SECOND REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED**]**

CONFERENCE COMMITTEE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 718

99TH GENERAL ASSEMBLY

2018

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4209S.11T

AN ACT

To repeal sections 191.227, 192.947, 195.070, 210.070, 334.036, 334.037, 334.104, 334.735, 334.747, 337.025, 337.029, 337.033, 338.202, 374.426, 376.811, 376.1237, 376.1550, and 632.005, RSMo, and to enact in lieu thereof twenty-four new sections relating to health care, with an emergency clause for certain sections.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Sections 191.227, 192.947, 195.070, 210.070, 334.036, 334.037,
2 334.104, 334.735, 334.747, 337.025, 337.029, 337.033, 338.202, 374.426, 376.811,
3 376.1237, 376.1550, and 632.005, RSMo, are repealed and twenty-four new
4 sections enacted in lieu thereof, to be known as sections 9.158, 9.192, 191.227,
5 191.1150, 192.947, 195.070, 195.265, 208.183, 210.070, 334.036, 334.037, 334.104,
6 334.735, 334.747, 337.025, 337.029, 337.033, 338.202, 374.426, 376.811, 376.1237,
7 376.1550, 630.875, and 632.005, to read as follows:

9.158. The month of November shall be known and designated as
2 "Diabetes Awareness Month". The citizens of the state of Missouri are
3 encouraged to participate in appropriate activities and events to
4 increase awareness of diabetes. Diabetes is a group of metabolic
5 diseases in which the body has elevated blood sugar levels over a
6 prolonged period of time and affects Missourians of all ages.

9.192. The years of 2018 to 2028 shall hereby be designated as the
2 "Show-Me Freedom from Opioid Addiction Decade".

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

191.227. 1. All physicians, chiropractors, hospitals, dentists, and other
2 duly licensed practitioners in this state, herein called "providers", shall, upon
3 written request of a patient, or guardian or legally authorized representative of
4 a patient, furnish a copy of his or her record of that patient's health history and
5 treatment rendered to the person submitting a written request, except that such
6 right shall be limited to access consistent with the patient's condition and sound
7 therapeutic treatment as determined by the provider. Beginning August 28,
8 1994, such record shall be furnished within a reasonable time of the receipt of the
9 request therefor and upon payment of a fee as provided in this section.
10 2. Health care providers may condition the furnishing of the patient's
11 health care records to the patient, the patient's authorized representative or any
12 other person or entity authorized by law to obtain or reproduce such records upon
13 payment of a fee for:
14 (1) (a) Search and retrieval, in an amount not more than twenty-four
15 dollars and eighty-five cents plus copying in the amount of fifty-seven cents per
16 page for the cost of supplies and labor plus, if the health care provider has
17 contracted for off-site records storage and management, any additional labor costs
18 of outside storage retrieval, not to exceed twenty-three dollars and twenty-six
19 cents, as adjusted annually pursuant to subsection 5 of this section; or
20 (b) The records shall be furnished electronically upon payment of the
21 search, retrieval, and copying fees set under this section at the time of the
22 request or one hundred eight dollars and eighty-eight cents total, whichever is
23 less, if such person:
24 a. Requests health records to be delivered electronically in a format of the
25 health care provider's choice;
26 b. The health care provider stores such records completely in an electronic
27 health record; and
28 c. The health care provider is capable of providing the requested records
29 and affidavit, if requested, in an electronic format;
30 (2) Postage, to include packaging and delivery cost;
31 (3) Notary fee, not to exceed two dollars, if requested.
32 3. **For purposes of subsections 1 and 2 of this section, "a copy of**
33 **his or her record of that patient's health history and treatment**
34 **rendered" or "the patient's health care records" include a statement or**
35 **record that no such health history or treatment record responsive to**
36 **the request exists.**
37 **4.** Notwithstanding provisions of this section to the contrary, providers

38 may charge for the reasonable cost of all duplications of health care record
39 material or information which cannot routinely be copied or duplicated on a
40 standard commercial photocopy machine.

41 [4.] **5.** The transfer of the patient's record done in good faith shall not
42 render the provider liable to the patient or any other person for any consequences
43 which resulted or may result from disclosure of the patient's record as required
44 by this section.

45 [5.] **6.** Effective February first of each year, the fees listed in subsection
46 2 of this section shall be increased or decreased annually based on the annual
47 percentage change in the unadjusted, U.S. city average, annual average inflation
48 rate of the medical care component of the Consumer Price Index for All Urban
49 Consumers (CPI-U). The current reference base of the index, as published by the
50 Bureau of Labor Statistics of the United States Department of Labor, shall be
51 used as the reference base. For purposes of this subsection, the annual average
52 inflation rate shall be based on a twelve-month calendar year beginning in
53 January and ending in December of each preceding calendar year. The
54 department of health and senior services shall report the annual adjustment and
55 the adjusted fees authorized in this section on the department's internet website
56 by February first of each year.

57 [6.] **7.** A health care provider may disclose a deceased patient's health
58 care records or payment records to the executor or administrator of the deceased
59 person's estate, or pursuant to a valid, unrevoked power of attorney for health
60 care that specifically directs that the deceased person's health care records be
61 released to the agent after death. If an executor, administrator, or agent has not
62 been appointed, the deceased prior to death did not specifically object to
63 disclosure of his or her records in writing, and such disclosure is not inconsistent
64 with any prior expressed preference of the deceased that is known to the health
65 care provider, a deceased patient's health care records may be released upon
66 written request of a person who is deemed as the personal representative of the
67 deceased person under this subsection. Priority shall be given to the deceased
68 patient's spouse and the records shall be released on the affidavit of the surviving
69 spouse that he or she is the surviving spouse. If there is no surviving spouse, the
70 health care records may be released to one of the following persons:

71 (1) The acting trustee of a trust created by the deceased patient either
72 alone or with the deceased patient's spouse;

73 (2) An adult child of the deceased patient on the affidavit of the adult
74 child that he or she is the adult child of the deceased;

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75 (3) A parent of the deceased patient on the affidavit of the parent that he
76 or she is the parent of the deceased;
77 (4) An adult brother or sister of the deceased patient on the affidavit of
78 the adult brother or sister that he or she is the adult brother or sister of the
79 deceased;
80 (5) A guardian or conservator of the deceased patient at the time of the
81 patient's death on the affidavit of the guardian or conservator that he or she is
82 the guardian or conservator of the deceased; or
83 (6) A guardian ad litem of the deceased's minor child based on the
84 affidavit of the guardian that he or she is the guardian ad litem of the minor
85 child of the deceased.

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191.1150. 1. This section shall be known as the "Caregiver,
2 **Advise, Record, and Enable (CARE) Act".**
3 **2. As used in this section, the following terms shall mean:**
4 **(1) "Admission", a patient's admission into a hospital as an in-**
5 **patient;**
6 **(2) "After-care", assistance that is provided by a caregiver to a**
7 **patient after the patient's discharge from a hospital that is related to**
8 **the condition of the patient at the time of discharge, including assisting**
9 **with activities of daily living, as defined in section 198.006;**
10 **instrumental activities of daily living, as defined in section 198.006; or**
11 **carrying out medical or nursing tasks as permitted by law;**
12 **(3) "Ambulatory surgical center", the same as defined in section**
13 **197.200;**
14 **(4) "Caregiver", an individual who is eighteen years of age or**
15 **older, is duly designated as a caregiver by a patient under this section,**
16 **and who provides after-care assistance to such patient in the patient's**
17 **residence;**
18 **(5) "Discharge", a patient's release from a hospital or an**
19 **ambulatory surgical center to the patient's residence following an**
20 **admission;**
21 **(6) "Hospital", the same as defined in section 197.020;**
22 **(7) "Residence", a dwelling that the patient considers to be his or**
23 **her home. "Residence" shall not include:**
24 **(a) A facility, the same as defined in section 198.006;**
25 **(b) A hospital, the same as defined in section 197.020;**
26 **(c) A prison, jail, or other detention or correctional facility**

27 **operated by the state or a political subdivision;**

28 **(d) A residential facility, the same as defined in section 630.005;**

29 **(e) A group home or developmental disability facility, the same**
30 **as defined in section 633.005; or**

31 **(f) Any other place of habitation provided by a public or private**
32 **entity which bears legal or contractual responsibility for the care,**
33 **control, or custody of the patient and which is compensated for doing**
34 **so.**

35 **3. A hospital or ambulatory surgical center shall provide each**
36 **patient or, if applicable, the patient's legal guardian with an**
37 **opportunity to designate a caregiver following the patient's admission**
38 **into a hospital or entry into an ambulatory surgical center and prior**
39 **to the patient's discharge. Such designation shall include a written**
40 **consent of the patient or the patient's legal guardian to release**
41 **otherwise confidential medical information to the designated caregiver**
42 **if such medical record would be needed to enable the completion of**
43 **after-care tasks. The written consent shall be in compliance with**
44 **federal and state laws concerning the release of personal health**
45 **information. Prior to discharge, a patient may elect to change his or**
46 **her caregiver in the event that the original designated caregiver**
47 **becomes unavailable, unwilling, or unable to care for the**
48 **patient. Designation of a caregiver by a patient or a patient's legal**
49 **guardian does not obligate any person to arrange or perform any after-**
50 **care tasks for the patient.**

51 **4. The hospital or ambulatory surgical center shall document the**
52 **patient's or the patient's legal guardian's designation of caregiver, the**
53 **relationship of the caregiver to the patient, and the caregiver's**
54 **available contact information.**

55 **5. If the patient or the patient's legal guardian declines to**
56 **designate a caregiver, the hospital or ambulatory surgical center shall**
57 **document such information.**

58 **6. The hospital or ambulatory surgical center shall notify a**
59 **patient's caregiver of the patient's discharge or transfer to another**
60 **facility as soon as practicable, which may be after the patient's**
61 **physician issues a discharge order. In the event that the hospital or**
62 **ambulatory surgical center is unable to contact the designated**
63 **caregiver, the lack of contact shall not interfere with, delay, or**

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64 **otherwise affect the medical care provided to the patient or an**
65 **appropriate discharge of the patient. The hospital or ambulatory**
66 **surgical center shall document the attempt to contact the caregiver.**

67 **7. Prior to being discharged, if the hospital or ambulatory**
68 **surgical center is able to contact the caregiver and the caregiver is**
69 **willing to assist, the hospital or ambulatory surgical center shall**
70 **provide the caregiver with the patient's discharge plan, if such plan**
71 **exists, or instructions for the after-care needs of the patient and give**
72 **the caregiver the opportunity to ask questions about the after-care**
73 **needs of the patient.**

74 **8. A hospital or ambulatory surgical center is not required nor**
75 **obligated to determine the ability of a caregiver to understand or**
76 **perform any of the after-care tasks outlined in this section.**

77 **9. Nothing in this section shall authorize or require**
78 **compensation of a caregiver by a state agency or a health carrier, as**
79 **defined in section 376.1350.**

