

House \_\_\_\_\_ Amendment NO. \_\_\_\_\_

Offered By \_\_\_\_\_

1 AMEND Senate Bill No. 358, Page 2, Section 191.607, Line 16, by inserting after said section and  
2 line the following:

3  
4 "192.067. 1. The department of health and senior services, for purposes of conducting  
5 epidemiological studies to be used in promoting and safeguarding the health of the citizens of  
6 Missouri under the authority of this chapter is authorized to receive information from patient  
7 medical records. The provisions of this section shall also apply to the collection, analysis, and  
8 disclosure of nosocomial infection data from patient records collected pursuant to section 192.667  
9 and to the collection of data under section 192.990.

10 2. The department shall maintain the confidentiality of all medical record information  
11 abstracted by or reported to the department. Medical information secured pursuant to the provisions  
12 of subsection 1 of this section may be released by the department only in a statistical aggregate form  
13 that precludes and prevents the identification of patient, physician, or medical facility except that  
14 medical information may be shared with other public health authorities and coinvestigators of a  
15 health study if they abide by the same confidentiality restrictions required of the department of  
16 health and senior services and except as otherwise authorized by the provisions of sections 192.665  
17 to 192.667, or section 192.990. The department of health and senior services, public health  
18 authorities and coinvestigators shall use the information collected only for the purposes provided for  
19 in this section ~~and~~, section 192.667, or section 192.990.

20 3. No individual or organization providing information to the department in accordance with  
21 this section shall be deemed to be or be held liable, either civilly or criminally, for divulging  
22 confidential information unless such individual organization acted in bad faith or with malicious  
23 purpose.

24 4. The department of health and senior services is authorized to reimburse medical care  
25 facilities, within the limits of appropriations made for that purpose, for the costs associated with  
26 abstracting data for special studies.

27 5. Any department of health and senior services employee, public health authority or  
28 coinvestigator of a study who knowingly releases information which violates the provisions of this  
29 section shall be guilty of a class A misdemeanor and, upon conviction, shall be punished as provided  
30 by law.

31 192.990. 1. There is hereby established within the department of health and senior services  
32 the "Pregnancy-Associated Mortality Review Board" to improve data collection and reporting with  
33 respect to maternal deaths. The department may collaborate with localities and with other states to  
34 meet the goals of the initiative.

35 2. For purposes of this section, the following terms shall mean:

36 (1) "Department", the Missouri department of health and senior services;

Action Taken \_\_\_\_\_ Date \_\_\_\_\_

1       (2) "Maternal death", the death of a woman while pregnant or during the one-year period  
2 following the date of the end of pregnancy, regardless of the cause of death and regardless of  
3 whether a delivery, miscarriage, or death occurs inside or outside of a hospital.

4       3. The board shall be composed of no more than eighteen members, with a chair elected  
5 from among its membership. The board shall meet at least twice per year and shall approve the  
6 strategic priorities, funding allocations, work processes, and products of the board. Members of the  
7 board shall be appointed by the director of the department. Members shall serve four-year terms,  
8 except that the initial terms shall be staggered so that approximately one-third serve three, four, and  
9 five-year terms.

10       4. The board shall have a multidisciplinary and diverse membership that represents a variety  
11 of medical and nursing specialties, including, but not limited to, obstetrics and maternal-fetal care,  
12 as well as state or local public health officials, epidemiologists, statisticians, community  
13 organizations, geographic regions, and other individuals or organizations that are most affected by  
14 maternal deaths and lack of access to maternal health care services.

15       5. The duties of the board shall include, but not be limited to:

16       (1) Conducting ongoing comprehensive, multidisciplinary reviews of all maternal deaths;

17       (2) Identifying factors associated with maternal deaths;

18       (3) Reviewing medical records and other relevant data, which shall include, to the extent  
19 available:

20       (a) A description of the maternal deaths determined by matching each death record of a  
21 maternal death to a birth certificate of an infant or fetal death record, as applicable, and an indication  
22 of whether the delivery, miscarriage, or death occurred inside or outside of a hospital;

23       (b) Data collected from medical examiner and coroner reports, as appropriate; and

24       (c) Using other appropriate methods or information to identify maternal deaths, including  
25 deaths from pregnancy outcomes not identified under paragraph (a) of this subdivision;

26       (4) Consulting with relevant experts, as needed;

27       (5) Analyzing cases to produce recommendations for reducing maternal mortality;

28       (6) Disseminating recommendations to policy makers, health care providers and facilities,  
29 and the general public;

30       (7) Recommending and promoting preventative strategies and making recommendations for  
31 systems changes;

32       (8) Protecting the confidentiality of the hospitals and individuals involved in any maternal  
33 deaths;

34       (9) Examining racial and social disparities in maternal deaths;

35       (10) Subject to appropriation, providing for voluntary and confidential case reporting of  
36 maternal deaths to the appropriate state health agency by family members of the deceased, and other  
37 appropriate individuals, for purposes of review by the board;

38       (11) Making publicly available the contact information of the board for use in such  
39 reporting;

40       (12) Conducting outreach to local professional organizations, community organizations, and  
41 social services agencies regarding the availability of the review board; and

42       (13) Ensuring that data collected under this section is made available, as appropriate and  
43 practicable, for research purposes, in a manner that protects individually identifiable or potentially  
44 identifiable information and that is consistent with state and federal privacy laws.

45       6. The board may contract with other entities consistent with the duties of the board.

46       7. (1) Before June 30, 2020, and annually thereafter, the board shall submit to the Director  
47 of the Centers for Disease Control and Prevention, the director of the department, the governor, and  
48 the general assembly a report on maternal mortality in the state based on data collected through  
49 ongoing comprehensive, multidisciplinary reviews of all maternal deaths, and any other projects or

1 efforts funded by the board. The data shall be collected using best practices to reliably determine  
2 and include all maternal deaths, regardless of the outcome of the pregnancy and shall include data,  
3 findings, and recommendations of the committee, and, as applicable, information on the  
4 implementation during such year of any recommendations submitted by the board in a previous  
5 year.

6 (2) The report shall be made available to the public on the department's website and the  
7 director shall disseminate the report to all health care providers and facilities that provide women's  
8 health services in the state.

9 8. The director of the department, or his or her designee, shall provide the board with the  
10 copy of the death certificate and any linked birth or fetal death certificate for any maternal death  
11 occurring within the state.

12 9. Upon request by the department, health care providers, health care facilities, clinics,  
13 laboratories, medical examiners, coroners, law enforcement agencies, driver's license bureaus, other  
14 state agencies, and facilities licensed by the department shall provide to the department data related  
15 to maternal deaths from sources such as medical records, autopsy reports, medical examiner's  
16 reports, coroner's reports, law enforcement reports, motor vehicle records, social services records,  
17 and other sources as appropriate. Such data requests shall be limited to maternal deaths which have  
18 occurred within the previous twenty-four months. No entity shall be held liable for civil damages or  
19 be subject to any criminal or disciplinary action when complying in good faith with a request from  
20 the department for information under the provisions of this subsection.

21 10. (1) The board shall protect the privacy and confidentiality of all patients, decedents,  
22 providers, hospitals, or any other participants involved in any maternal deaths. In no case shall any  
23 individually identifiable health information be provided to the public or submitted to an information  
24 clearinghouse.

25 (2) Nothing in this subsection shall prohibit the board or department from publishing  
26 statistical compilations and research reports that:

27 (a) Are based on confidential information relating to mortality reviews under this section;  
28 and

29 (b) Do not contain identifying information or any other information that could be used to  
30 ultimately identify the individuals concerned.

31 (3) Information, records, reports, statements, notes, memoranda, or other data collected  
32 under this section shall not be admissible as evidence in any action of any kind in any court or  
33 before any other tribunal, board, agency, or person. Such information, records, reports, notes,  
34 memoranda, data obtained by the department or any other person, statements, notes, memoranda, or  
35 other data shall not be exhibited nor their contents disclosed in any way, in whole or in part, by any  
36 officer or representative of the department or any other person. No person participating in such  
37 review shall disclose, in any manner, the information so obtained except in strict conformity with  
38 such review project. Such information shall not be subject to disclosure under chapter 610.

39 (4) All information, records of interviews, written reports, statements, notes, memoranda, or  
40 other data obtained by the department, the board, and other persons, agencies, or organizations so  
41 authorized by the department under this section shall be confidential.

42 (5) All proceedings and activities of the board, opinions of members of such board formed  
43 as a result of such proceedings and activities, and records obtained, created, or maintained under this  
44 section, including records of interviews, written reports, statements, notes, memoranda, or other data  
45 obtained by the department or any other person, agency, or organization acting jointly or under  
46 contract with the department in connection with the requirements of this section, shall be  
47 confidential and shall not be subject to subpoena, discovery, or introduction into evidence in any  
48 civil or criminal proceeding; provided, however, that nothing in this section shall be construed to  
49 limit or restrict the right to discover or use in any civil or criminal proceeding anything that is

1 available from another source and entirely independent of the board's proceedings.

2 (6) Members of the board shall not be questioned in any civil or criminal proceeding  
 3 regarding the information presented in or opinions formed as a result of a meeting or  
 4 communication of the board; provided, however, that nothing in this section shall be construed to  
 5 prevent a member of the board from testifying to information obtained independently of the board or  
 6 which is public information.

7 11. The department may use grant program funds to support the efforts of the board and may  
 8 apply for additional federal government and private foundation grants as needed. The department  
 9 may also accept private, foundation, city, county, or federal moneys to implement the provisions of  
 10 this section.

