (4), (21), (23), or (24)~~ or a professional licensed under chapter 491.

The department shall adopt by rule statewide standards for mental health assessments, which must be based on current relevant professional and accreditation standards.

Section 5. Subsection (6) of section 394.496, Florida Statutes, is amended to read:

394.496 Service planning.—

(6) A professional as defined in s. 394.455(3), (5), (27), (30), or (31) ~~394.455(2), (4), (21), (23), or (24)~~ or a professional licensed under chapter 491 must be included among those persons developing the services plan.

Section 6. Subsection (6) of section 394.9085, Florida Statutes, is amended to read:

394.9085 Behavioral provider liability.—

(6) For purposes of this section, the terms "receiving facility," "addictions receiving facility," and "detoxification services," ~~"addictions receiving facility," and "receiving~~

~~facility"~~ have the same meanings as ~~those~~ provided in ss. 394.455(33), 397.311(18)(a)1., and 397.311(18)(a)4., ~~397.311(18)(a)1., and 394.455(26),~~ respectively.

Section 7. Paragraph (b) of subsection (2) of section 409.972, Florida Statutes, is amended to read:

409.972 Mandatory and voluntary enrollment.—

(2) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by s. 394.455(40) ~~394.455(32)~~.

Section 8. Subsection (7) of section 744.704, Florida Statutes, is amended to read:

744.704 Powers and duties.—

(7) A public guardian shall not commit a ward to a mental health treatment facility, as defined in s. 394.455(40) ~~394.455(32)~~, without an involuntary placement proceeding as provided by law.

Section 9. This act shall take effect July 1, 2014.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 829 (2014)

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

Committee/Subcommittee hearing bill: Select Committee on Health Care Workforce Innovation

Representative Campbell offered the following:

Amendment (with title amendment)

Remove lines 292-310 and insert:

3.a. A physician, physician assistant, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, ~~or~~ clinical social worker, or advanced registered nurse practitioner may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer shall take the person named in the certificate into custody and

deliver him or her to the nearest receiving facility for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record. Any receiving facility accepting the patient based on this certificate must send a copy of the certificate to the Agency for Health Care Administration on the next working day.

b. A physician assistant or an advanced registered nurse practitioner may not execute a certificate as provided in sub-subparagraph a. unless he or she completed at least 40 clock hours of training approved by the relevant board concerning the Florida Mental Health Act as part of his or her education and training program or has subsequently completed and passed a 40-clock-hour course approved by the relevant board concerning the Florida Mental Health Act. In addition, such a physician assistant or advanced registered nurse practitioner may not execute a certificate as provided in sub-subparagraph a. unless he or she annually completes 3 hours of approved continuing education concerning the Florida Mental Health Act.

T I T L E A M E N D M E N T

Remove line 9 and insert:

persons believed to have mental illness; providing education and continuing education requirements for such physician assistants and advanced registered nurse practitioners; amending ss.