80 **10. Nothing in this section shall require a hospital or ambulatory**
81 **surgical center to take actions that are inconsistent with or duplicative**
82 **of the standards of the federal Medicare program under Title XVIII of**
83 **the Social Security Act and its conditions of participation in the Code**
84 **of Federal Regulations or the standards of a national accrediting**
85 **organization with deeming authority under Section 1865(a)(1) of the**
86 **Social Security Act.**

87 **11. Nothing in this section shall create a private right of action**
88 **against a hospital, ambulatory surgical center, a hospital or ambulatory**
89 **surgical center employee, or an individual with whom a hospital or**
90 **ambulatory surgical center has a contractual relationship.**

91 **12. A hospital, ambulatory surgical center, hospital or**
92 **ambulatory surgical center employee, or an individual with whom a**
93 **hospital or ambulatory surgical center has a contractual relationship**
94 **shall not be liable in any way for an act or omission of the caregiver.**

95 **13. No act or omission under this section by a hospital,**
96 **ambulatory surgical center, hospital or ambulatory surgical center**
97 **employee, or an individual with whom a hospital or ambulatory**
98 **surgical center has a contractual relationship shall give rise to a**
99 **citation, sanction, or any other adverse action by any licensing**
100 **authority to whom such individual or entity is subject.**

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101 **14. Nothing in this section shall be construed to interfere with**
102 **the rights of an attorney-in-fact under a durable power of health care**
103 **under sections 404.800 to 404.872.**
104 **15. The department of health and senior services shall provide**
105 **ambulatory surgical centers and hospitals a standard form that may be**
106 **used to satisfy the requirements of this section. Nothing in this section**
107 **shall prohibit a hospital or ambulatory surgical center from continuing**
108 **the use of a current patient communication or disclosure form to**
109 **satisfy the requirements of this section, provided that the facility's**
110 **current form is compliant with Centers for Medicare and Medicaid**
111 **Services (CMS) standards and regulations.**

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192.947. 1. No individual or health care entity organized under the laws
2 of this state shall be subject to any adverse action by the state or any agency,
3 board, or subdivision thereof, including civil or criminal prosecution, denial of any
4 right or privilege, the imposition of a civil or administrative penalty or sanction,
5 or disciplinary action by any accreditation or licensing board or commission if
6 such individual or health care entity, in its normal course of business and within
7 its applicable licenses and regulations, acts in good faith upon or in furtherance
8 of any order or recommendation by a neurologist authorized under section
9 192.945 relating to the medical use and administration of hemp extract with
10 respect to an eligible patient.
11 2. The provisions of subsection 1 of this section shall apply to the
12 recommendation, possession, handling, storage, transfer, destruction, dispensing,
13 or administration of hemp extract, including any act in preparation of such
14 dispensing or administration.
15 3. **[**This section shall not be construed to limit the rights provided under
16 law for a patient to bring a civil action for damages against a physician, hospital,
17 registered or licensed practical nurse, pharmacist, any other individual or entity
18 providing health care services, or an employee of any entity listed in this
19 subsection.**] Notwithstanding the provisions of section 538.210 or any**
20 **other law to the contrary, any physician licensed under chapter 334,**
21 **any hospital licensed under chapter 197, any pharmacist licensed under**
22 **chapter 338, any nurse licensed under chapter 335, or any other person**
23 **employed or directed by any of the above, which provides care,**
24 **treatment or professional services to any patient under section 192.945**
25 **shall not be liable for any civil damages for acts or omissions unless the**
26 **damages were occasioned by gross negligence or by willful or wanton**

27 **acts or omissions by such physician, hospital, pharmacist, nurse, or**
28 **person in rendering such care and treatment.**

195.070. 1. A physician, podiatrist, dentist, a registered optometrist
2 certified to administer pharmaceutical agents as provided in section 336.220, or
3 an assistant physician in accordance with section 334.037 or a physician assistant
4 in accordance with section 334.747 in good faith and in the course of his or her
5 professional practice only, may prescribe, administer, and dispense controlled
6 substances or he or she may cause the same to be administered or dispensed by
7 an individual as authorized by statute.

8 2. An advanced practice registered nurse, as defined in section 335.016,
9 but not a certified registered nurse anesthetist as defined in subdivision (8) of
10 section 335.016, who holds a certificate of controlled substance prescriptive
11 authority from the board of nursing under section 335.019 and who is delegated
12 the authority to prescribe controlled substances under a collaborative practice
13 arrangement under section 334.104 may prescribe any controlled substances
14 listed in Schedules III, IV, and V of section 195.017, and may have restricted
15 authority in Schedule II. Prescriptions for Schedule II medications prescribed by
16 an advanced practice registered nurse who has a certificate of controlled
17 substance prescriptive authority are restricted to only those medications
18 containing hydrocodone. However, no such certified advanced practice registered
19 nurse shall prescribe controlled substance for his or her own self or
20 family. Schedule III narcotic controlled substance and Schedule II - hydrocodone
21 prescriptions shall be limited to a one hundred twenty-hour supply without refill.

22 3. A veterinarian, in good faith and in the course of the veterinarian's
23 professional practice only, and not for use by a human being, may prescribe,
24 administer, and dispense controlled substances and the veterinarian may cause
25 them to be administered by an assistant or orderly under his or her direction and
26 supervision.

27 4. A practitioner shall not accept any portion of a controlled substance
28 unused by a patient, for any reason, if such practitioner did not originally
29 dispense the drug**, except as provided in section 195.265**.

30 5. An individual practitioner shall not prescribe or dispense a controlled
31 substance for such practitioner's personal use except in a medical emergency.

195.265. 1. Unused controlled substances may be accepted from
2 **ultimate users, from hospice or home health care providers on behalf**
3 **of ultimate users to the extent federal law allows, or any person**
4 **lawfully entitled to dispose of a decedent's property if the decedent was**

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5 **an ultimate user who died while in lawful possession of a controlled**
6 **substance, through:**
7 **(1) Collection receptacles, drug disposal boxes, mail back**
8 **packages, and other means by a Drug Enforcement Agency-authorized**
9 **collector in accordance with federal regulations even if the authorized**
10 **collector did not originally dispense the drug; or**
11 **(2) Drug take back programs conducted by federal, state, tribal,**
12 **or local law enforcement agencies in partnership with any person or**
13 **entity.**
14 **This subsection shall supersede and preempt any local ordinances or**
15 **regulations, including any ordinances or regulations enacted by any**
16 **political subdivision of the state, regarding the disposal of unused**
17 **controlled substances. For the purposes of this section, the term**
18 **"ultimate user" shall mean a person who has lawfully obtained and**
19 **possesses a controlled substance for his or her own use or for the use**
20 **of a member of his or her household or for an animal owned by him or**
21 **her or a member of his or her household.**
22 **2. By August 28, 2019, the department of health and senior**
23 **services shall develop an education and awareness program regarding**
24 **drug disposal, including controlled substances. The education and**
25 **awareness program may include, but not be limited to:**
26 **(1) A web-based resource that:**
27 **(a) Describes available drug disposal options including take**
28 **back, take back events, mail back packages, in-home disposal options**
29 **that render a product safe from misuse, or any other methods that**
30 **comply with state and federal laws and regulations, may reduce the**
31 **availability of unused controlled substances, and may minimize the**
32 **potential environmental impact of drug disposal;**
33 **(b) Provides a list of drug disposal take back sites, which may be**
34 **sorted and searched by name or location and is updated every six**
35 **months by the department;**
36 **(c) Provides a list of take back events and mail back events in**
37 **the state, including the date, time, and location information for each**
38 **event and is updated every six months by the department; and**
39 **(d) Provides information for authorized collectors regarding**
40 **state and federal requirements to comply with the provisions of**
41 **subsection 1 of this section; and**

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42 **(2) Promotional activities designed to ensure consumer**
43 **awareness of proper storage and disposal of prescription drugs,**
44 **including controlled substances.**

208.183. 1. There shall be established an "Advisory Council on
2 **Rare Diseases and Personalized Medicine" within the MO HealthNet**
3 **division. The advisory council shall serve as an expert advisory**
4 **committee to the drug utilization review board, providing necessary**
5 **consultation to the board when the board makes recommendations or**
6 **determinations regarding beneficiary access to drugs or biological**
7 **products for rare diseases, or when the board itself determines that it**
8 **lacks the specific scientific, medical, or technical expertise necessary**
9 **for the proper performance of its responsibilities and such necessary**
10 **expertise can be provided by experts outside the board. "Beneficiary**
11 **access", as used in this section, shall mean developing prior**
12 **authorization and reauthorization criteria for a rare disease drug,**
13 **including placement on a preferred drug list or a formulary, as well as**
14 **payment, cost-sharing, drug utilization review, or medication therapy**
15 **management.**
16 **2. The advisory council on rare diseases and personalized**
17 **medicine shall be composed of the following health care professionals,**
18 **who shall be appointed by the director of the department of social**
19 **services:**
20 **(1) Two physicians affiliated with a public school of medicine**
21 **who are licensed and practicing in this state with experience**
22 **researching, diagnosing, or treating rare diseases;**
23 **(2) Two physicians affiliated with private schools of medicine**
24 **headquartered in this state who are licensed and practicing in this**
25 **state with experience researching, diagnosing, or treating rare**
26 **diseases;**
27 **(3) A physician who holds a doctor of osteopathy degree, who is**
28 **active in medical practice, and who is affiliated with a school of**
29 **medicine in this state with experience researching, diagnosing, or**
30 **treating rare diseases;**
31 **(4) Two medical researchers from either academic research**
32 **institutions or medical research organizations in this state who have**
33 **received federal or foundation grant funding for rare disease research;**
34 **(5) A registered nurse or advanced practice registered nurse**

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35 **licensed and practicing in this state with experience treating rare**
36 **diseases;**
37 **(6) A pharmacist practicing in a hospital in this state which has**
38 **a designated orphan disease center;**
39 **(7) A professor employed by a pharmacy program in this state**
40 **that is fully accredited by the Accreditation Council for Pharmacy**
41 **Education and who has advanced scientific or medical training in**
42 **orphan and rare disease treatments;**
43 **(8) One individual representing the rare disease community or**
44 **who is living with a rare disease;**
45 **(9) One member who represents a rare disease foundation;**
46 **(10) A representative from a rare disease center located within**
47 **one of the state's comprehensive pediatric hospitals;**
48 **(11) The chairperson of the joint committee on the life sciences**
49 **or the chairperson's designee; and**
50 **(12) The chairperson of the drug utilization review board, or the**
51 **chairperson's designee, who shall serve as an ex officio, nonvoting**
52 **member of the advisory council.**
53 **3. The director shall convene the first meeting of the advisory**
54 **council on rare diseases and personalized medicine no later than**
55 **February 28, 2019. Following the first meeting, the advisory council**
56 **shall meet upon the call of the chairperson of the drug utilization**
57 **review board or upon the request of a majority of the council members.**
58 **4. The drug utilization review board, when making**
59 **recommendations or determinations regarding beneficiary access to**
60 **drugs and biological products for rare diseases, as defined in the**
61 **federal Orphan Drug Act of 1983, P.L. 97-414, and drugs and biological**
62 **products that are approved by the U.S. Food and Drug Administration**
63 **and within the emerging fields of personalized medicine and**
64 **noninheritable gene editing therapeutics, shall request and consider**
65 **information from the advisory council on rare diseases and**
66 **personalized medicine.**
67 **5. The drug utilization review board shall seek the input of the**
68 **advisory council on rare diseases and personalized medicine to address**
69 **topics for consultation under this section including, but not limited to:**
70 **(1) Rare diseases;**
71 **(2) The severity of rare diseases;**