11 193.015. As used in sections 193.005 to 193.325, unless the context clearly indicates  
 12 otherwise, the following terms shall mean:

13 (1) "Advanced practice registered nurse", a person licensed to practice as an advanced  
 14 practice registered nurse under chapter 335, and who has been delegated tasks outlined in section  
 15 193.145 by a physician with whom they have entered into a collaborative practice arrangement  
 16 under chapter 334;

17 (2) "Assistant physician", as such term is defined in section 334.036, and who has been  
 18 delegated tasks outlined in section 193.145 by a physician with whom they have entered into a  
 19 collaborative practice arrangement under chapter 334;

20 (3) "Dead body", a human body or such parts of such human body from the condition of  
 21 which it reasonably may be concluded that death recently occurred;

22 (4) "Department", the department of health and senior services;

23 (5) "Final disposition", the burial, interment, cremation, removal from the state, or other  
 24 authorized disposition of a dead body or fetus;

25 (6) "Institution", any establishment, public or private, which provides inpatient or outpatient  
 26 medical, surgical, or diagnostic care or treatment or nursing, custodian, or domiciliary care, or to  
 27 which persons are committed by law;

28 (7) "Live birth", the complete expulsion or extraction from its mother of a child, irrespective  
 29 of the duration of pregnancy, which after such expulsion or extraction, breathes or shows any other  
 30 evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement  
 31 of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached;

32 (8) "Physician", a person authorized or licensed to practice medicine or osteopathy pursuant  
 33 to chapter 334;

34 (9) "Physician assistant", a person licensed to practice as a physician assistant pursuant to  
 35 chapter 334, and who has been delegated tasks outlined in section 193.145 by a physician with  
 36 whom they have entered into a ~~[supervision agreement]~~ collaborative practice arrangement under  
 37 chapter 334;

38 (10) "Spontaneous fetal death", a noninduced death prior to the complete expulsion or  
 39 extraction from its mother of a fetus, irrespective of the duration of pregnancy; the death is indicated  
 40 by the fact that after such expulsion or extraction the fetus does not breathe or show any other  
 41 evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement  
 42 of voluntary muscles;

43 (11) "State registrar", state registrar of vital statistics of the state of Missouri;

44 (12) "System of vital statistics", the registration, collection, preservation, amendment and  
 45 certification of vital records; the collection of other reports required by sections 193.005 to 193.325  
 46 and section 194.060; and activities related thereto including the tabulation, analysis and publication  
 47 of vital statistics;

48 (13) "Vital records", certificates or reports of birth, death, marriage, dissolution of marriage  
 49 and data related thereto;

(14) "Vital statistics", the data derived from certificates and reports of birth, death, spontaneous fetal death, marriage, dissolution of marriage and related reports.

198.082. 1. Each certified nursing assistant hired to work in a skilled nursing or intermediate care facility after January 1, 1980, shall have successfully completed a nursing assistant training program approved by the department or shall enroll in and begin the first available approved training program which is scheduled to commence within ninety days of the date of the certified nursing assistant's employment and which shall be completed within four months of employment. Training programs shall be offered at any facility licensed ~~[or approved]~~ by the department of health and senior services; any skilled nursing or intermediate care unit in a Missouri veterans home, as defined in section 42.002; or any hospital, as defined in section 197.020. Training programs shall be ~~[which is most]~~ reasonably accessible to the enrollees in each class. The program may be established by ~~[the]~~ a skilled nursing or intermediate care facility, unit, or hospital; by a professional organization~~;~~<sub>2</sub> or by the department, and training shall be given by the personnel of the facility, unit, or hospital; by a professional organization~~;~~<sub>2</sub> by the department~~;~~<sub>2</sub> by any community college<sub>2</sub> or by the vocational education department of any high school.

2. As used in this section the term "certified nursing assistant" means an employee~~;~~<sub>2</sub> who has completed the training required under subsection 1 of this section, who has passed the certification exam, and ~~[including a nurse's aide or an orderly,]~~ who is assigned by a skilled nursing or intermediate care facility, unit, or hospital to provide or assist in the provision of direct resident health care services under the supervision of a nurse licensed under the nursing practice law, chapter 335.

3. This section shall not apply to any person otherwise regulated or licensed to perform health care services under the laws of this state. It shall not apply to volunteers or to members of religious or fraternal orders which operate and administer the facility, if such volunteers or members work without compensation.

~~[3.]~~ 4. The training program ~~[after January 1, 1989, shall consist of at least the following:~~  
~~—— (1) A training program consisting]~~ requirements shall be defined in regulation by the department and shall require ~~[of]~~ at least seventy-five classroom hours of training ~~[on basic nursing skills, clinical practice, resident safety and rights, the social and psychological problems of residents, and the methods of handling and caring for mentally confused residents such as those with Alzheimer's disease and related disorders,]~~ and one hundred hours supervised and on-the-job training. On-the-job training sites shall include supervised practical training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse. The [one hundred hours] training shall be completed within four months of employment and may consist of normal employment as nurse assistants or hospital nursing support staff under the supervision of a licensed nurse; and

~~—— (2) Continuing in-service training to assure continuing competency in existing and new nursing skills. All nursing assistants trained prior to January 1, 1989, shall attend, by August 31, 1989, an entire special retraining program established by rule or regulation of the department which shall contain information on methods of handling mentally confused residents and which may be offered on premises by the employing facility].~~

~~[4.]~~ 5. Certified nursing assistants who have not successfully completed the nursing assistant training program prior to employment may begin duties as a certified nursing assistant ~~[only after completing an initial twelve hours of basic orientation approved by the department]~~ and may provide direct resident care only if under the ~~[general]~~ direct supervision of a licensed nurse prior to completion of the seventy-five classroom hours of the training program.

6. The competency evaluation shall be performed in a facility, as defined in 42 CFR Sec. 483.5, or laboratory setting comparable to the setting in which the individual shall function as a

1 certified nursing assistant.

2 7. Persons completing the training requirements of unlicensed assistive personnel under 19  
3 CSR 30-20.125 or its successor regulation, and who have completed the competency evaluation,  
4 shall be allowed to sit for the certified nursing assistant examination and be deemed to have fulfilled  
5 the classroom and clinical standards for designation as a certified nursing assistant.

6 8. The department of health and senior services may offer additional training programs and  
7 certifications to students who are already certified as nursing assistants according to regulations  
8 promulgated by the department and curriculum approved by the board.

9 334.037. 1. A physician may enter into collaborative practice arrangements with assistant  
10 physicians. Collaborative practice arrangements shall be in the form of written agreements, jointly  
11 agreed-upon protocols, or standing orders for the delivery of health care services. Collaborative  
12 practice arrangements, which shall be in writing, may delegate to an assistant physician the  
13 authority to administer or dispense drugs and provide treatment as long as the delivery of such  
14 health care services is within the scope of practice of the assistant physician and is consistent with  
15 that assistant physician's skill, training, and competence and the skill and training of the  
16 collaborating physician.

17 2. The written collaborative practice arrangement shall contain at least the following  
18 provisions:

19 (1) Complete names, home and business addresses, zip codes, and telephone numbers of the  
20 collaborating physician and the assistant physician;

21 (2) A list of all other offices or locations besides those listed in subdivision (1) of this  
22 subsection where the collaborating physician authorized the assistant physician to prescribe;

23 (3) A requirement that there shall be posted at every office where the assistant physician is  
24 authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure  
25 statement informing patients that they may be seen by an assistant physician and have the right to  
26 see the collaborating physician;

27 (4) All specialty or board certifications of the collaborating physician and all certifications  
28 of the assistant physician;

29 (5) The manner of collaboration between the collaborating physician and the assistant  
30 physician, including how the collaborating physician and the assistant physician shall:

31 (a) Engage in collaborative practice consistent with each professional's skill, training,  
32 education, and competence;

33 (b) Maintain geographic proximity; except, the collaborative practice arrangement may  
34 allow for geographic proximity to be waived for a maximum of twenty-eight days per calendar year  
35 for rural health clinics as defined by Pub. L. 95-210 (42 U.S.C. Section 1395x), as amended, as long  
36 as the collaborative practice arrangement includes alternative plans as required in paragraph (c) of  
37 this subdivision. Such exception to geographic proximity shall apply only to independent rural  
38 health clinics, provider-based rural health clinics if the provider is a critical access hospital as  
39 provided in 42 U.S.C. Section 1395i-4, and provider-based rural health clinics if the main location  
40 of the hospital sponsor is greater than fifty miles from the clinic. The collaborating physician shall  
41 maintain documentation related to such requirement and present it to the state board of registration  
42 for the healing arts when requested; and

43 (c) Provide coverage during absence, incapacity, infirmity, or emergency by the  
44 collaborating physician;

45 (6) A description of the assistant physician's controlled substance prescriptive authority in  
46 collaboration with the physician, including a list of the controlled substances the physician  
47 authorizes the assistant physician to prescribe and documentation that it is consistent with each  
48 professional's education, knowledge, skill, and competence;

49 (7) A list of all other written practice agreements of the collaborating physician and the

1 assistant physician;

2 (8) The duration of the written practice agreement between the collaborating physician and  
3 the assistant physician;

4 (9) A description of the time and manner of the collaborating physician's review of the  
5 assistant physician's delivery of health care services. The description shall include provisions that  
6 the assistant physician shall submit a minimum of ten percent of the charts documenting the  
7 assistant physician's delivery of health care services to the collaborating physician for review by the  
8 collaborating physician, or any other physician designated in the collaborative practice arrangement,  
9 every fourteen days; and

10 (10) The collaborating physician, or any other physician designated in the collaborative  
11 practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in  
12 which the assistant physician prescribes controlled substances. The charts reviewed under this  
13 subdivision may be counted in the number of charts required to be reviewed under subdivision (9) of  
14 this subsection.

15 3. The state board of registration for the healing arts under section 334.125 shall promulgate  
16 rules regulating the use of collaborative practice arrangements for assistant physicians. Such rules  
17 shall specify:

18 (1) Geographic areas to be covered;

19 (2) The methods of treatment that may be covered by collaborative practice arrangements;

20 (3) In conjunction with deans of medical schools and primary care residency program  
21 directors in the state, the development and implementation of educational methods and programs  
22 undertaken during the collaborative practice service which shall facilitate the advancement of the  
23 assistant physician's medical knowledge and capabilities, and which may lead to credit toward a  
24 future residency program for programs that deem such documented educational achievements  
25 acceptable; and

26 (4) The requirements for review of services provided under collaborative practice  
27 arrangements, including delegating authority to prescribe controlled substances.