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72 **(3) The unmet medical need associated with rare diseases;**
73 **(4) The impact of particular coverage, cost-sharing, tiering,**
74 **utilization management, prior authorization, medication therapy**
75 **management, or other Medicaid policies on access to rare disease**
76 **therapies;**
77 **(5) An assessment of the benefits and risks of therapies to treat**
78 **rare diseases;**
79 **(6) The impact of particular coverage, cost-sharing, tiering,**
80 **utilization management, prior authorization, medication therapy**
81 **management, or other Medicaid policies on patients' adherence to the**
82 **treatment regimen prescribed or otherwise recommended by their**
83 **physicians;**
84 **(7) Whether beneficiaries who need treatment from or a**
85 **consultation with a rare disease specialist have adequate access and,**
86 **if not, what factors are causing the limited access; and**
87 **(8) The demographics and the clinical description of patient**
88 **populations.**
89 **6. Nothing in this section shall be construed to create a legal**
90 **right for a consultation on any matter or to require the drug utilization**
91 **review board to meet with any particular expert or stakeholder.**
92 **7. Recommendations of the advisory council on rare diseases and**
93 **personalized medicine on an applicable treatment of a rare disease**
94 **shall be explained in writing to members of the drug utilization review**
95 **board during public hearings.**
96 **8. For purposes of this section, a "rare disease drug" shall mean**
97 **a drug used to treat a rare medical condition, defined as any disease or**
98 **condition that affects fewer than two hundred thousand persons in the**
99 **United States, such as cystic fibrosis, hemophilia, and multiple**
100 **myeloma.**
101 **9. All members of the advisory council on rare diseases and**
102 **personalized medicine shall annually sign a conflict of interest**
103 **statement revealing economic or other relationships with entities that**
104 **could influence a member's decisions, and at least twenty percent of the**
105 **advisory council members shall not have a conflict of interest with**
106 **respect to any insurer, pharmaceutical benefits manager, or**
107 **pharmaceutical manufacturer.**

210.070. **[**Every**]** **1. A** physician, midwife**,** or nurse who shall be in

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attendance upon a newborn infant or its mother[,] shall drop into the eyes of such infant [immediately after delivery,] a prophylactic [solution] **medication** approved by the state department of health and senior services[, and shall within forty-eight hours thereafter, report in writing to the board of health or county physician of the city, town or county where such birth occurs, his or her compliance with this section, stating the solution used by him or her].

2. Administration of such eye drops shall not be required if a parent or legal guardian of such infant objects to the treatment because it is against the religious beliefs of the parent or legal guardian.

334.036. 1. For purposes of this section, the following terms shall mean:

(1) "Assistant physician", any medical school graduate who:

(a) Is a resident and citizen of the United States or is a legal resident alien;

(b) Has successfully completed [Step 1 and] Step 2 of the United States Medical Licensing Examination or the equivalent of such [steps] **step** of any other board-approved medical licensing examination within the [two-year] **three-year** period immediately preceding application for licensure as an assistant physician, [but in no event more than] **or within** three years after graduation from a medical college or osteopathic medical college**, whichever is later**;

(c) Has not completed an approved postgraduate residency and has successfully completed Step 2 of the United States Medical Licensing Examination or the equivalent of such step of any other board-approved medical licensing examination within the immediately preceding [two-year] **three-year** period unless when such [two-year] **three-year** anniversary occurred he or she was serving as a resident physician in an accredited residency in the United States and continued to do so within thirty days prior to application for licensure as an assistant physician; and

(d) Has proficiency in the English language.

Any medical school graduate who could have applied for licensure and complied with the provisions of this subdivision at any time between August 28, 2014, and August 28, 2017, may apply for licensure and shall be deemed in compliance with the provisions of this subdivision;

(2) "Assistant physician collaborative practice arrangement", an agreement between a physician and an assistant physician that meets the requirements of this section and section 334.037;

(3) "Medical school graduate", any person who has graduated from a medical college or osteopathic medical college described in section 334.031.

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29 2. (1) An assistant physician collaborative practice arrangement shall
30 limit the assistant physician to providing only primary care services and only in
31 medically underserved rural or urban areas of this state or in any pilot project
32 areas established in which assistant physicians may practice.

33 (2) For a physician-assistant physician team working in a rural health
34 clinic under the federal Rural Health Clinic Services Act, P.L. 95-210, as
35 amended:

36 (a) An assistant physician shall be considered a physician assistant for
37 purposes of regulations of the Centers for Medicare and Medicaid Services (CMS);
38 and

39 (b) No supervision requirements in addition to the minimum federal law
40 shall be required.

41 3. (1) For purposes of this section, the licensure of assistant physicians
42 shall take place within processes established by rules of the state board of
43 registration for the healing arts. The board of healing arts is authorized to
44 establish rules under chapter 536 establishing licensure and renewal procedures,
45 supervision, collaborative practice arrangements, fees, and addressing such other
46 matters as are necessary to protect the public and discipline the profession. **No**
47 **licensure fee for an assistant physician shall exceed the amount of any**
48 **licensure fee for a physician assistant.** An application for licensure may be
49 denied or the licensure of an assistant physician may be suspended or revoked by
50 the board in the same manner and for violation of the standards as set forth by
51 section 334.100, or such other standards of conduct set by the board by rule. **No**
52 **rule or regulation shall require an assistant physician to complete more**
53 **hours of continuing medical education than that of a licensed**
54 **physician.**

55 (2) Any rule or portion of a rule, as that term is defined in section
56 536.010, that is created under the authority delegated in this section shall
57 become effective only if it complies with and is subject to all of the provisions of
58 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
59 nonseverable and if any of the powers vested with the general assembly under
60 chapter 536 to review, to delay the effective date, or to disapprove and annul a
61 rule are subsequently held unconstitutional, then the grant of rulemaking
62 authority and any rule proposed or adopted after August 28, 2014, shall be
63 invalid and void.

64 **(3) Any rules or regulations regarding assistant physicians in**
65 **effect as of the effective date of this section that conflict with the**

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66 **provisions of this section and section 334.037 shall be null and void as**
67 **of the effective date of this section.**
68 4. An assistant physician shall clearly identify himself or herself as an
69 assistant physician and shall be permitted to use the terms "doctor", "Dr.", or
70 "doc". No assistant physician shall practice or attempt to practice without an
71 assistant physician collaborative practice arrangement, except as otherwise
72 provided in this section and in an emergency situation.
73 5. The collaborating physician is responsible at all times for the oversight
74 of the activities of and accepts responsibility for primary care services rendered
75 by the assistant physician.
76 6. The provisions of section 334.037 shall apply to all assistant physician
77 collaborative practice arrangements. **[**To be eligible to practice as an assistant
78 physician, a licensed assistant physician shall enter into an assistant physician
79 collaborative practice arrangement within six months of his or her initial
80 licensure and shall not have more than a six-month time period between
81 collaborative practice arrangements during his or her licensure period.**]** Any
82 renewal of licensure under this section shall include verification of actual practice
83 under a collaborative practice arrangement in accordance with this subsection
84 during the immediately preceding licensure period.
85 **7. Each health carrier or health benefit plan that offers or issues**
86 **health benefit plans that are delivered, issued for delivery, continued,**
87 **or renewed in this state shall reimburse an assistant physician for the**
88 **diagnosis, consultation, or treatment of an insured or enrollee on the**
89 **same basis that the health carrier or health benefit plan covers the**
90 **service when it is delivered by another comparable mid-level health**
91 **care provider including, but not limited to, a physician assistant.**

334.037. 1. A physician may enter into collaborative practice
2 arrangements with assistant physicians. Collaborative practice arrangements
3 shall be in the form of written agreements, jointly agreed-upon protocols, or
4 standing orders for the delivery of health care services. Collaborative practice
5 arrangements, which shall be in writing, may delegate to an assistant physician
6 the authority to administer or dispense drugs and provide treatment as long as
7 the delivery of such health care services is within the scope of practice of the
8 assistant physician and is consistent with that assistant physician's skill,
9 training, and competence and the skill and training of the collaborating
10 physician.
11 2. The written collaborative practice arrangement shall contain at least

12 the following provisions:
13 (1) Complete names, home and business addresses, zip codes, and
14 telephone numbers of the collaborating physician and the assistant physician;
15 (2) A list of all other offices or locations besides those listed in subdivision
16 (1) of this subsection where the collaborating physician authorized the assistant
17 physician to prescribe;
18 (3) A requirement that there shall be posted at every office where the
19 assistant physician is authorized to prescribe, in collaboration with a physician,
20 a prominently displayed disclosure statement informing patients that they may
21 be seen by an assistant physician and have the right to see the collaborating
22 physician;
23 (4) All specialty or board certifications of the collaborating physician and
24 all certifications of the assistant physician;
25 (5) The manner of collaboration between the collaborating physician and
26 the assistant physician, including how the collaborating physician and the
27 assistant physician shall:
28 (a) Engage in collaborative practice consistent with each professional's
29 skill, training, education, and competence;
30 (b) Maintain geographic proximity; except, the collaborative practice
31 arrangement may allow for geographic proximity to be waived for a maximum of
32 twenty-eight days per calendar year for rural health clinics as defined by **[**P.L.**]**
33 **Pub. L.** 95-210 **[**,**] (42 U.S.C. Section 1395x), as amended,** as long as the
34 collaborative practice arrangement includes alternative plans as required in
35 paragraph (c) of this subdivision. Such exception to geographic proximity shall
36 apply only to independent rural health clinics, provider-based rural health clinics
37 if the provider is a critical access hospital as provided in 42 U.S.C. Section 1395i-
38 4, and provider-based rural health clinics if the main location of the hospital
39 sponsor is greater than fifty miles from the clinic. The collaborating physician
40 shall maintain documentation related to such requirement and present it to the
41 state board of registration for the healing arts when requested; and
42 (c) Provide coverage during absence, incapacity, infirmity, or emergency
43 by the collaborating physician;
44 (6) A description of the assistant physician's controlled substance
45 prescriptive authority in collaboration with the physician, including a list of the
46 controlled substances the physician authorizes the assistant physician to
47 prescribe and documentation that it is consistent with each professional's
48 education, knowledge, skill, and competence;

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49 (7) A list of all other written practice agreements of the collaborating
50 physician and the assistant physician;
51 (8) The duration of the written practice agreement between the
52 collaborating physician and the assistant physician;
53 (9) A description of the time and manner of the collaborating physician's
54 review of the assistant physician's delivery of health care services. The
55 description shall include provisions that the assistant physician shall submit a
56 minimum of ten percent of the charts documenting the assistant physician's
57 delivery of health care services to the collaborating physician for review by the
58 collaborating physician, or any other physician designated in the collaborative
59 practice arrangement, every fourteen days; and
60 (10) The collaborating physician, or any other physician designated in the
61 collaborative practice arrangement, shall review every fourteen days a minimum
62 of twenty percent of the charts in which the assistant physician prescribes
63 controlled substances. The charts reviewed under this subdivision may be
64 counted in the number of charts required to be reviewed under subdivision (9) of
65 this subsection.
66 3. The state board of registration for the healing arts under section
67 334.125 shall promulgate rules regulating the use of collaborative practice
68 arrangements for assistant physicians. Such rules shall specify:
69 (1) Geographic areas to be covered;
70 (2) The methods of treatment that may be covered by collaborative
71 practice arrangements;
72 (3) In conjunction with deans of medical schools and primary care
73 residency program directors in the state, the development and implementation of
74 educational methods and programs undertaken during the collaborative practice
75 service which shall facilitate the advancement of the assistant physician's medical
76 knowledge and capabilities, and which may lead to credit toward a future
77 residency program for programs that deem such documented educational
78 achievements acceptable; and
79 (4) The requirements for review of services provided under collaborative
80 practice arrangements, including delegating authority to prescribe controlled
81 substances.
82 Any rules relating to dispensing or distribution of medications or devices by
83 prescription or prescription drug orders under this section shall be subject to the
84 approval of the state board of pharmacy. Any rules relating to dispensing or
85 distribution of controlled substances by prescription or prescription drug orders

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86 under this section shall be subject to the approval of the department of health
87 and senior services and the state board of pharmacy. The state board of
88 registration for the healing arts shall promulgate rules applicable to assistant
89 physicians that shall be consistent with guidelines for federally funded
90 clinics. The rulemaking authority granted in this subsection shall not extend to
91 collaborative practice arrangements of hospital employees providing inpatient
92 care within hospitals as defined in chapter 197 or population-based public health
93 services as defined by 20 CSR 2150-5.100 as of April 30, 2008.

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

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

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

120 7. The collaborating physician shall determine and document the
121 completion of at least a one-month period of time during which the assistant
122 physician shall practice with the collaborating physician continuously present

123 before practicing in a setting where the collaborating physician is not
124 continuously present. **No rule or regulation shall require the collaborating**
125 **physician to review more than ten percent of the assistant physician's**
126 **patient charts or records during such one-month period.** Such limitation
127 shall not apply to collaborative arrangements of providers of population-based
128 public health services as defined by 20 CSR 2150-5.100 as of April 30, 2008.
129 8. No agreement made under this section shall supersede current hospital
130 licensing regulations governing hospital medication orders under protocols or
131 standing orders for the purpose of delivering inpatient or emergency care within
132 a hospital as defined in section 197.020 if such protocols or standing orders have
133 been approved by the hospital's medical staff and pharmaceutical therapeutics
134 committee.
135 9. No contract or other agreement shall require a physician to act as a
136 collaborating physician for an assistant physician against the physician's will. A
137 physician shall have the right to refuse to act as a collaborating physician,
138 without penalty, for a particular assistant physician. No contract or other
139 agreement shall limit the collaborating physician's ultimate authority over any
140 protocols or standing orders or in the delegation of the physician's authority to
141 any assistant physician, but such requirement shall not authorize a physician in
142 implementing such protocols, standing orders, or delegation to violate applicable
143 standards for safe medical practice established by a hospital's medical staff.
144 10. No contract or other agreement shall require any assistant physician
145 to serve as a collaborating assistant physician for any collaborating physician
146 against the assistant physician's will. An assistant physician shall have the right
147 to refuse to collaborate, without penalty, with a particular physician.
148 11. All collaborating physicians and assistant physicians in collaborative
149 practice arrangements shall wear identification badges while acting within the
150 scope of their collaborative practice arrangement. The identification badges shall
151 prominently display the licensure status of such collaborating physicians and
152 assistant physicians.
153 12. (1) An assistant physician with a certificate of controlled substance
154 prescriptive authority as provided in this section may prescribe any controlled
155 substance listed in Schedule III, IV, or V of section 195.017, and may have
156 restricted authority in Schedule II, when delegated the authority to prescribe
157 controlled substances in a collaborative practice arrangement. Prescriptions for
158 Schedule II medications prescribed by an assistant physician who has a
159 certificate of controlled substance prescriptive authority are restricted to only

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160 those medications containing hydrocodone. Such authority shall be filed with the
161 state board of registration for the healing arts. The collaborating physician shall
162 maintain the right to limit a specific scheduled drug or scheduled drug category
163 that the assistant physician is permitted to prescribe. Any limitations shall be
164 listed in the collaborative practice arrangement. Assistant physicians shall not
165 prescribe controlled substances for themselves or members of their
166 families. Schedule III controlled substances and Schedule II - hydrocodone
167 prescriptions shall be limited to a five-day supply without refill**, except that**
168 **buprenorphine may be prescribed for up to a thirty-day supply without**
169 **refill for patients receiving medication assisted treatment for substance**
170 **use disorders under the direction of the collaborating**
171 **physician**. Assistant physicians who are authorized to prescribe controlled
172 substances under this section shall register with the federal Drug Enforcement
173 Administration and the state bureau of narcotics and dangerous drugs, and shall
174 include the Drug Enforcement Administration registration number on
175 prescriptions for controlled substances.

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

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

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

10 2. Collaborative practice arrangements, which shall be in writing, may

11 delegate to a registered professional nurse the authority to administer, dispense
12 or prescribe drugs and provide treatment if the registered professional nurse is
13 an advanced practice registered nurse as defined in subdivision (2) of section
14 335.016. Collaborative practice arrangements may delegate to an advanced
15 practice registered nurse, as defined in section 335.016, the authority to
16 administer, dispense, or prescribe controlled substances listed in Schedules III,
17 IV, and V of section 195.017, and Schedule II - hydrocodone; except that, the
18 collaborative practice arrangement shall not delegate the authority to administer
19 any controlled substances listed in Schedules III, IV, and V of section 195.017, or
20 Schedule II - hydrocodone for the purpose of inducing sedation or general
21 anesthesia for therapeutic, diagnostic, or surgical procedures. Schedule III
22 narcotic controlled substance and Schedule II - hydrocodone prescriptions shall
23 be limited to a one hundred twenty-hour supply without refill. Such collaborative
24 practice arrangements shall be in the form of written agreements, jointly agreed-
25 upon protocols or standing orders for the delivery of health care services. **An**
26 **advanced practice registered nurse may prescribe buprenorphine for**
27 **up to a thirty-day supply without refill for patient's receiving**
28 **medication assisted treatment for substance use disorders under the**
29 **direction of the collaborating physician.**

30 3. The written collaborative practice arrangement shall contain at least
31 the following provisions:

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

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

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

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

45 (5) The manner of collaboration between the collaborating physician and
46 the advanced practice registered nurse, including how the collaborating physician
47 and the advanced practice registered nurse will:

48 (a) Engage in collaborative practice consistent with each professional's
49 skill, training, education, and competence;
50 (b) Maintain geographic proximity, except the collaborative practice
51 arrangement may allow for geographic proximity to be waived for a maximum of
52 twenty-eight days per calendar year for rural health clinics as defined by P.L. 95-
53 210, as long as the collaborative practice arrangement includes alternative plans
54 as required in paragraph (c) of this subdivision. This exception to geographic
55 proximity shall apply only to independent rural health clinics, provider-based
56 rural health clinics where the provider is a critical access hospital as provided in
57 42 U.S.C. Section 1395i-4, and provider-based rural health clinics where the main
58 location of the hospital sponsor is greater than fifty miles from the clinic. The
59 collaborating physician is required to maintain documentation related to this
60 requirement and to present it to the state board of registration for the healing
61 arts when requested; and
62 (c) Provide coverage during absence, incapacity, infirmity, or emergency
63 by the collaborating physician;
64 (6) A description of the advanced practice registered nurse's controlled
65 substance prescriptive authority in collaboration with the physician, including a
66 list of the controlled substances the physician authorizes the nurse to prescribe
67 and documentation that it is consistent with each professional's education,
68 knowledge, skill, and competence;
69 (7) A list of all other written practice agreements of the collaborating
70 physician and the advanced practice registered nurse;
71 (8) The duration of the written practice agreement between the
72 collaborating physician and the advanced practice registered nurse;
73 (9) A description of the time and manner of the collaborating physician's
74 review of the advanced practice registered nurse's delivery of health care
75 services. The description shall include provisions that the advanced practice
76 registered nurse shall submit a minimum of ten percent of the charts
77 documenting the advanced practice registered nurse's delivery of health care
78 services to the collaborating physician for review by the collaborating physician,
79 or any other physician designated in the collaborative practice arrangement,
80 every fourteen days; and
81 (10) The collaborating physician, or any other physician designated in the
82 collaborative practice arrangement, shall review every fourteen days a minimum
83 of twenty percent of the charts in which the advanced practice registered nurse
84 prescribes controlled substances. The charts reviewed under this subdivision may

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85 be counted in the number of charts required to be reviewed under subdivision (9)
86 of this subsection.
87 4. The state board of registration for the healing arts pursuant to section
88 334.125 and the board of nursing pursuant to section 335.036 may jointly
89 promulgate rules regulating the use of collaborative practice arrangements. Such
90 rules shall be limited to specifying geographic areas to be covered, the methods
91 of treatment that may be covered by collaborative practice arrangements and the
92 requirements for review of services provided pursuant to collaborative practice
93 arrangements including delegating authority to prescribe controlled
94 substances. Any rules relating to dispensing or distribution of medications or
95 devices by prescription or prescription drug orders under this section shall be
96 subject to the approval of the state board of pharmacy. Any rules relating to
97 dispensing or distribution of controlled substances by prescription or prescription
98 drug orders under this section shall be subject to the approval of the department
99 of health and senior services and the state board of pharmacy. In order to take
100 effect, such rules shall be approved by a majority vote of a quorum of each
101 board. Neither the state board of registration for the healing arts nor the board
102 of nursing may separately promulgate rules relating to collaborative practice
103 arrangements. Such jointly promulgated rules shall be consistent with guidelines
104 for federally funded clinics. The rulemaking authority granted in this subsection
105 shall not extend to collaborative practice arrangements of hospital employees
106 providing inpatient care within hospitals as defined pursuant to chapter 197 or
107 population-based public health services as defined by 20 CSR 2150-5.100 as of
108 April 30, 2008.
109 5. The state board of registration for the healing arts shall not deny,
110 revoke, suspend or otherwise take disciplinary action against a physician for
111 health care services delegated to a registered professional nurse provided the
112 provisions of this section and the rules promulgated thereunder are
113 satisfied. Upon the written request of a physician subject to a disciplinary action
114 imposed as a result of an agreement between a physician and a registered
115 professional nurse or registered physician assistant, whether written or not, prior
116 to August 28, 1993, all records of such disciplinary licensure action and all
117 records pertaining to the filing, investigation or review of an alleged violation of
118 this chapter incurred as a result of such an agreement shall be removed from the
119 records of the state board of registration for the healing arts and the division of
120 professional registration and shall not be disclosed to any public or private entity
121 seeking such information from the board or the division. The state board of

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122 registration for the healing arts shall take action to correct reports of alleged
123 violations and disciplinary actions as described in this section which have been
124 submitted to the National Practitioner Data Bank. In subsequent applications
125 or representations relating to his medical practice, a physician completing forms
126 or documents shall not be required to report any actions of the state board of
127 registration for the healing arts for which the records are subject to removal
128 under this section.