28  
29 Any rules relating to dispensing or distribution of medications or devices by prescription or  
30 prescription drug orders under this section shall be subject to the approval of the state board of  
31 pharmacy. Any rules relating to dispensing or distribution of controlled substances by prescription  
32 or prescription drug orders under this section shall be subject to the approval of the department of  
33 health and senior services and the state board of pharmacy. The state board of registration for the  
34 healing arts shall promulgate rules applicable to assistant physicians that shall be consistent with  
35 guidelines for federally funded clinics. The rulemaking authority granted in this subsection shall not  
36 extend to collaborative practice arrangements of hospital employees providing inpatient care within  
37 hospitals as defined in chapter 197 or population-based public health services as defined by 20 CSR  
38 2150- 5.100 as of April 30, 2008.

39 4. The state board of registration for the healing arts shall not deny, revoke, suspend, or  
40 otherwise take disciplinary action against a collaborating physician for health care services  
41 delegated to an assistant physician provided the provisions of this section and the rules promulgated  
42 thereunder are satisfied.

43 5. Within thirty days of any change and on each renewal, the state board of registration for  
44 the healing arts shall require every physician to identify whether the physician is engaged in any  
45 collaborative practice arrangement, including collaborative practice arrangements delegating the  
46 authority to prescribe controlled substances, and also report to the board the name of each assistant  
47 physician with whom the physician has entered into such arrangement. The board may make such  
48 information available to the public. The board shall track the reported information and may  
49 routinely conduct random reviews of such arrangements to ensure that arrangements are carried out

1 for compliance under this chapter.

2 6. A collaborating physician ~~[or supervising physician]~~ shall not enter into a collaborative  
3 practice arrangement ~~[or supervision agreement]~~ with more than six full-time equivalent assistant  
4 physicians, full-time equivalent physician assistants, or full-time equivalent advance practice  
5 registered nurses, or any combination thereof. Such limitation shall not apply to collaborative  
6 arrangements of hospital employees providing inpatient care service in hospitals as defined in  
7 chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April  
8 30, 2008, or to a certified registered nurse anesthetist providing anesthesia services under the  
9 supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately  
10 available if needed as set out in subsection 7 of section 334.104.

11 7. The collaborating physician shall determine and document the completion of at least a  
12 one-month period of time during which the assistant physician shall practice with the collaborating  
13 physician continuously present before practicing in a setting where the collaborating physician is not  
14 continuously present. No rule or regulation shall require the collaborating physician to review more  
15 than ten percent of the assistant physician's patient charts or records during such one-month period.  
16 Such limitation shall not apply to collaborative arrangements of providers of population-based  
17 public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

18 8. No agreement made under this section shall supersede current hospital licensing  
19 regulations governing hospital medication orders under protocols or standing orders for the purpose  
20 of delivering inpatient or emergency care within a hospital as defined in section 197.020 if such  
21 protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical  
22 therapeutics committee.

23 9. No contract or other agreement shall require a physician to act as a collaborating  
24 physician for an assistant physician against the physician's will. A physician shall have the right to  
25 refuse to act as a collaborating physician, without penalty, for a particular assistant physician. No  
26 contract or other agreement shall limit the collaborating physician's ultimate authority over any  
27 protocols or standing orders or in the delegation of the physician's authority to any assistant  
28 physician, but such requirement shall not authorize a physician in implementing such protocols,  
29 standing orders, or delegation to violate applicable standards for safe medical practice established  
30 by a hospital's medical staff.

31 10. No contract or other agreement shall require any assistant physician to serve as a  
32 collaborating assistant physician for any collaborating physician against the assistant physician's  
33 will. An assistant physician shall have the right to refuse to collaborate, without penalty, with a  
34 particular physician.

35 11. All collaborating physicians and assistant physicians in collaborative practice  
36 arrangements shall wear identification badges while acting within the scope of their collaborative  
37 practice arrangement. The identification badges shall prominently display the licensure status of  
38 such collaborating physicians and assistant physicians.

39 12. (1) An assistant physician with a certificate of controlled substance prescriptive  
40 authority as provided in this section may prescribe any controlled substance listed in Schedule III,  
41 IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the  
42 authority to prescribe controlled substances in a collaborative practice arrangement. Prescriptions  
43 for Schedule II medications prescribed by an assistant physician who has a certificate of controlled  
44 substance prescriptive authority are restricted to only those medications containing hydrocodone.  
45 Such authority shall be filed with the state board of registration for the healing arts. The  
46 collaborating physician shall maintain the right to limit a specific scheduled drug or scheduled drug  
47 category that the assistant physician is permitted to prescribe. Any limitations shall be listed in the  
48 collaborative practice arrangement. Assistant physicians shall not prescribe controlled substances  
49 for themselves or members of their families. Schedule III controlled substances and Schedule II -



1 hydrocodone prescriptions shall be limited to a five-day supply without refill, except that  
2 buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving  
3 medication-assisted treatment for substance use disorders under the direction of the collaborating  
4 physician. Assistant physicians who are authorized to prescribe controlled substances under this  
5 section shall register with the federal Drug Enforcement Administration and the state bureau of  
6 narcotics and dangerous drugs, and shall include the Drug Enforcement Administration registration  
7 number on prescriptions for controlled substances.

8 (2) The collaborating physician shall be responsible to determine and document the  
9 completion of at least one hundred twenty hours in a four-month period by the assistant physician  
10 during which the assistant physician shall practice with the collaborating physician on-site prior to  
11 prescribing controlled substances when the collaborating physician is not on-site. Such limitation  
12 shall not apply to assistant physicians of population-based public health services as defined in 20  
13 CSR 2150-5.100 as of April 30, 2009, or assistant physicians providing opioid addiction treatment.

14 (3) An assistant physician shall receive a certificate of controlled substance prescriptive  
15 authority from the state board of registration for the healing arts upon verification of licensure under  
16 section 334.036.

17 13. Nothing in this section or section 334.036 shall be construed to limit the authority of  
18 hospitals or hospital medical staff to make employment or medical staff credentialing or privileging  
19 decisions.

20 334.104. 1. A physician may enter into collaborative practice arrangements with registered  
21 professional nurses. Collaborative practice arrangements shall be in the form of written agreements,  
22 jointly agreed-upon protocols, or standing orders for the delivery of health care services.  
23 Collaborative practice arrangements, which shall be in writing, may delegate to a registered  
24 professional nurse the authority to administer or dispense drugs and provide treatment as long as the  
25 delivery of such health care services is within the scope of practice of the registered professional  
26 nurse and is consistent with that nurse's skill, training and competence.

27 2. Collaborative practice arrangements, which shall be in writing, may delegate to a  
28 registered professional nurse the authority to administer, dispense or prescribe drugs and provide  
29 treatment if the registered professional nurse is an advanced practice registered nurse as defined in  
30 subdivision (2) of section 335.016. Collaborative practice arrangements may delegate to an  
31 advanced practice registered nurse, as defined in section 335.016, the authority to administer,  
32 dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017,  
33 and Schedule II - hydrocodone; except that, the collaborative practice arrangement shall not  
34 delegate the authority to administer any controlled substances listed in Schedules III, IV, and V of  
35 section 195.017, or Schedule II - hydrocodone for the purpose of inducing sedation or general  
36 anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III narcotic controlled  
37 substance and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-  
38 hour supply without refill. Such collaborative practice arrangements shall be in the form of written  
39 agreements, jointly agreed-upon protocols or standing orders for the delivery of health care services.  
40 An advanced practice registered nurse may prescribe buprenorphine for up to a thirty-day supply  
41 without refill for patients receiving medication-assisted treatment for substance use disorders under  
42 the direction of the collaborating physician.

43 3. The written collaborative practice arrangement shall contain at least the following  
44 provisions:

45 (1) Complete names, home and business addresses, zip codes, and telephone numbers of the  
46 collaborating physician and the advanced practice registered nurse;

47 (2) A list of all other offices or locations besides those listed in subdivision (1) of this  
48 subsection where the collaborating physician authorized the advanced practice registered nurse to  
49 prescribe;

1 (3) A requirement that there shall be posted at every office where the advanced practice  
2 registered nurse is authorized to prescribe, in collaboration with a physician, a prominently  
3 displayed disclosure statement informing patients that they may be seen by an advanced practice  
4 registered nurse and have the right to see the collaborating physician;

5 (4) All specialty or board certifications of the collaborating physician and all certifications  
6 of the advanced practice registered nurse;

7 (5) The manner of collaboration between the collaborating physician and the advanced  
8 practice registered nurse, including how the collaborating physician and the advanced practice  
9 registered nurse will:

10 (a) Engage in collaborative practice consistent with each professional's skill, training,  
11 education, and competence;

12 (b) Maintain geographic proximity, except the collaborative practice arrangement may allow  
13 for geographic proximity to be waived for a maximum of twenty-eight days per calendar year for  
14 rural health clinics as defined by P.L. 95-210, as long as the collaborative practice arrangement  
15 includes alternative plans as required in paragraph (c) of this subdivision. This exception to  
16 geographic proximity shall apply only to independent rural health clinics, provider-based rural  
17 health clinics where the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-  
18 4, and provider-based rural health clinics where the main location of the hospital sponsor is greater  
19 than fifty miles from the clinic. The collaborating physician is required to maintain documentation  
20 related to this requirement and to present it to the state board of registration for the healing arts  
21 when requested; and

22 (c) Provide coverage during absence, incapacity, infirmity, or emergency by the  
23 collaborating physician;

24 (6) A description of the advanced practice registered nurse's controlled substance  
25 prescriptive authority in collaboration with the physician, including a list of the controlled  
26 substances the physician authorizes the nurse to prescribe and documentation that it is consistent  
27 with each professional's education, knowledge, skill, and competence;

28 (7) A list of all other written practice agreements of the collaborating physician and the  
29 advanced practice registered nurse;

30 (8) The duration of the written practice agreement between the collaborating physician and  
31 the advanced practice registered nurse;

32 (9) A description of the time and manner of the collaborating physician's review of the  
33 advanced practice registered nurse's delivery of health care services. The description shall include  
34 provisions that the advanced practice registered nurse shall submit a minimum of ten percent of the  
35 charts documenting the advanced practice registered nurse's delivery of health care services to the  
36 collaborating physician for review by the collaborating physician, or any other physician designated  
37 in the collaborative practice arrangement, every fourteen days; and

38 (10) The collaborating physician, or any other physician designated in the collaborative  
39 practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in  
40 which the advanced practice registered nurse prescribes controlled substances. The charts reviewed  
41 under this subdivision may be counted in the number of charts required to be reviewed under  
42 subdivision (9) of this subsection.