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

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

150 8. A collaborating physician **or supervising physician** shall not enter
151 into a collaborative practice arrangement **or supervision agreement** with more
152 than **[**three**] six** full-time equivalent advanced practice registered nurses**, full-**
153 **time equivalent licensed physician assistants, or full-time equivalent**
154 **assistant physicians, or any combination thereof**. This limitation shall not
155 apply to collaborative arrangements of hospital employees providing inpatient
156 care service in hospitals as defined in chapter 197 or population-based public
157 health services as defined by 20 CSR 2150-5.100 as of April 30, 2008**, or to a**
158 **certified registered nurse anesthetist providing anesthesia services**

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159 **under the supervision of an anesthesiologist or other physician, dentist,**
160 **or podiatrist who is immediately available if needed as set out in**
161 **subsection 7 of this section**.
162 9. It is the responsibility of the collaborating physician to determine and
163 document the completion of at least a one-month period of time during which the
164 advanced practice registered nurse shall practice with the collaborating physician
165 continuously present before practicing in a setting where the collaborating
166 physician is not continuously present. This limitation shall not apply to
167 collaborative arrangements of providers of population-based public health services
168 as defined by 20 CSR 2150-5.100 as of April 30, 2008.
169 10. No agreement made under this section shall supersede current
170 hospital licensing regulations governing hospital medication orders under
171 protocols or standing orders for the purpose of delivering inpatient or emergency
172 care within a hospital as defined in section 197.020 if such protocols or standing
173 orders have been approved by the hospital's medical staff and pharmaceutical
174 therapeutics committee.
175 11. No contract or other agreement shall require a physician to act as a
176 collaborating physician for an advanced practice registered nurse against the
177 physician's will. A physician shall have the right to refuse to act as a
178 collaborating physician, without penalty, for a particular advanced practice
179 registered nurse. No contract or other agreement shall limit the collaborating
180 physician's ultimate authority over any protocols or standing orders or in the
181 delegation of the physician's authority to any advanced practice registered nurse,
182 but this requirement shall not authorize a physician in implementing such
183 protocols, standing orders, or delegation to violate applicable standards for safe
184 medical practice established by hospital's medical staff.
185 12. No contract or other agreement shall require any advanced practice
186 registered nurse to serve as a collaborating advanced practice registered nurse
187 for any collaborating physician against the advanced practice registered nurse's
188 will. An advanced practice registered nurse shall have the right to refuse to
189 collaborate, without penalty, with a particular physician.
334.735. 1. As used in sections 334.735 to 334.749, the following terms
2 mean:
3 (1) "Applicant", any individual who seeks to become licensed as a
4 physician assistant;
5 (2) "Certification" or "registration", a process by a certifying entity that
6 grants recognition to applicants meeting predetermined qualifications specified

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7 by such certifying entity;

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

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

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

15 (6) "Physician assistant", a person who has graduated from a physician
16 assistant program accredited by the American Medical Association's Committee
17 on Allied Health Education and Accreditation or by its successor agency, who has
18 passed the certifying examination administered by the National Commission on
19 Certification of Physician Assistants and has active certification by the National
20 Commission on Certification of Physician Assistants who provides health care
21 services delegated by a licensed physician. A person who has been employed as
22 a physician assistant for three years prior to August 28, 1989, who has passed the
23 National Commission on Certification of Physician Assistants examination, and
24 has active certification of the National Commission on Certification of Physician
25 Assistants;

26 (7) "Recognition", the formal process of becoming a certifying entity as
27 required by the provisions of sections 334.735 to 334.749;

28 (8) "Supervision", control exercised over a physician assistant working
29 with a supervising physician and oversight of the activities of and accepting
30 responsibility for the physician assistant's delivery of care. The physician
31 assistant shall only practice at a location where the physician routinely provides
32 patient care, except existing patients of the supervising physician in the patient's
33 home and correctional facilities. The supervising physician must be immediately
34 available in person or via telecommunication during the time the physician
35 assistant is providing patient care. Prior to commencing practice, the supervising
36 physician and physician assistant shall attest on a form provided by the board
37 that the physician shall provide supervision appropriate to the physician
38 assistant's training and that the physician assistant shall not practice beyond the
39 physician assistant's training and experience. Appropriate supervision shall
40 require the supervising physician to be working within the same facility as the
41 physician assistant for at least four hours within one calendar day for every
42 fourteen days on which the physician assistant provides patient care as described
43 in subsection 3 of this section. Only days in which the physician assistant

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44 provides patient care as described in subsection 3 of this section shall be counted
45 toward the fourteen-day period. The requirement of appropriate supervision shall
46 be applied so that no more than thirteen calendar days in which a physician
47 assistant provides patient care shall pass between the physician's four hours
48 working within the same facility. The board shall promulgate rules pursuant to
49 chapter 536 for documentation of joint review of the physician assistant activity
50 by the supervising physician and the physician assistant.

51 2. (1) A supervision agreement shall limit the physician assistant to
52 practice only at locations described in subdivision (8) of subsection 1 of this
53 section, **[**where the supervising physician is no further than fifty miles by road
54 using the most direct route available and where the location is not so situated as
55 to create an impediment to effective intervention and supervision of patient care
56 or adequate review of services**] within a geographic proximity to be**
57 **determined by the board of registration for the healing arts**.

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

64 3. The scope of practice of a physician assistant shall consist only of the
65 following services and procedures:

66 (1) Taking patient histories;

67 (2) Performing physical examinations of a patient;

68 (3) Performing or assisting in the performance of routine office laboratory
69 and patient screening procedures;

70 (4) Performing routine therapeutic procedures;

71 (5) Recording diagnostic impressions and evaluating situations calling for
72 attention of a physician to institute treatment procedures;

73 (6) Instructing and counseling patients regarding mental and physical
74 health using procedures reviewed and approved by a licensed physician;

75 (7) Assisting the supervising physician in institutional settings, including
76 reviewing of treatment plans, ordering of tests and diagnostic laboratory and
77 radiological services, and ordering of therapies, using procedures reviewed and
78 approved by a licensed physician;

79 (8) Assisting in surgery;

80 (9) Performing such other tasks not prohibited by law under the

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81 supervision of a licensed physician as the physician's assistant has been trained
82 and is proficient to perform; and
83 (10) Physician assistants shall not perform or prescribe abortions.
84 4. Physician assistants shall not prescribe any drug, medicine, device or
85 therapy unless pursuant to a physician supervision agreement in accordance with
86 the law, nor prescribe lenses, prisms or contact lenses for the aid, relief or
87 correction of vision or the measurement of visual power or visual efficiency of the
88 human eye, nor administer or monitor general or regional block anesthesia during
89 diagnostic tests, surgery or obstetric procedures. Prescribing of drugs,
90 medications, devices or therapies by a physician assistant shall be pursuant to
91 a physician assistant supervision agreement which is specific to the clinical
92 conditions treated by the supervising physician and the physician assistant shall
93 be subject to the following:
94 (1) A physician assistant shall only prescribe controlled substances in
95 accordance with section 334.747;
96 (2) The types of drugs, medications, devices or therapies prescribed by a
97 physician assistant shall be consistent with the scopes of practice of the physician
98 assistant and the supervising physician;
99 (3) All prescriptions shall conform with state and federal laws and
100 regulations and shall include the name, address and telephone number of the
101 physician assistant and the supervising physician;
102 (4) A physician assistant, or advanced practice registered nurse as defined
103 in section 335.016 may request, receive and sign for noncontrolled professional
104 samples and may distribute professional samples to patients; and
105 (5) A physician assistant shall not prescribe any drugs, medicines, devices
106 or therapies the supervising physician is not qualified or authorized to prescribe.
107 5. A physician assistant shall clearly identify himself or herself as a
108 physician assistant and shall not use or permit to be used in the physician
109 assistant's behalf the terms "doctor", "Dr." or "doc" nor hold himself or herself out
110 in any way to be a physician or surgeon. No physician assistant shall practice or
111 attempt to practice without physician supervision or in any location where the
112 supervising physician is not immediately available for consultation, assistance
113 and intervention, except as otherwise provided in this section, and in an
114 emergency situation, nor shall any physician assistant bill a patient
115 independently or directly for any services or procedure by the physician assistant;
116 except that, nothing in this subsection shall be construed to prohibit a physician
117 assistant from enrolling with the department of social services as a MO

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118 HealthNet or Medicaid provider while acting under a supervision agreement
119 between the physician and physician assistant.

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

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

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

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

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

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

149 (a) Attest on a form provided by the board that the physician shall provide
150 supervision appropriate to the physician assistant's training and experience and
151 that the physician assistant shall not practice beyond the scope of the physician
152 assistant's training and experience nor the supervising physician's capabilities
153 and training; and

154 (b) Provide coverage during absence, incapacity, infirmity, or emergency

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155 by the supervising physician;

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

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

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

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

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

179 11. No contract or other agreement shall require a physician to act as a
180 supervising physician for a physician assistant against the physician's will. A
181 physician shall have the right to refuse to act as a supervising physician, without
182 penalty, for a particular physician assistant. No contract or other agreement
183 shall limit the supervising physician's ultimate authority over any protocols or
184 standing orders or in the delegation of the physician's authority to any physician
185 assistant, but this requirement shall not authorize a physician in implementing
186 such protocols, standing orders, or delegation to violate applicable standards for
187 safe medical practice established by the hospital's medical staff.

188 12. Physician assistants shall file with the board a copy of their
189 supervising physician form.