43 4. The state board of registration for the healing arts pursuant to section 334.125 and the  
44 board of nursing pursuant to section 335.036 may jointly promulgate rules regulating the use of  
45 collaborative practice arrangements. Such rules shall be limited to specifying geographic areas to be  
46 covered, the methods of treatment that may be covered by collaborative practice arrangements and  
47 the requirements for review of services provided pursuant to collaborative practice arrangements  
48 including delegating authority to prescribe controlled substances. Any rules relating to dispensing  
49 or distribution of medications or devices by prescription or prescription drug orders under this

1 section shall be subject to the approval of the state board of pharmacy. Any rules relating to  
2 dispensing or distribution of controlled substances by prescription or prescription drug orders under  
3 this section shall be subject to the approval of the department of health and senior services and the  
4 state board of pharmacy. In order to take effect, such rules shall be approved by a majority vote of a  
5 quorum of each board. Neither the state board of registration for the healing arts nor the board of  
6 nursing may separately promulgate rules relating to collaborative practice arrangements. Such  
7 jointly promulgated rules shall be consistent with guidelines for federally funded clinics. The  
8 rulemaking authority granted in this subsection shall not extend to collaborative practice  
9 arrangements of hospital employees providing inpatient care within hospitals as defined pursuant to  
10 chapter 197 or population-based public health services as defined by 20 CSR 2150-5.100 as of April  
11 30, 2008.

12 5. The state board of registration for the healing arts shall not deny, revoke, suspend or  
13 otherwise take disciplinary action against a physician for health care services delegated to a  
14 registered professional nurse provided the provisions of this section and the rules promulgated  
15 thereunder are satisfied. Upon the written request of a physician subject to a disciplinary action  
16 imposed as a result of an agreement between a physician and a registered professional nurse or  
17 registered physician assistant, whether written or not, prior to August 28, 1993, all records of such  
18 disciplinary licensure action and all records pertaining to the filing, investigation or review of an  
19 alleged violation of this chapter incurred as a result of such an agreement shall be removed from the  
20 records of the state board of registration for the healing arts and the division of professional  
21 registration and shall not be disclosed to any public or private entity seeking such information from  
22 the board or the division. The state board of registration for the healing arts shall take action to  
23 correct reports of alleged violations and disciplinary actions as described in this section which have  
24 been submitted to the National Practitioner Data Bank. In subsequent applications or  
25 representations relating to his medical practice, a physician completing forms or documents shall  
26 not be required to report any actions of the state board of registration for the healing arts for which  
27 the records are subject to removal under this section.

28 6. Within thirty days of any change and on each renewal, the state board of registration for  
29 the healing arts shall require every physician to identify whether the physician is engaged in any  
30 collaborative practice agreement, including collaborative practice agreements delegating the  
31 authority to prescribe controlled substances, or physician assistant agreement and also report to the  
32 board the name of each licensed professional with whom the physician has entered into such  
33 agreement. The board may make this information available to the public. The board shall track the  
34 reported information and may routinely conduct random reviews of such agreements to ensure that  
35 agreements are carried out for compliance under this chapter.

36 7. Notwithstanding any law to the contrary, a certified registered nurse anesthetist as defined  
37 in subdivision (8) of section 335.016 shall be permitted to provide anesthesia services without a  
38 collaborative practice arrangement provided that he or she is under the supervision of an  
39 anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed.  
40 Nothing in this subsection shall be construed to prohibit or prevent a certified registered nurse  
41 anesthetist as defined in subdivision (8) of section 335.016 from entering into a collaborative  
42 practice arrangement under this section, except that the collaborative practice arrangement may not  
43 delegate the authority to prescribe any controlled substances listed in Schedules III, IV, and V of  
44 section 195.017, or Schedule II - hydrocodone.

45 8. A collaborating physician ~~[or supervising physician]~~ shall not enter into a collaborative  
46 practice arrangement ~~[or supervision agreement]~~ with more than six full-time equivalent advanced  
47 practice registered nurses, full-time equivalent licensed physician assistants, or full-time equivalent  
48 assistant physicians, or any combination thereof. This limitation shall not apply to collaborative  
49 arrangements of hospital employees providing inpatient care service in hospitals as defined in

chapter 197 or population-based public health services as defined by 20 CSR 2150- 5.100 as of April 30, 2008, or to a certified registered nurse anesthetist providing anesthesia services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed as set out in subsection 7 of this section.

9. It is the responsibility of the collaborating physician to determine and document the completion of at least a one-month period of time during which the advanced practice registered nurse shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. This limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

10. No agreement made under this section shall supersede current hospital licensing regulations governing hospital medication orders under protocols or standing orders for the purpose of delivering inpatient or emergency care within a hospital as defined in section 197.020 if such protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

11. No contract or other agreement shall require a physician to act as a collaborating physician for an advanced practice registered nurse against the physician's will. A physician shall have the right to refuse to act as a collaborating physician, without penalty, for a particular advanced practice registered nurse. No contract or other agreement shall limit the collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any advanced practice registered nurse, but this requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by hospital's medical staff.

12. No contract or other agreement shall require any advanced practice registered nurse to serve as a collaborating advanced practice registered nurse for any collaborating physician against the advanced practice registered nurse's will. An advanced practice registered nurse shall have the right to refuse to collaborate, without penalty, with a particular physician.

334.108. 1. Prior to prescribing any drug, controlled substance, or other treatment through telemedicine, as defined in section 191.1145, or the internet, a physician shall establish a valid physician-patient relationship as described in section 191.1146. This relationship shall include:

- (1) Obtaining a reliable medical history and performing a physical examination of the patient, adequate to establish the diagnosis for which the drug is being prescribed and to identify underlying conditions or contraindications to the treatment recommended or provided;
- (2) Having sufficient dialogue with the patient regarding treatment options and the risks and benefits of treatment or treatments;
- (3) If appropriate, following up with the patient to assess the therapeutic outcome;
- (4) Maintaining a contemporaneous medical record that is readily available to the patient and, subject to the patient's consent, to the patient's other health care professionals; and
- (5) Maintaining the electronic prescription information as part of the patient's medical record.

2. The requirements of subsection 1 of this section may be satisfied by the prescribing physician's designee when treatment is provided in:

- (1) A hospital as defined in section 197.020;
- (2) A hospice program as defined in section 197.250;
- (3) Home health services provided by a home health agency as defined in section 197.400;
- (4) Accordance with a collaborative practice agreement as defined in section 334.104;
- (5) Conjunction with a physician assistant licensed pursuant to section 334.738;
- (6) Conjunction with an assistant physician licensed under section 334.036;
- (7) Consultation with another physician who has an ongoing physician-patient relationship

with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications; or

(8) On-call or cross-coverage situations.

3. No health care provider, as defined in section 376.1350, shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an evaluation over the telephone; except that, a physician~~[-]~~ or such physician's on-call designee, or an advanced practice registered nurse, a physician assistant, or an assistant physician in a collaborative practice arrangement with such physician, ~~[a physician assistant in a supervision agreement with such physician, or an assistant physician in a supervision agreement with such physician]~~ may prescribe any drug, controlled substance, or other treatment that is within his or her scope of practice to a patient based solely on a telephone evaluation if a previously established and ongoing physician-patient relationship exists between such physician and the patient being treated.

4. No health care provider shall prescribe any drug, controlled substance, or other treatment to a patient based solely on an internet request or an internet questionnaire.

334.735. 1. As used in sections 334.735 to 334.749, the following terms mean:

(1) "Applicant", any individual who seeks to become licensed as a physician assistant;

(2) "Certification" or "registration", a process by a certifying entity that grants recognition to applicants meeting predetermined qualifications specified by such certifying entity;

(3) "Certifying entity", the nongovernmental agency or association which certifies or registers individuals who have completed academic and training requirements;

(4) "Collaborative practice arrangement", written agreements, jointly agreed upon protocols, or standing orders, all of which shall be in writing, for the delivery of health care services;

(5) "Department", the department of insurance, financial institutions and professional registration or a designated agency thereof;

~~[(5)]~~ (6) "License", a document issued to an applicant by the board acknowledging that the applicant is entitled to practice as a physician assistant;

~~[(6)]~~ (7) "Physician assistant", a person who has graduated from a physician assistant program accredited by the ~~[American Medical Association's Committee on Allied Health Education and Accreditation or by its successor agency]~~ Accreditation Review Commission on Education for the Physician Assistant or its successor agency, prior to 2001, or the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs, who has passed the certifying examination administered by the National Commission on Certification of Physician Assistants and has active certification by the National Commission on Certification of Physician Assistants who provides health care services delegated by a licensed physician. A person who has been employed as a physician assistant for three years prior to August 28, 1989, who has passed the National Commission on Certification of Physician Assistants examination, and has active certification of the National Commission on Certification of Physician Assistants;

~~[(7)]~~ (8) "Recognition", the formal process of becoming a certifying entity as required by the provisions of sections 334.735 to 334.749;

~~[(8)]~~ "Supervision", control exercised over a physician assistant working with a supervising physician and oversight of the activities of and accepting responsibility for the physician assistant's delivery of care. ~~The physician assistant shall only practice at a location where the physician routinely provides patient care, except existing patients of the supervising physician in the patient's home and correctional facilities. The supervising physician must be immediately available in person or via telecommunication during the time the physician assistant is providing patient care. Prior to commencing practice, the supervising physician and physician assistant shall attest on a form provided by the board that the physician shall provide supervision appropriate to the physician assistant's training and that the physician assistant shall not practice beyond the physician assistant's~~

training and experience. ~~Appropriate supervision shall require the supervising physician to be working within the same facility as the physician assistant for at least four hours within one calendar day for every fourteen days on which the physician assistant provides patient care as described in subsection 3 of this section. Only days in which the physician assistant provides patient care as described in subsection 3 of this section shall be counted toward the fourteen-day period. The requirement of appropriate supervision shall be applied so that no more than thirteen calendar days in which a physician assistant provides patient care shall pass between the physician's four hours working within the same facility. The board shall promulgate rules pursuant to chapter 536 for documentation of joint review of the physician assistant activity by the supervising physician and the physician assistant.~~