190 13. No physician shall be designated to serve as supervising physician **or**
191 **collaborating physician** for more than **[**three**]** **six** full-time equivalent licensed

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192 physician assistants**, full-time equivalent advanced practice registered**
193 **nurses, or full-time equivalent assistant physicians, or any combination**
194 **thereof**. This limitation shall not apply to physician assistant agreements of
195 hospital employees providing inpatient care service in hospitals as defined in
196 chapter 197**, or to a certified registered nurse anesthetist providing**
197 **anesthesia services under the supervision of an anesthesiologist or**
198 **other physician, dentist, or podiatrist who is immediately available if**
199 **needed as set out in subsection 7 of section 334.104**.

334.747. 1. A physician assistant with a certificate of controlled
2 substance prescriptive authority as provided in this section may prescribe any
3 controlled substance listed in Schedule III, IV, or V of section 195.017, and may
4 have restricted authority in Schedule II, when delegated the authority to
5 prescribe controlled substances in a supervision agreement. Such authority shall
6 be listed on the supervision verification form on file with the state board of
7 healing arts. The supervising physician shall maintain the right to limit a
8 specific scheduled drug or scheduled drug category that the physician assistant
9 is permitted to prescribe. Any limitations shall be listed on the supervision
10 form. Prescriptions for Schedule II medications prescribed by a physician
11 assistant with authority to prescribe delegated in a supervision agreement are
12 restricted to only those medications containing hydrocodone. Physician assistants
13 shall not prescribe controlled substances for themselves or members of their
14 families. Schedule III controlled substances and Schedule II - hydrocodone
15 prescriptions shall be limited to a five-day supply without refill**, except that**
16 **buprenorphine may be prescribed for up to a thirty-day supply without**
17 **refill for patients receiving medication assisted treatment for substance**
18 **use disorders under the direction of the supervising**
19 **physician**. Physician assistants who are authorized to prescribe controlled
20 substances under this section shall register with the federal Drug Enforcement
21 Administration and the state bureau of narcotics and dangerous drugs, and shall
22 include the Drug Enforcement Administration registration number on
23 prescriptions for controlled substances.

24 2. The supervising physician shall be responsible to determine and
25 document the completion of at least one hundred twenty hours in a four-month
26 period by the physician assistant during which the physician assistant shall
27 practice with the supervising physician on-site prior to prescribing controlled
28 substances when the supervising physician is not on-site. Such limitation shall
29 not apply to physician assistants of population-based public health services as

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30 defined in 20 CSR 2150-5.100 as of April 30, 2009.
31 3. A physician assistant shall receive a certificate of controlled substance
32 prescriptive authority from the board of healing arts upon verification of the
33 completion of the following educational requirements:
34 (1) Successful completion of an advanced pharmacology course that
35 includes clinical training in the prescription of drugs, medicines, and therapeutic
36 devices. A course or courses with advanced pharmacological content in a
37 physician assistant program accredited by the Accreditation Review Commission
38 on Education for the Physician Assistant (ARC-PA) or its predecessor agency
39 shall satisfy such requirement;
40 (2) Completion of a minimum of three hundred clock hours of clinical
41 training by the supervising physician in the prescription of drugs, medicines, and
42 therapeutic devices;
43 (3) Completion of a minimum of one year of supervised clinical practice
44 or supervised clinical rotations. One year of clinical rotations in a program
45 accredited by the Accreditation Review Commission on Education for the
46 Physician Assistant (ARC-PA) or its predecessor agency, which includes
47 pharmacotherapeutics as a component of its clinical training, shall satisfy such
48 requirement. Proof of such training shall serve to document experience in the
49 prescribing of drugs, medicines, and therapeutic devices;
50 (4) A physician assistant previously licensed in a jurisdiction where
51 physician assistants are authorized to prescribe controlled substances may obtain
52 a state bureau of narcotics and dangerous drugs registration if a supervising
53 physician can attest that the physician assistant has met the requirements of
54 subdivisions (1) to (3) of this subsection and provides documentation of existing
55 federal Drug Enforcement Agency registration.

337.025. 1. The provisions of this section shall govern the education and
2 experience requirements for initial licensure as a psychologist for the following
3 persons:
4 (1) A person who has not matriculated in a graduate degree program
5 which is primarily psychological in nature on or before August 28, 1990; and
6 (2) A person who is matriculated after August 28, 1990, in a graduate
7 degree program designed to train professional psychologists.
8 2. Each applicant shall submit satisfactory evidence to the committee that
9 the applicant has received a doctoral degree in psychology from a recognized
10 educational institution, and has had at least one year of satisfactory supervised
11 professional experience in the field of psychology.

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12 3. A doctoral degree in psychology is defined as:

13 (1) A program accredited, or provisionally accredited, by the American
14 Psychological Association [or] **(APA),** the Canadian Psychological Association
15 **(CPA), or the Psychological Clinical Science Accreditation System**
16 **(PCSAS); provided that, such program includes a supervised practicum,**
17 **internship, field, or laboratory training appropriate to the practice of**
18 **psychology**; or

19 (2) A program designated or approved, including provisional approval, by
20 the Association of State and Provincial Psychology Boards or the Council for the
21 National Register of Health Service Providers in Psychology, or both; or

22 (3) A graduate program that meets all of the following criteria:

23 (a) The program, wherever it may be administratively housed, shall be
24 clearly identified and labeled as a psychology program. Such a program shall
25 specify in pertinent institutional catalogues and brochures its intent to educate
26 and train professional psychologists;

27 (b) The psychology program shall stand as a recognizable, coherent
28 organizational entity within the institution of higher education;

29 (c) There shall be a clear authority and primary responsibility for the core
30 and specialty areas whether or not the program cuts across administrative lines;

31 (d) The program shall be an integrated, organized, sequence of study;

32 (e) There shall be an identifiable psychology faculty and a psychologist
33 responsible for the program;

34 (f) The program shall have an identifiable body of students who are
35 matriculated in that program for a degree;

36 (g) The program shall include a supervised practicum, internship, field,
37 or laboratory training appropriate to the practice of psychology;

38 (h) The curriculum shall encompass a minimum of three academic years
39 of full-time graduate study, with a minimum of one year's residency at the
40 educational institution granting the doctoral degree; and

41 (i) Require the completion by the applicant of a core program in
42 psychology which shall be met by the completion and award of at least one three-
43 semester-hour graduate credit course or a combination of graduate credit courses
44 totaling three semester hours or five quarter hours in each of the following areas:

45 a. The biological bases of behavior such as courses in: physiological
46 psychology, comparative psychology, neuropsychology, sensation and perception,
47 psychopharmacology;

48 b. The cognitive-affective bases of behavior such as courses in: learning,

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49 thinking, motivation, emotion, and cognitive psychology;
50 c. The social bases of behavior such as courses in: social psychology,
51 group processes/dynamics, interpersonal relationships, and organizational and
52 systems theory;
53 d. Individual differences such as courses in: personality theory, human
54 development, abnormal psychology, developmental psychology, child psychology,
55 adolescent psychology, psychology of aging, and theories of personality;
56 e. The scientific methods and procedures of understanding, predicting and
57 influencing human behavior such as courses in: statistics, experimental design,
58 psychometrics, individual testing, group testing, and research design and
59 methodology.
60 4. Acceptable supervised professional experience may be accrued through
61 preinternship, internship, predoctoral postinternship, or postdoctoral
62 experiences. The academic training director or the postdoctoral training
63 supervisor shall attest to the hours accrued to meet the requirements of this
64 section. Such hours shall consist of:
65 (1) A minimum of fifteen hundred hours of experience in a successfully
66 completed internship to be completed in not less than twelve nor more than
67 twenty-four months; and
68 (2) A minimum of two thousand hours of experience consisting of any
69 combination of the following:
70 (a) Preinternship and predoctoral postinternship professional experience
71 that occurs following the completion of the first year of the doctoral program or
72 at any time while in a doctoral program after completion of a master's degree in
73 psychology or equivalent as defined by rule by the committee;
74 (b) Up to seven hundred fifty hours obtained while on the internship
75 under subdivision (1) of this subsection but beyond the fifteen hundred hours
76 identified in subdivision (1) of this subsection; or
77 (c) Postdoctoral professional experience obtained in no more than twenty-
78 four consecutive calendar months. In no case shall this experience be
79 accumulated at a rate of more than fifty hours per week. Postdoctoral supervised
80 professional experience for prospective health service providers and other
81 applicants shall involve and relate to the delivery of psychological services in
82 accordance with professional requirements and relevant to the applicant's
83 intended area of practice.
84 5. Experience for those applicants who intend to seek health service
85 provider certification and who have completed a program in one or more of the

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86 American Psychological Association designated health service provider delivery
87 areas shall be obtained under the primary supervision of a licensed psychologist
88 who is also a health service provider or who otherwise meets the requirements for
89 health service provider certification. Experience for those applicants who do not
90 intend to seek health service provider certification shall be obtained under the
91 primary supervision of a licensed psychologist or such other qualified mental
92 health professional approved by the committee.

93 6. For postinternship and postdoctoral hours, the psychological activities
94 of the applicant shall be performed pursuant to the primary supervisor's order,
95 control, and full professional responsibility. The primary supervisor shall
96 maintain a continuing relationship with the applicant and shall meet with the
97 applicant a minimum of one hour per month in face-to-face individual
98 supervision. Clinical supervision may be delegated by the primary supervisor to
99 one or more secondary supervisors who are qualified psychologists. The
100 secondary supervisors shall retain order, control, and full professional
101 responsibility for the applicant's clinical work under their supervision and shall
102 meet with the applicant a minimum of one hour per week in face-to-face
103 individual supervision. If the primary supervisor is also the clinical supervisor,
104 meetings shall be a minimum of one hour per week. Group supervision shall not
105 be acceptable for supervised professional experience. The primary supervisor
106 shall certify to the committee that the applicant has complied with these
107 requirements and that the applicant has demonstrated ethical and competent
108 practice of psychology. The changing by an agency of the primary supervisor
109 during the course of the supervised experience shall not invalidate the supervised
110 experience.

111 7. The committee by rule shall provide procedures for exceptions and
112 variances from the requirements for once a week face-to-face supervision due to
113 vacations, illness, pregnancy, and other good causes.

337.029. 1. A psychologist licensed in another jurisdiction who has had
2 no violations and no suspensions and no revocation of a license to practice
3 psychology in any jurisdiction may receive a license in Missouri, provided the
4 psychologist passes a written examination on Missouri laws and regulations
5 governing the practice of psychology and meets one of the following criteria:

6 (1) Is a diplomate of the American Board of Professional Psychology;

7 (2) Is a member of the National Register of Health Service Providers in
8 Psychology;

9 (3) Is currently licensed or certified as a psychologist in another

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jurisdiction who is then a signatory to the Association of State and Provincial Psychology Board's reciprocity agreement;

(4) Is currently licensed or certified as a psychologist in another state, territory of the United States, or the District of Columbia and:

(a) Has a doctoral degree in psychology from a program accredited, or provisionally accredited, by the American Psychological Association **or the Psychological Clinical Science Accreditation System,** or that meets the requirements as set forth in subdivision (3) of subsection 3 of section 337.025;

(b) Has been licensed for the preceding five years; and

(c) Has had no disciplinary action taken against the license for the preceding five years; or

(5) Holds a current certificate of professional qualification (CPQ) issued by the Association of State and Provincial Psychology Boards (ASPPB).