~~2. (1) A supervision agreement shall limit the physician assistant to practice only at locations described in subdivision (8) of subsection 1 of this section, within a geographic proximity to be determined by the board of registration for the healing arts.~~

~~(2) For a physician-physician assistant team working in a certified community behavioral health clinic as defined by P.L. 113-93 and a rural health clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as amended, or a federally qualified health center as defined in 42 U.S.C. Section 1395 of the Public Health Service Act, as amended, no supervision requirements in addition to the minimum federal law shall be required.~~

~~3.] 2.~~ The scope of practice of a physician assistant shall consist only of the following services and procedures:

- (1) Taking patient histories;
- (2) Performing physical examinations of a patient;
- (3) Performing or assisting in the performance of routine office laboratory and patient screening procedures;
- (4) Performing routine therapeutic procedures;
- (5) Recording diagnostic impressions and evaluating situations calling for attention of a physician to institute treatment procedures;
- (6) Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by a ~~[licensed]~~ collaborating physician;
- (7) Assisting the supervising physician in institutional settings, including reviewing of treatment plans, ordering of tests and diagnostic laboratory and radiological services, and ordering of therapies, using procedures reviewed and approved by a licensed physician;
- (8) Assisting in surgery; and
- (9) Performing such other tasks not prohibited by law under the ~~[supervision of]~~ collaborative practice arrangement with a licensed physician as the physician[s] assistant has been trained and is proficient to perform~~[-and~~

~~(10)].~~

3. Physician assistants shall not perform or prescribe abortions.

4. Physician assistants shall not prescribe any drug, medicine, device or therapy unless pursuant to a ~~[physician supervision agreement]~~ collaborative practice arrangement in accordance with the law, nor prescribe lenses, prisms or contact lenses for the aid, relief or correction of vision or the measurement of visual power or visual efficiency of the human eye, nor administer or monitor general or regional block anesthesia during diagnostic tests, surgery or obstetric procedures. Prescribing of drugs, medications, devices or therapies by a physician assistant shall be pursuant to a ~~[physician assistant supervision agreement]~~ collaborative practice arrangement which is specific to the clinical conditions treated by the supervising physician and the physician assistant shall be subject to the following:

- (1) A physician assistant shall only prescribe controlled substances in accordance with section 334.747;

(2) The types of drugs, medications, devices or therapies prescribed by a physician assistant shall be consistent with the scopes of practice of the physician assistant and the ~~[supervising]~~ collaborating physician;

(3) All prescriptions shall conform with state and federal laws and regulations and shall include the name, address and telephone number of the physician assistant and the supervising physician;

(4) A physician assistant, or advanced practice registered nurse as defined in section 335.016 may request, receive and sign for noncontrolled professional samples and may distribute professional samples to patients; and

(5) A physician assistant shall not prescribe any drugs, medicines, devices or therapies the ~~[supervising]~~ collaborating physician is not qualified or authorized to prescribe.

5. A physician assistant shall clearly identify himself or herself as a physician assistant and shall not use or permit to be used in the physician assistant's behalf the terms "doctor", "Dr." or "doc" nor hold himself or herself out in any way to be a physician or surgeon. No physician assistant shall practice or attempt to practice without physician ~~[supervision]~~ collaboration or in any location where the ~~[supervising]~~ collaborating physician is not immediately available for consultation, assistance and intervention, except as otherwise provided in this section, and in an emergency situation, nor shall any physician assistant bill a patient independently or directly for any services or procedure by the physician assistant; except that, nothing in this subsection shall be construed to prohibit a physician assistant from enrolling with a third party plan or the department of social services as a MO HealthNet or Medicaid provider while acting under a ~~[supervision agreement]~~ collaborative practice arrangement between the physician and physician assistant.

6. ~~[For purposes of this section, the]~~ The licensing of physician assistants shall take place within processes established by the state board of registration for the healing arts through rule and regulation. The board of healing arts is authorized to establish rules pursuant to chapter 536 establishing licensing and renewal procedures, ~~[supervision, supervision agreements]~~ collaboration, collaborative practice arrangements, fees, and addressing such other matters as are necessary to protect the public and discipline the profession. An application for licensing may be denied or the license of a physician assistant may be suspended or revoked by the board in the same manner and for violation of the standards as set forth by section 334.100, or such other standards of conduct set by the board by rule or regulation. Persons licensed pursuant to the provisions of chapter 335 shall not be required to be licensed as physician assistants. All applicants for physician assistant licensure who complete a physician assistant training program after January 1, 2008, shall have a master's degree from a physician assistant program.

7. ~~["Physician assistant supervision agreement" means a written agreement, jointly agreed-upon protocols or standing order between a supervising physician and a physician assistant, which provides for the delegation of health care services from a supervising physician to a physician assistant and the review of such services. The agreement shall contain at least the following provisions:~~

—— (1) Complete names, home and business addresses, zip codes, telephone numbers, and state license numbers of the supervising physician and the physician assistant;

—— (2) A list of all offices or locations where the physician routinely provides patient care, and in which of such offices or locations the supervising physician has authorized the physician assistant to practice;

—— (3) All specialty or board certifications of the supervising physician;

—— (4) The manner of supervision between the supervising physician and the physician assistant, including how the supervising physician and the physician assistant shall:

—— (a) Attest on a form provided by the board that the physician shall provide supervision appropriate to the physician assistant's training and experience and that the physician assistant shall

not practice beyond the scope of the physician assistant's training and experience nor the supervising physician's capabilities and training; and

—— (b) Provide coverage during absence, incapacity, infirmity, or emergency by the supervising physician;

—— (5) The duration of the supervision agreement between the supervising physician and physician assistant; and

—— (6) A description of the time and manner of the supervising physician's review of the physician assistant's delivery of health care services. Such description shall include provisions that the supervising physician, or a designated supervising physician listed in the supervision agreement review a minimum of ten percent of the charts of the physician assistant's delivery of health care services every fourteen days.

—— 8. When a physician assistant supervision agreement is utilized to provide health care services for conditions other than acute self-limited or well-defined problems, the supervising physician or other physician designated in the supervision agreement shall see the patient for evaluation and approve or formulate the plan of treatment for new or significantly changed conditions as soon as practical, but in no case more than two weeks after the patient has been seen by the physician assistant.

—— 9.] At all times the physician is responsible for the oversight of the activities of, and accepts responsibility for, health care services rendered by the physician assistant.

[10. It is the responsibility of the supervising physician to determine and document the completion of at least a one-month period of time during which the licensed physician assistant shall practice with a supervising physician continuously present before practicing in a setting where a supervising physician is not continuously present.

—— 11.] 8. A physician may enter into collaborative practice arrangements with physician assistants. Collaborative practice arrangements, which shall be in writing, may delegate to a physician assistant the authority to prescribe, administer, or dispense drugs and provide treatment which is within the skill, training, and competence of the physician assistant. Collaborative practice arrangements may delegate to a physician assistant, as defined in section 334.735, the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V of section 195.017, and Schedule II - hydrocodone. Schedule III narcotic controlled substances and Schedule II - hydrocodone prescriptions shall be limited to a one hundred twenty-hour supply without refill. Such collaborative practice arrangements shall be in the form of a written arrangement, jointly agreed-upon protocols, or standing orders for the delivery of health care services.

9. The written collaborative practice arrangement shall contain at least the following provisions:

(1) Complete names, home and business addresses, zip codes, and telephone numbers of the collaborating physician and the physician assistant;

(2) A list of all other offices or locations, other than those listed in subdivision (1) of this subsection, where the collaborating physician has authorized the physician assistant to prescribe;

(3) A requirement that there shall be posted at every office where the physician assistant is authorized to prescribe, in collaboration with a physician, a prominently displayed disclosure statement informing patients that they may be seen by a physician assistant and have the right to see the collaborating physician;

(4) All specialty or board certifications of the collaborating physician and all certifications of the physician assistant;

(5) The manner of collaboration between the collaborating physician and the physician assistant, including how the collaborating physician and the physician assistant will:

(a) Engage in collaborative practice consistent with each professional's skill, training, education, and competence;



(b) Maintain geographic proximity, as determined by the board of registration for the healing arts; and

(c) Provide coverage during absence, incapacity, infirmity, or emergency of the collaborating physician;

(6) A list of all other written collaborative practice arrangements of the collaborating physician and the physician assistant;

(7) The duration of the written practice arrangement between the collaborating physician and the physician assistant;

(8) A description of the time and manner of the collaborating physician's review of the physician assistant's delivery of health care services. The description shall include provisions that the physician assistant shall submit a minimum of ten percent of the charts documenting the physician assistant's delivery of health care services to the collaborating physician for review by the collaborating physician, or any other physician designated in the collaborative practice arrangement, every fourteen days. Reviews may be conducted electronically;

(9) The collaborating physician, or any other physician designated in the collaborative practice arrangement, shall review every fourteen days a minimum of twenty percent of the charts in which the physician assistant prescribes controlled substances. The charts reviewed under this subdivision may be counted in the number of charts required to be reviewed under subdivision (8) of this subsection; and

(10) A statement that no collaboration requirements in addition to the federal law shall be required for a physician-physician assistant team working in a certified community behavioral health clinic as defined by Pub.L. 113-93, or a rural health clinic under the federal Rural Health Services Act, Pub.L. 95-210, as amended, or a federally qualified health center as defined in 42 U.S.C. Section 1395 of the Public Health Service Act, as amended.

10. The state board of registration for the healing arts under section 334.125 may promulgate rules regulating the use of collaborative practice arrangements.

11. The state board of registration for the healing arts shall not deny, revoke, suspend, or otherwise take disciplinary action against a collaborating physician for health care services delegated to a physician assistant, provided that the provisions of this section and the rules promulgated thereunder are satisfied.

12. Within thirty days of any change and on each renewal, the state board of registration for the healing arts shall require every physician to identify whether the physician is engaged in any collaborative practice arrangement, including collaborative practice arrangements delegating the authority to prescribe controlled substances, and also report to the board the name of each physician assistant with whom the physician has entered into such arrangement. The board may make such information available to the public. The board shall track the reported information and may routinely conduct random reviews of such arrangements to ensure that the arrangements are carried out in compliance with this chapter.

13. The collaborating physician shall determine and document the completion of a period of time during which the physician assistant shall practice with the collaborating physician continuously present before practicing in a setting where the collaborating physician is not continuously present. This limitation shall not apply to collaborative arrangements of providers of population-based public health services as defined by 20 CSR 2150-5.100 as of April 30, 2009.

14. No contract or other ~~[agreement]~~ arrangement shall require a physician to act as a ~~[supervising]~~ collaborating physician for a physician assistant against the physician's will. A physician shall have the right to refuse to act as a supervising physician, without penalty, for a particular physician assistant. No contract or other agreement shall limit the ~~[supervising]~~ collaborating physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any physician assistant~~], but this requirement shall not~~

1 authorize a physician in implementing such protocols, standing orders, or delegation to violate  
 2 applicable standards for safe medical practice established by the hospital's medical staff]. No  
 3 contract or other arrangement shall require any physician assistant to collaborate with any physician  
 4 against the physician assistant's will. A physician assistant shall have the right to refuse to  
 5 collaborate, without penalty, with a particular physician.

6 [12.] 15. Physician assistants shall file with the board a copy of their [supervising]  
 7 collaborating physician form.

8 [13.] 16. No physician shall be designated to serve as [supervising physician or] a  
 9 collaborating physician for more than six full-time equivalent licensed physician assistants, full-time  
 10 equivalent advanced practice registered nurses, or full-time equivalent assistant physicians, or any  
 11 combination thereof. This limitation shall not apply to physician assistant [agreements]  
 12 collaborative practice arrangements of hospital employees providing inpatient care service in  
 13 hospitals as defined in chapter 197, or to a certified registered nurse anesthetist providing anesthesia  
 14 services under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is  
 15 immediately available if needed as set out in subsection 7 of section 334.104.

16 17. No arrangement made under this section shall supercede current hospital licensing  
 17 regulations governing hospital medication orders under protocols or standing orders for the purpose  
 18 of delivering inpatient or emergency care within a hospital, as defined in section 197.020, if such  
 19 protocols or standing orders have been approved by the hospital's medical staff and pharmaceutical  
 20 therapeutics committee.

21 334.736. Notwithstanding any other provision of sections 334.735 to 334.749, the board  
 22 may issue without examination a temporary license to practice as a physician assistant. Upon the  
 23 applicant paying a temporary license fee and the submission of all necessary documents as  
 24 determined by the board, the board may grant a temporary license to any person who meets the  
 25 qualifications provided in [section] sections 334.735 to 334.749 which shall be valid until the results  
 26 of the next examination are announced. The temporary license may be renewed at the discretion of  
 27 the board and upon payment of the temporary license fee.

28 334.747. 1. A physician assistant with a certificate of controlled substance prescriptive  
 29 authority as provided in this section may prescribe any controlled substance listed in Schedule III,  
 30 IV, or V of section 195.017, and may have restricted authority in Schedule II, when delegated the  
 31 authority to prescribe controlled substances in a [supervision agreement] collaborative practice  
 32 arrangement. Such authority shall be listed on the [supervision verification] collaborating physician  
 33 form on file with the state board of healing arts. The [supervising] collaborating physician shall  
 34 maintain the right to limit a specific scheduled drug or scheduled drug category that the physician  
 35 assistant is permitted to prescribe. Any limitations shall be listed on the [supervision] collaborating  
 36 physician form. Prescriptions for Schedule II medications prescribed by a physician assistant with  
 37 authority to prescribe delegated in a [supervision agreement] collaborative practice arrangement are  
 38 restricted to only those medications containing hydrocodone. Physician assistants shall not  
 39 prescribe controlled substances for themselves or members of their families. Schedule III controlled  
 40 substances and Schedule II - hydrocodone prescriptions shall be limited to a five-day supply without  
 41 refill, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for  
 42 patients receiving medication-assisted treatment for substance use disorders under the direction of  
 43 the [supervising] collaborating physician. Physician assistants who are authorized to prescribe  
 44 controlled substances under this section shall register with the federal Drug Enforcement  
 45 Administration and the state bureau of narcotics and dangerous drugs, and shall include the Drug  
 46 Enforcement Administration registration number on prescriptions for controlled substances.

47 2. The [supervising] collaborating physician shall be responsible to determine and document  
 48 the completion of at least one hundred twenty hours in a four-month period by the physician  
 49 assistant during which the physician assistant shall practice with the [supervising] collaborating

1 physician on-site prior to prescribing controlled substances when the [supervising] collaborating  
2 physician is not on-site. Such limitation shall not apply to physician assistants of population-based  
3 public health services as defined in 20 CSR 2150-5.100 as of April 30, 2009.

4 3. A physician assistant shall receive a certificate of controlled substance prescriptive  
5 authority from the board of healing arts upon verification of the completion of the following  
6 educational requirements:

7 (1) Successful completion of an advanced pharmacology course that includes clinical  
8 training in the prescription of drugs, medicines, and therapeutic devices. A course or courses with  
9 advanced pharmacological content in a physician assistant program accredited by the Accreditation  
10 Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency  
11 shall satisfy such requirement;

12 (2) Completion of a minimum of three hundred clock hours of clinical training by the  
13 [supervising] collaborating physician in the prescription of drugs, medicines, and therapeutic  
14 devices;

15 (3) Completion of a minimum of one year of supervised clinical practice or supervised  
16 clinical rotations. One year of clinical rotations in a program accredited by the Accreditation  
17 Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency,  
18 which includes pharmacotherapeutics as a component of its clinical training, shall satisfy such  
19 requirement. Proof of such training shall serve to document experience in the prescribing of drugs,  
20 medicines, and therapeutic devices;

21 (4) A physician assistant previously licensed in a jurisdiction where physician assistants are  
22 authorized to prescribe controlled substances may obtain a state bureau of narcotics and dangerous  
23 drugs registration if a [supervising] collaborating physician can attest that the physician assistant has  
24 met the requirements of subdivisions (1) to (3) of this subsection and provides documentation of  
25 existing federal Drug Enforcement Agency registration.

26 334.749. 1. There is hereby established an "Advisory Commission for Physician Assistants"  
27 which shall guide, advise and make recommendations to the board. The commission shall also be  
28 responsible for the ongoing examination of the scope of practice and promoting the continuing role  
29 of physician assistants in the delivery of health care services. The commission shall assist the board  
30 in carrying out the provisions of sections 334.735 to 334.749.

31 2. The commission shall be appointed no later than October 1, 1996, and shall consist of  
32 five members, one member of the board, two licensed physician assistants, one physician and one  
33 lay member. The two licensed physician assistant members, the physician member and the lay  
34 member shall be appointed by the director of the division of professional registration. Each licensed  
35 physician assistant member shall be a citizen of the United States and a resident of this state, and  
36 shall be licensed as a physician assistant by this state. The physician member shall be a United  
37 States citizen, a resident of this state, have an active Missouri license to practice medicine in this  
38 state and shall be a [supervising] collaborating physician, at the time of appointment, to a licensed  
39 physician assistant. The lay member shall be a United States citizen and a resident of this state. The  
40 licensed physician assistant members shall be appointed to serve three-year terms, except that the  
41 first commission appointed shall consist of one member whose term shall be for one year and one  
42 member whose term shall be for two years. The physician member and lay member shall each be  
43 appointed to serve a three-year term. No physician assistant member nor the physician member  
44 shall be appointed for more than two consecutive three-year terms. The president of the Missouri  
45 Academy of Physicians Assistants in office at the time shall, at least ninety days prior to the  
46 expiration of a term of a physician assistant member of a commission member or as soon as feasible  
47 after such a vacancy on the commission otherwise occurs, submit to the director of the division of  
48 professional registration a list of five physician assistants qualified and willing to fill the vacancy in  
49 question, with the request and recommendation that the director appoint one of the five persons so

1 listed, and with the list so submitted, the president of the Missouri Academy of Physicians  
 2 Assistants shall include in his or her letter of transmittal a description of the method by which the  
 3 names were chosen by that association.

4 3. Notwithstanding any other provision of law to the contrary, any appointed member of the  
 5 commission shall receive as compensation an amount established by the director of the division of  
 6 professional registration not to exceed seventy dollars per day for commission business plus actual  
 7 and necessary expenses. The director of the division of professional registration shall establish by  
 8 rule guidelines for payment. All staff for the commission shall be provided by the state board of  
 9 registration for the healing arts.

10 4. The commission shall hold an open annual meeting at which time it shall elect from its  
 11 membership a chairman and secretary. The commission may hold such additional meetings as may  
 12 be required in the performance of its duties, provided that notice of every meeting shall be given to  
 13 each member at least ten days prior to the date of the meeting. A quorum of the commission shall  
 14 consist of a majority of its members.

15 5. On August 28, 1998, all members of the advisory commission for registered physician  
 16 assistants shall become members of the advisory commission for physician assistants and their  
 17 successor shall be appointed in the same manner and at the time their terms would have expired as  
 18 members of the advisory commission for registered physician assistants.

19 334.1135. 1. There is hereby established a joint task force to be known as the "Joint Task  
 20 Force on Radiologic Technologist Licensure".