2. Notwithstanding the provisions of subsection 1 of this section, applicants may be required to pass an oral examination as adopted by the committee.

3. A psychologist who receives a license for the practice of psychology in the state of Missouri on the basis of reciprocity as listed in subsection 1 of this section or by endorsement of the score from the examination of professional practice in psychology score will also be eligible for and shall receive certification from the committee as a health service provider if the psychologist meets one or more of the following criteria:

(1) Is a diplomate of the American Board of Professional Psychology in one or more of the specialties recognized by the American Board of Professional Psychology as pertaining to health service delivery;

(2) Is a member of the National Register of Health Service Providers in Psychology; or

(3) Has completed or obtained through education, training, or experience the requisite knowledge comparable to that which is required pursuant to section 337.033.

337.033. 1. A licensed psychologist shall limit his or her practice to demonstrated areas of competence as documented by relevant professional education, training, and experience. A psychologist trained in one area shall not practice in another area without obtaining additional relevant professional education, training, and experience through an acceptable program of respecialization.

2. A psychologist may not represent or hold himself or herself out as a

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8 state certified or registered psychological health service provider unless the
9 psychologist has first received the psychologist health service provider
10 certification from the committee; provided, however, nothing in this section shall
11 be construed to limit or prevent a licensed, whether temporary, provisional or
12 permanent, psychologist who does not hold a health service provider certificate
13 from providing psychological services so long as such services are consistent with
14 subsection 1 of this section.

15 3. "Relevant professional education and training" for health service
16 provider certification, except those entitled to certification pursuant to subsection
17 5 or 6 of this section, shall be defined as a licensed psychologist whose graduate
18 psychology degree from a recognized educational institution is in an area
19 designated by the American Psychological Association as pertaining to health
20 service delivery or a psychologist who subsequent to receipt of his or her graduate
21 degree in psychology has either completed a respecialization program from a
22 recognized educational institution in one or more of the American Psychological
23 Association recognized clinical health service provider areas and who in addition
24 has completed at least one year of postdegree supervised experience in such
25 clinical area or a psychologist who has obtained comparable education and
26 training acceptable to the committee through completion of postdoctoral
27 fellowships or otherwise.

28 4. The degree or respecialization program certificate shall be obtained
29 from a recognized program of graduate study in one or more of the health service
30 delivery areas designated by the American Psychological Association as
31 pertaining to health service delivery, which shall meet one of the criteria
32 established by subdivisions (1) to (3) of this subsection:

33 (1) A doctoral degree or completion of a recognized respecialization
34 program in one or more of the American Psychological Association designated
35 health service provider delivery areas which is accredited, or provisionally
36 accredited, **either** by the American Psychological Association **or the**
37 **Psychological Clinical Science Accreditation System**; or

38 (2) A clinical or counseling psychology doctoral degree program or
39 respecialization program designated, or provisionally approved, by the Association
40 of State and Provincial Psychology Boards or the Council for the National
41 Register of Health Service Providers in Psychology, or both; or

42 (3) A doctoral degree or completion of a respecialization program in one
43 or more of the American Psychological Association designated health service
44 provider delivery areas that meets the following criteria:

45 (a) The program, wherever it may be administratively housed, shall be
46 clearly identified and labeled as being in one or more of the American
47 Psychological Association designated health service provider delivery areas;
48 (b) Such a program shall specify in pertinent institutional catalogues and
49 brochures its intent to educate and train professional psychologists in one or more
50 of the American Psychological Association designated health service provider
51 delivery areas.
52 5. A person who is lawfully licensed as a psychologist pursuant to the
53 provisions of this chapter on August 28, 1989, or who has been approved to sit for
54 examination prior to August 28, 1989, and who subsequently passes the
55 examination shall be deemed to have met all requirements for health service
56 provider certification; provided, however, that such person shall be governed by
57 the provisions of subsection 1 of this section with respect to limitation of practice.
58 6. Any person who is lawfully licensed as a psychologist in this state and
59 who meets one or more of the following criteria shall automatically, upon
60 payment of the requisite fee, be entitled to receive a health service provider
61 certification from the committee:
62 (1) Is a diplomate of the American Board of Professional Psychology in one
63 or more of the specialties recognized by the American Board of Professional
64 Psychology as pertaining to health service delivery; or
65 (2) Is a member of the National Register of Health Service Providers in
66 Psychology.
338.202. 1. Notwithstanding any other provision of law to the contrary,
2 unless the prescriber has specified on the prescription that dispensing a
3 prescription for a maintenance medication in an initial amount followed by
4 periodic refills is medically necessary, a pharmacist may exercise his or her
5 professional judgment to dispense varying quantities of maintenance medication
6 per fill, up to the total number of dosage units as authorized by the prescriber on
7 the original prescription, including any refills. Dispensing of the maintenance
8 medication based on refills authorized by the physician or prescriber on the
9 prescription shall be limited to no more than a ninety-day supply of the
10 medication, and the maintenance medication shall have been previously
11 prescribed to the patient for at least a three-month period. **The supply**
12 **limitations provided in this subsection shall not apply if the**
13 **prescription is issued by a practitioner located in another state**
14 **according to and in compliance with the applicable laws of that state**
15 **and the United States or dispensed to a patient who is a member of the**

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16 **United States Armed Forces serving outside the United States.**

17 2. For the purposes of this section, "maintenance medication" is and
18 means a medication prescribed for chronic long-term conditions and that is taken
19 on a regular, recurring basis; except that, it shall not include controlled
20 substances, as defined in and under section 195.010.

374.426. 1. Any entity in the business of delivering or financing health
2 care shall provide data regarding quality of patient care and patient satisfaction
3 to the director of the department of insurance, financial institutions and
4 professional registration. Failure to provide such data as required by the director
5 of the department of insurance, financial institutions and professional
6 registration shall constitute grounds for violation of the unfair trade practices act,
7 sections 375.930 to 375.948.

8 2. In defining data standards for quality of care and patient satisfaction,
9 the director of the department of insurance, financial institutions and
10 professional registration shall:

11 (1) Use as the initial data set the HMO Employer Data and Information
12 Set developed by the National Committee for Quality Assurance;

13 (2) Consult with nationally recognized accreditation organizations,
14 including but not limited to the National Committee for Quality Assurance and
15 the Joint Committee on Accreditation of Health Care Organizations; and

16 (3) Consult with a state committee of a national committee convened to
17 develop standards regarding uniform billing of health care claims.

18 **3. In defining data standards for quality of care and patient**
19 **satisfaction, the director of the department of insurance, financial**
20 **institutions and professional registration shall not require patient**
21 **scoring of pain control.**

22 **4. Beginning August 28, 2018, the director of the department of**
23 **insurance, financial institutions and professional registration shall**
24 **discontinue the use of patient satisfaction scores and shall not make**
25 **them available to the public to the extent allowed by federal law.**

376.811. 1. Every insurance company and health services corporation
2 doing business in this state shall offer in all health insurance policies benefits or
3 coverage for chemical dependency meeting the following minimum standards:

4 (1) Coverage for outpatient treatment through a nonresidential treatment
5 program, or through partial- or full-day program services, of not less than twenty-
6 six days per policy benefit period;

7 (2) Coverage for residential treatment program of not less than twenty-

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8 one days per policy benefit period;
9 (3) Coverage for medical or social setting detoxification of not less than
10 six days per policy benefit period;
11 (4) **Coverage for medication-assisted treatment for substance use**
12 **disorders for use in treating such patient's condition, including opioid-**
13 **use and heroin-use disorders;**
14 **[**(4)**]** **(5)** The coverages set forth in this subsection may be subject to a
15 separate lifetime frequency cap of not less than ten episodes of treatment, except
16 that such separate lifetime frequency cap shall not apply to medical detoxification
17 in a life-threatening situation as determined by the treating physician and
18 subsequently documented within forty-eight hours of treatment to the reasonable
19 satisfaction of the insurance company or health services corporation; and
20 **[**(5)**]** **(6)** The coverages set forth in this subsection:
21 (a) Shall be subject to the same coinsurance, co-payment and deductible
22 factors as apply to physical illness;
23 (b) May be administered pursuant to a managed care program established
24 by the insurance company or health services corporation; and
25 (c) May deliver covered services through a system of contractual
26 arrangements with one or more providers, hospitals, nonresidential or residential
27 treatment programs, or other mental health service delivery entities certified by
28 the department of mental health, or accredited by a nationally recognized
29 organization, or licensed by the state of Missouri.
30 2. In addition to the coverages set forth in subsection 1 of this section,
31 every insurance company, health services corporation and health maintenance
32 organization doing business in this state shall offer in all health insurance
33 policies, benefits or coverages for recognized mental illness, excluding chemical
34 dependency, meeting the following minimum standards:
35 (1) Coverage for outpatient treatment, including treatment through
36 partial- or full-day program services, for mental health services for a recognized
37 mental illness rendered by a licensed professional to the same extent as any other
38 illness;
39 (2) Coverage for residential treatment programs for the therapeutic care
40 and treatment of a recognized mental illness when prescribed by a licensed
41 professional and rendered in a psychiatric residential treatment center licensed
42 by the department of mental health or accredited by the Joint Commission on
43 Accreditation of Hospitals to the same extent as any other illness;
44 (3) Coverage for inpatient hospital treatment for a recognized mental

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45 illness to the same extent as for any other illness, not to exceed ninety days per
46 year;
47 (4) The coverages set forth in this subsection shall be subject to the same
48 coinsurance, co-payment, deductible, annual maximum and lifetime maximum
49 factors as apply to physical illness; and
50 (5) The coverages set forth in this subsection may be administered
51 pursuant to a managed care program established by the insurance company,
52 health services corporation or health maintenance organization, and covered
53 services may be delivered through a system of contractual arrangements with one
54 or more providers, community mental health centers, hospitals, nonresidential or
55 residential treatment programs, or other mental health service delivery entities
56 certified by the department of mental health, or accredited by a nationally
57 recognized organization, or licensed by the state of Missouri.
58 3. The offer required by sections 376.810 to 376.814 may be accepted or
59 rejected by the group or individual policyholder or contract holder and, if
60 accepted, shall fully and completely satisfy and substitute for the coverage under
61 section 376.779. Nothing in sections 376.810 to 376.814 shall prohibit an
62 insurance company, health services corporation or health maintenance
63 organization from including all or part of the coverages set forth in sections
64 376.810 to 376.814 as standard coverage in their policies or contracts issued in
65 this state.
66 4. Every insurance company, health services corporation and health
67 maintenance organization doing business in this state shall offer in all health
68 insurance policies mental health benefits or coverage as part of the policy or as
69 a supplement to the policy. Such mental health benefits or coverage shall include
70 at least two sessions per year to a licensed psychiatrist, licensed psychologist,
71 licensed professional counselor, licensed clinical social worker, or, subject to
72 contractual provisions, a licensed marital and family therapist, acting within the
73 scope of such license and under the following minimum standards:
74 (1) Coverage and benefits in this subsection shall be for the purpose of
75 diagnosis or assessment, but not dependent upon findings; and
76 (2) Coverage and benefits in this subsection shall not be subject to any
77 conditions of preapproval, and shall be deemed reimbursable as long as the
78 provisions of this subsection are satisfied; and
79 (3) Coverage and benefits in this subsection shall be subject to the same
80 coinsurance, co-payment and deductible factors as apply to regular office visits
81 under coverages and benefits for physical illness.