21 2. The task force shall be composed of the following:

22 (1) Two members of the senate, one of whom shall be appointed by the president pro  
 23 tempore and one by the minority leader of the senate;

24 (2) Two members of the house of representatives, one of whom shall be appointed by the  
 25 speaker and one by the minority leader of the house of representatives;

26 (3) A clinic administrator, or his or her designee, appointed by the Missouri Association of  
 27 Rural Health Clinics;

28 (4) A physician appointed by the Missouri State Medical Association;

29 (5) A pain management physician appointed by the Missouri Society of Anesthesiologists;

30 (6) A radiologic technologist appointed by the Missouri Society of Radiologic  
 31 Technologists;

32 (7) A nuclear medicine technologist appointed by the Missouri Valley Chapter of the  
 33 Society of Nuclear Medicine and Molecular Imaging;

34 (8) An administrator of an ambulatory surgical center appointed by the Missouri  
 35 Ambulatory Surgical Center Association;

36 (9) A physician appointed by the Missouri Academy of Family Physicians;

37 (10) A certified registered nurse anesthetist appointed by the Missouri Association of Nurse  
 38 Anesthetists;

39 (11) A physician appointed by the Missouri Radiological Society;

40 (12) The director of the Missouri state board of registration for the healing arts, or his or her  
 41 designee; and

42 (13) The director of the Missouri state board of nursing, or his or her designee.

43 3. The joint task force shall review the current status of licensure of radiologic technologists  
 44 in Missouri and shall develop a plan to address the most appropriate method to protect public safety  
 45 when radiologic imaging and radiologic procedures are utilized. The plan shall include:

46 (1) An analysis of the risks associated if radiologic technologists are not licensed;

47 (2) The creation of a Radiologic Imaging and Radiation Therapy Advisory Commission;

48 (3) Procedures to address the specific needs of rural health care and the availability of  
 49 licensed radiologic technologists;

1       (4) Requirements for licensure of radiographer, radiation therapist, nuclear medicine  
 2 technologist, nuclear medicine advanced associate, radiologist assistant, limited x-ray machine  
 3 operators;

4       (5) Reasonable exemptions to licensure;

5       (6) Continuing education and training;

6       (7) Penalty provisions; and

7       (8) Other items that the task force deems relevant for the proper determination of licensure  
 8 of radiologic technologists in Missouri.

9       4. The task force shall meet within thirty days of its creation and select a chair and vice  
 10 chair. A majority of the task force shall constitute a quorum, but the concurrence of a majority of  
 11 total members shall be required for the determination of any matter within the joint task force's  
 12 duties.

13       5. The task force shall be staffed by legislative personnel of as is deemed necessary to assist  
 14 the task force in the performance of its duties.

15       6. The members of the task force shall serve without compensation, but may, subject to  
 16 appropriation, be entitled to reimbursement for actual and necessary expenses incurred in the  
 17 performance of their official duties.

18       7. The task force shall submit a full report of its activities, including the plan developed  
 19 under subsection 3 of this section, to the general assembly on or before January 15, 2020. The task  
 20 force shall send copies of the report to the director of the division of professional registration.

21       335.175. 1. No later than January 1, 2014, there is hereby established within the state board  
 22 of registration for the healing arts and the state board of nursing the "Utilization of Telehealth by  
 23 Nurses". An advanced practice registered nurse (APRN) providing nursing services under a  
 24 collaborative practice arrangement under section 334.104 may provide such services outside the  
 25 geographic proximity requirements of section 334.104 if the collaborating physician and advanced  
 26 practice registered nurse utilize telehealth in the care of the patient and if the services are provided  
 27 in a rural area of need. Telehealth providers shall be required to obtain patient consent before  
 28 telehealth services are initiated and ensure confidentiality of medical information.

29       2. As used in this section, "telehealth" shall have the same meaning as such term is defined  
 30 in section 191.1145.

31       3. (1) The boards shall jointly promulgate rules governing the practice of telehealth under  
 32 this section. Such rules shall address, but not be limited to, appropriate standards for the use of  
 33 telehealth.

34       (2) Any rule or portion of a rule, as that term is defined in section 536.010, that is created  
 35 under the authority delegated in this section shall become effective only if it complies with and is  
 36 subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and  
 37 chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to  
 38 chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently  
 39 held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after  
 40 August 28, 2013, shall be invalid and void.

41       4. For purposes of this section, "rural area of need" means any rural area of this state which  
 42 is located in a health professional shortage area as defined in section 354.650.

43       ~~[5. Under section 23.253 of the Missouri sunset act:~~

44       ~~—— (1) The provisions of the new program authorized under this section shall automatically~~  
 45 ~~sunset six years after August 28, 2013, unless reauthorized by an act of the general assembly; and~~

46       ~~—— (2) If such program is reauthorized, the program authorized under this section shall~~  
 47 ~~automatically sunset twelve years after the effective date of the reauthorization of this section; and~~

48       ~~—— (3) This section shall terminate on September first of the calendar year immediately~~  
 49 ~~following the calendar year in which the program authorized under this section is sunset.]~~

338.010. 1. The "practice of pharmacy" means the interpretation, implementation, and evaluation of medical prescription orders, including any legend drugs under 21 U.S.C. Section 353; receipt, transmission, or handling of such orders or facilitating the dispensing of such orders; the designing, initiating, implementing, and monitoring of a medication therapeutic plan as defined by the prescription order so long as the prescription order is specific to each patient for care by a pharmacist; the compounding, dispensing, labeling, and administration of drugs and devices pursuant to medical prescription orders and administration of viral influenza, pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, and meningitis vaccines by written protocol authorized by a physician for persons at least seven years of age or the age recommended by the Centers for Disease Control and Prevention, whichever is higher, or the administration of pneumonia, shingles, hepatitis A, hepatitis B, diphtheria, tetanus, pertussis, meningitis, and viral influenza vaccines by written protocol authorized by a physician for a specific patient as authorized by rule; the participation in drug selection according to state law and participation in drug utilization reviews; the proper and safe storage of drugs and devices and the maintenance of proper records thereof; consultation with patients and other health care practitioners, and veterinarians and their clients about legend drugs, about the safe and effective use of drugs and devices; and the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management and control of a pharmacy. No person shall engage in the practice of pharmacy unless he or she is licensed under the provisions of this chapter. This chapter shall not be construed to prohibit the use of auxiliary personnel under the direct supervision of a pharmacist from assisting the pharmacist in any of his or her duties. This assistance in no way is intended to relieve the pharmacist from his or her responsibilities for compliance with this chapter and he or she will be responsible for the actions of the auxiliary personnel acting in his or her assistance. This chapter shall also not be construed to prohibit or interfere with any legally registered practitioner of medicine, dentistry, or podiatry, or veterinary medicine only for use in animals, or the practice of optometry in accordance with and as provided in sections 195.070 and 336.220 in the compounding, administering, prescribing, or dispensing of his or her own prescriptions.

2. Any pharmacist who accepts a prescription order for a medication therapeutic plan shall have a written protocol from the physician who refers the patient for medication therapy services. The written protocol and the prescription order for a medication therapeutic plan shall come from the physician only, and shall not come from a nurse engaged in a collaborative practice arrangement under section 334.104, or from a physician assistant engaged in a ~~[supervision agreement]~~ collaborative practice arrangement under section 334.735.

3. Nothing in this section shall be construed as to prevent any person, firm or corporation from owning a pharmacy regulated by sections 338.210 to 338.315, provided that a licensed pharmacist is in charge of such pharmacy.

4. Nothing in this section shall be construed to apply to or interfere with the sale of nonprescription drugs and the ordinary household remedies and such drugs or medicines as are normally sold by those engaged in the sale of general merchandise.

5. No health carrier as defined in chapter 376 shall require any physician with which they contract to enter into a written protocol with a pharmacist for medication therapeutic services.

6. This section shall not be construed to allow a pharmacist to diagnose or independently prescribe pharmaceuticals.

7. The state board of registration for the healing arts, under section 334.125, and the state board of pharmacy, under section 338.140, shall jointly promulgate rules regulating the use of protocols for prescription orders for medication therapy services and administration of viral influenza vaccines. Such rules shall require protocols to include provisions allowing for timely communication between the pharmacist and the referring physician, and any other patient protection provisions deemed appropriate by both boards. In order to take effect, such rules shall be approved

1 by a majority vote of a quorum of each board. Neither board shall separately promulgate rules  
2 regulating the use of protocols for prescription orders for medication therapy services and  
3 administration of viral influenza vaccines. Any rule or portion of a rule, as that term is defined in  
4 section 536.010, that is created under the authority delegated in this section shall become effective  
5 only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable,  
6 section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested  
7 with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to  
8 disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking  
9 authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

10 8. The state board of pharmacy may grant a certificate of medication therapeutic plan  
11 authority to a licensed pharmacist who submits proof of successful completion of a board-approved  
12 course of academic clinical study beyond a bachelor of science in pharmacy, including but not  
13 limited to clinical assessment skills, from a nationally accredited college or university, or a  
14 certification of equivalence issued by a nationally recognized professional organization and  
15 approved by the board of pharmacy.

16 9. Any pharmacist who has received a certificate of medication therapeutic plan authority  
17 may engage in the designing, initiating, implementing, and monitoring of a medication therapeutic  
18 plan as defined by a prescription order from a physician that is specific to each patient for care by a  
19 pharmacist.

20 10. Nothing in this section shall be construed to allow a pharmacist to make a therapeutic  
21 substitution of a pharmaceutical prescribed by a physician unless authorized by the written protocol  
22 or the physician's prescription order.

23 11. "Veterinarian", "doctor of veterinary medicine", "practitioner of veterinary medicine",  
24 "DVM", "VMD", "BVSe", "BVMS", "BSe (Vet Science)", "VMB", "MRCVS", or an equivalent  
25 title means a person who has received a doctor's degree in veterinary medicine from an accredited  
26 school of veterinary medicine or holds an Educational Commission for Foreign Veterinary  
27 Graduates (EDFVG) certificate issued by the American Veterinary Medical Association (AVMA).

28 12. In addition to other requirements established by the joint promulgation of rules by the  
29 board of pharmacy and the state board of registration for the healing arts:

30 (1) A pharmacist shall administer vaccines by protocol in accordance with treatment  
31 guidelines established by the Centers for Disease Control and Prevention (CDC);

32 (2) A pharmacist who is administering a vaccine shall request a patient to remain in the  
33 pharmacy a safe amount of time after administering the vaccine to observe any adverse reactions.  
34 Such pharmacist shall have adopted emergency treatment protocols;

35 (3) In addition to other requirements by the board, a pharmacist shall receive additional  
36 training as required by the board and evidenced by receiving a certificate from the board upon  
37 completion, and shall display the certification in his or her pharmacy where vaccines are delivered.

38 13. A pharmacist shall inform the patient that the administration of the vaccine will be  
39 entered into the ShowMeVax system, as administered by the department of health and senior  
40 services. The patient shall attest to the inclusion of such information in the system by signing a  
41 form provided by the pharmacist. If the patient indicates that he or she does not want such  
42 information entered into the ShowMeVax system, the pharmacist shall provide a written report  
43 within fourteen days of administration of a vaccine to the patient's primary health care provider, if  
44 provided by the patient, containing:

45 (1) The identity of the patient;

46 (2) The identity of the vaccine or vaccines administered;

47 (3) The route of administration;

48 (4) The anatomic site of the administration;

49 (5) The dose administered; and

(6) The date of administration.

630.175. 1. No person admitted on a voluntary or involuntary basis to any mental health facility or mental health program in which people are civilly detained pursuant to chapter 632 and no patient, resident or client of a residential facility or day program operated, funded or licensed by the department shall be subject to physical or chemical restraint, isolation or seclusion unless it is determined by the head of the facility, the attending licensed physician, or in the circumstances specifically set forth in this section, by an advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a ~~[supervision agreement]~~ collaborative practice arrangement, with the attending licensed physician that the chosen intervention is imminently necessary to protect the health and safety of the patient, resident, client or others and that it provides the least restrictive environment. An advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a ~~[supervision agreement]~~ collaborative practice arrangement, with the attending licensed physician may make a determination that the chosen intervention is necessary for patients, residents, or clients of facilities or programs operated by the department, in hospitals as defined in section 197.020 that only provide psychiatric care and in dedicated psychiatric units of general acute care hospitals as hospitals are defined in section 197.020. Any determination made by the advanced practice registered nurse, physician assistant, or assistant physician shall be documented as required in subsection 2 of this section and reviewed in person by the attending licensed physician if the episode of restraint is to extend beyond:

- (1) Four hours duration in the case of a person under eighteen years of age;
- (2) Eight hours duration in the case of a person eighteen years of age or older; or
- (3) For any total length of restraint lasting more than four hours duration in a twenty-four-hour period in the case of a person under eighteen years of age or beyond eight hours duration in the case of a person eighteen years of age or older in a twenty-four-hour period.

The review shall occur prior to the time limit specified under subsection 6 of this section and shall be documented by the licensed physician under subsection 2 of this section.

2. Every use of physical or chemical restraint, isolation or seclusion and the reasons therefor shall be made a part of the clinical record of the patient, resident or client under the signature of the head of the facility, or the attending licensed physician, or the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a ~~[supervision agreement]~~ collaborative practice arrangement, with the attending licensed physician.

3. Physical or chemical restraint, isolation or seclusion shall not be considered standard treatment or habilitation and shall cease as soon as the circumstances causing the need for such action have ended.

4. The use of security escort devices, including devices designed to restrict physical movement, which are used to maintain safety and security and to prevent escape during transport outside of a facility shall not be considered physical restraint within the meaning of this section. Individuals who have been civilly detained under sections 632.300 to 632.475 may be placed in security escort devices when transported outside of the facility if it is determined by the head of the facility, or the attending licensed physician, or the advanced practice registered nurse in a collaborative practice arrangement, or a physician assistant or an assistant physician with a ~~[supervision agreement]~~ collaborative practice arrangement, with the attending licensed physician that the use of security escort devices is necessary to protect the health and safety of the patient, resident, client, or other persons or is necessary to prevent escape. Individuals who have been civilly detained under sections 632.480 to 632.513 or committed under chapter 552 shall be placed in security escort devices when transported outside of the facility unless it is determined by the head of the facility, or the attending licensed physician, or the advanced practice registered nurse in a



1 collaborative practice arrangement, or a physician assistant or an assistant physician with a  
 2 ~~[supervision agreement]~~ collaborative practice arrangement, with the attending licensed physician  
 3 that security escort devices are not necessary to protect the health and safety of the patient, resident,  
 4 client, or other persons or is not necessary to prevent escape.

5 5. Extraordinary measures employed by the head of the facility to ensure the safety and  
 6 security of patients, residents, clients, and other persons during times of natural or man-made  
 7 disasters shall not be considered restraint, isolation, or seclusion within the meaning of this section.

8 6. Orders issued under this section by the advanced practice registered nurse in a  
 9 collaborative practice arrangement, or a physician assistant or an assistant physician with a  
 10 ~~[supervision agreement]~~ collaborative practice arrangement, with the attending licensed physician  
 11 shall be reviewed in person by the attending licensed physician of the facility within twenty-four  
 12 hours or the next regular working day of the order being issued, and such review shall be  
 13 documented in the clinical record of the patient, resident, or client.

14 7. For purposes of this subsection, "division" shall mean the division of developmental  
 15 disabilities. Restraint or seclusion shall not be used in habilitation centers or community programs  
 16 that serve persons with developmental disabilities that are operated or funded by the division unless  
 17 such procedure is part of an emergency intervention system approved by the division and is  
 18 identified in such person's individual support plan. Direct-care staff that serve persons with  
 19 developmental disabilities in habilitation centers or community programs operated or funded by the  
 20 division shall be trained in an emergency intervention system approved by the division when such  
 21 emergency intervention system is identified in a consumer's individual support plan.

22 630.875. 1. This section shall be known and may be cited as the "Improved Access to  
 23 Treatment for Opioid Addictions Act" or "IATOA Act".

24 2. As used in this section, the following terms mean:

25 (1) "Department", the department of mental health;

26 (2) "IATOA program", the improved access to treatment for opioid addictions program  
 27 created under subsection 3 of this section.

28 3. Subject to appropriations, the department shall create and oversee an "Improved Access  
 29 to Treatment for Opioid Addictions Program", which is hereby created and whose purpose is to  
 30 disseminate information and best practices regarding opioid addiction and to facilitate collaborations  
 31 to better treat and prevent opioid addiction in this state. The IATOA program shall facilitate  
 32 partnerships between assistant physicians, physician assistants, and advanced practice registered  
 33 nurses practicing in federally qualified health centers, rural health clinics, and other health care  
 34 facilities and physicians practicing at remote facilities located in this state. The IATOA program  
 35 shall provide resources that grant patients and their treating assistant physicians, physician  
 36 assistants, advanced practice registered nurses, or physicians access to knowledge and expertise  
 37 through means such as telemedicine and Extension for Community Healthcare Outcomes (ECHO)  
 38 programs established under section 191.1140.

39 4. Assistant physicians, physician assistants, and advanced practice registered nurses who  
 40 participate in the IATOA program shall complete the necessary requirements to prescribe  
 41 buprenorphine within at least thirty days of joining the IATOA program.

42 5. For the purposes of the IATOA program, a remote collaborating ~~[or supervising]~~  
 43 physician working with an on-site assistant physician, physician assistant, or advanced practice  
 44 registered nurse shall be considered to be on-site. An assistant physician, physician assistant, or  
 45 advanced practice registered nurse collaborating with a remote physician shall comply with all laws  
 46 and requirements applicable to assistant physicians, physician assistants, or advanced practice  
 47 registered nurses with on-site supervision before providing treatment to a patient.

48 6. An assistant physician, physician assistant, or advanced practice registered nurse  
 49 collaborating with a physician who is waiver-certified for the use of buprenorphine may participate

1 in the IATOA program in any area of the state and provide all services and functions of an assistant  
2 physician, physician assistant, or advanced practice registered nurse.

3 7. The department may develop curriculum and benchmark examinations on the subject of  
4 opioid addiction and treatment. The department may collaborate with specialists, institutions of  
5 higher education, and medical schools for such development. Completion of such a curriculum and  
6 passing of such an examination by an assistant physician, physician assistant, advanced practice  
7 registered nurse, or physician shall result in a certificate awarded by the department or sponsoring  
8 institution, if any.

9 8. An assistant physician, physician assistant, or advanced practice registered nurse  
10 participating in the IATOA program may also:

- 11 (1) Engage in community education;
- 12 (2) Engage in professional education outreach programs with local treatment providers;
- 13 (3) Serve as a liaison to courts;
- 14 (4) Serve as a liaison to addiction support organizations;
- 15 (5) Provide educational outreach to schools;
- 16 (6) Treat physical ailments of patients in an addiction treatment program or considering  
17 entering such a program;
- 18 (7) Refer patients to treatment centers;
- 19 (8) Assist patients with court and social service obligations;
- 20 (9) Perform other functions as authorized by the department; and
- 21 (10) Provide mental health services in collaboration with a qualified licensed physician.

22  
23 The list of authorizations in this subsection is a nonexclusive list, and assistant physicians, physician  
24 assistants, or advanced practice registered nurses participating in the IATOA program may perform  
25 other actions.

26 9. When an overdose survivor arrives in the emergency department, the assistant physician,  
27 physician assistant, or advanced practice registered nurse serving as a recovery coach or, if the  
28 assistant physician, physician assistant, or advanced practice registered nurse is unavailable, another  
29 properly trained recovery coach shall, when reasonably practicable, meet with the overdose survivor  
30 and provide treatment options and support available to the overdose survivor. The department shall  
31 assist recovery coaches in providing treatment options and support to overdose survivors.

32 10. The provisions of this section shall supersede any contradictory statutes, rules, or  
33 regulations. The department shall implement the improved access to treatment for opioid addictions  
34 program as soon as reasonably possible using guidance within this section. Further refinement to  
35 the improved access to treatment for opioid addictions program may be done through the rules  
36 process.

37 11. The department shall promulgate rules to implement the provisions of the improved  
38 access to treatment for opioid addictions act as soon as reasonably possible. Any rule or portion of a  
39 rule, as that term is defined in section 536.010, that is created under the authority delegated in this  
40 section shall become effective only if it complies with and is subject to all of the provisions of  
41 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and  
42 if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the  
43 effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the  
44 grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be  
45 invalid and void."; and

46  
47 Further amend said bill by amending the title, enacting clause, and intersectional references  
48 accordingly.