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82 5. If the group or individual policyholder or contract holder rejects the
83 offer required by this section, then the coverage shall be governed by the mental
84 health and chemical dependency insurance act as provided in sections 376.825 to
85 376.836.
86 6. This section shall not apply to a supplemental insurance policy,
87 including a life care contract, accident-only policy, specified disease policy,
88 hospital policy providing a fixed daily benefit only, Medicare supplement policy,
89 long-term care policy, hospitalization-surgical care policy, short-term major
90 medical policy of six months or less duration, or any other supplemental policy
91 as determined by the director of the department of insurance, financial
92 institutions and professional registration.

376.1237. 1. Each health carrier or health benefit plan that offers or
2 issues health benefit plans which are delivered, issued for delivery, continued, or
3 renewed in this state on or after January 1, 2014, and that provides coverage for
4 prescription eye drops shall provide coverage for the refilling of an eye drop
5 prescription prior to the last day of the prescribed dosage period without regard
6 to a coverage restriction for early refill of prescription renewals as long as the
7 prescribing health care provider authorizes such early refill, and the health
8 carrier or the health benefit plan is notified.
9 2. For the purposes of this section, health carrier and health benefit plan
10 shall have the same meaning as defined in section 376.1350.
11 3. The coverage required by this section shall not be subject to any greater
12 deductible or co-payment than other similar health care services provided by the
13 health benefit plan.
14 4. The provisions of this section shall not apply to a supplemental
15 insurance policy, including a life care contract, accident-only policy, specified
16 disease policy, hospital policy providing a fixed daily benefit only, Medicare
17 supplement policy, long-term care policy, short-term major medical policies of six
18 months' or less duration, or any other supplemental policy as determined by the
19 director of the department of insurance, financial institutions and professional
20 registration.
21 **[**5. The provisions of this section shall terminate on January 1, 2020.**]**

376.1550. 1. Notwithstanding any other provision of law to the contrary,
2 each health carrier that offers or issues health benefit plans which are delivered,
3 issued for delivery, continued, or renewed in this state on or after January 1,
4 2005, shall provide coverage for a mental health condition, as defined in this
5 section, and shall comply with the following provisions:

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6 (1) A health benefit plan shall provide coverage for treatment of a mental
7 health condition and shall not establish any rate, term, or condition that places
8 a greater financial burden on an insured for access to treatment for a mental
9 health condition than for access to treatment for a physical health condition. Any
10 deductible or out-of-pocket limits required by a health carrier or health benefit
11 plan shall be comprehensive for coverage of all health conditions, whether mental
12 or physical;

13 (2) The coverages set forth is this subsection:

14 (a) May be administered pursuant to a managed care program established
15 by the health carrier; and

16 (b) May deliver covered services through a system of contractual
17 arrangements with one or more providers, hospitals, nonresidential or residential
18 treatment programs, or other mental health service delivery entities certified by
19 the department of mental health, or accredited by a nationally recognized
20 organization, or licensed by the state of Missouri;

21 (3) A health benefit plan that does not otherwise provide for management
22 of care under the plan or that does not provide for the same degree of
23 management of care for all health conditions may provide coverage for treatment
24 of mental health conditions through a managed care organization; provided that
25 the managed care organization is in compliance with rules adopted by the
26 department of insurance, financial institutions and professional registration that
27 assure that the system for delivery of treatment for mental health conditions does
28 not diminish or negate the purpose of this section. The rules adopted by the
29 director shall assure that:

30 (a) Timely and appropriate access to care is available;

31 (b) The quantity, location, and specialty distribution of health care
32 providers is adequate; and

33 (c) Administrative or clinical protocols do not serve to reduce access to
34 medically necessary treatment for any insured;

35 (4) Coverage for treatment for chemical dependency shall comply with
36 sections 376.779, 376.810 to 376.814, and 376.825 to 376.836 and for the purposes
37 of this subdivision the term "health insurance policy" as used in sections 376.779,
38 376.810 to 376.814, and 376.825 to 376.836, the term "health insurance policy"
39 shall include group coverage.

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

41 (1) "Chemical dependency", the psychological or physiological dependence
42 upon and abuse of drugs, including alcohol, characterized by drug tolerance or

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43 withdrawal and impairment of social or occupational role functioning or both;
44 (2) "Health benefit plan", the same meaning as such term is defined in
45 section 376.1350;
46 (3) "Health carrier", the same meaning as such term is defined in section
47 376.1350;
48 (4) "Mental health condition", any condition or disorder defined by
49 categories listed in the most recent edition of the Diagnostic and Statistical
50 Manual of Mental Disorders **[**except for chemical dependency**]**;
51 (5) "Managed care organization", any financing mechanism or system that
52 manages care delivery for its members or subscribers, including health
53 maintenance organizations and any other similar health care delivery system or
54 organization;
55 (6) "Rate, term, or condition", any lifetime or annual payment limits,
56 deductibles, co-payments, coinsurance, and other cost-sharing requirements, out-
57 of-pocket limits, visit limits, and any other financial component of a health
58 benefit plan that affects the insured.
59 3. This section shall not apply to a health plan or policy that is
60 individually underwritten or provides such coverage for specific individuals and
61 members of their families pursuant to section 376.779, sections 376.810 to
62 376.814, and sections 376.825 to 376.836, a supplemental insurance policy,
63 including a life care contract, accident-only policy, specified disease policy,
64 hospital policy providing a fixed daily benefit only, Medicare supplement policy,
65 long-term care policy, hospitalization-surgical care policy, short-term major
66 medical policies of six months or less duration, or any other supplemental policy
67 as determined by the director of the department of insurance, financial
68 institutions and professional registration.
69 4. Notwithstanding any other provision of law to the contrary, all health
70 insurance policies that cover state employees, including the Missouri consolidated
71 health care plan, shall include coverage for mental illness. Multiyear group
72 policies need not comply until the expiration of their current multiyear term
73 unless the policyholder elects to comply before that time.
74 5. The provisions of this section shall not be violated if the insurer decides
75 to apply different limits or exclude entirely from coverage the following:
76 (1) Marital, family, educational, or training services unless medically
77 necessary and clinically appropriate;
78 (2) Services rendered or billed by a school or halfway house;
79 (3) Care that is custodial in nature;

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80 (4) Services and supplies that are not immediately nor clinically
81 appropriate; or
82 (5) Treatments that are considered experimental.
83 6. The director shall grant a policyholder a waiver from the provisions of
84 this section if the policyholder demonstrates to the director by actual experience
85 over any consecutive twenty-four-month period that compliance with this section
86 has increased the cost of the health insurance policy by an amount that results
87 in a two percent increase in premium costs to the policyholder. The director shall
88 promulgate rules establishing a procedure and appropriate standards for making
89 such a demonstration. Any rule or portion of a rule, as that term is defined in
90 section 536.010, that is created under the authority delegated in this section shall
91 become effective only if it complies with and is subject to all of the provisions of
92 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
93 nonseverable and if any of the powers vested with the general assembly pursuant
94 to chapter 536 to review, to delay the effective date, or to disapprove and annul
95 a rule are subsequently held unconstitutional, then the grant of rulemaking
96 authority and any rule proposed or adopted after August 28, 2004, shall be
97 invalid and void.

630.875. 1. This section shall be known and may be cited as the
2 **"Improved Access to Treatment for Opioid Addictions Act" or "IATOA**
3 **Act".**
4 **2. As used in this section, the following terms mean:**
5 **(1) "Department", the department of mental health;**
6 **(2) "IATOA program", the improved access to treatment for opioid**
7 **addictions program created under subsection 3 of this section.**
8 **3. Subject to appropriations, the department shall create and**
9 **oversee an "Improved Access to Treatment for Opioid Addictions**
10 **Program", which is hereby created and whose purpose is to disseminate**
11 **information and best practices regarding opioid addiction and to**
12 **facilitate collaborations to better treat and prevent opioid addiction in**
13 **this state. The IATOA program shall facilitate partnerships between**
14 **assistant physicians, physician assistants, and advanced practice**
15 **registered nurses practicing in federally qualified health centers, rural**
16 **health clinics, and other health care facilities and physicians practicing**
17 **at remote facilities located in this state. The IATOA program shall**
18 **provide resources that grant patients and their treating assistant**
19 **physicians, physician assistants, advanced practice registered nurses,**

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20 **or physicians access to knowledge and expertise through means such**
21 **as telemedicine and Extension for Community Healthcare Outcomes**
22 **(ECHO) programs established under section 191.1140.**
23 **4. Assistant physicians, physician assistants, and advanced**
24 **practice registered nurses who participate in the IATOA program shall**
25 **complete the necessary requirements to prescribe buprenorphine**
26 **within at least thirty days of joining the IATOA program.**
27 **5. For the purposes of the IATOA program, a remote**
28 **collaborating or supervising physician working with an on-site**
29 **assistant physician, physician assistant, or advanced practice**
30 **registered nurse shall be considered to be on-site. An assistant**
31 **physician, physician assistant, or advanced practice registered nurse**
32 **collaborating with a remote physician shall comply with all laws and**
33 **requirements applicable to assistant physicians, physician assistants,**
34 **or advanced practice registered nurses with on-site supervision before**
35 **providing treatment to a patient.**
36 **6. An assistant physician, physician assistant, or advanced**
37 **practice registered nurse collaborating with a physician who is waiver-**
38 **certified for the use of buprenorphine, may participate in the IATOA**
39 **program in any area of the state and provide all services and functions**
40 **of an assistant physician, physician assistant, or advanced practice**
41 **registered nurse.**
42 **7. The department may develop curriculum and benchmark**
43 **examinations on the subject of opioid addiction and treatment. The**
44 **department may collaborate with specialists, institutions of higher**
45 **education, and medical schools for such development. Completion of**
46 **such a curriculum and passing of such an examination by an assistant**
47 **physician, physician assistant, advanced practice registered nurse, or**
48 **physician shall result in a certificate awarded by the department or**
49 **sponsoring institution, if any.**
50 **8. An assistant physician, physician assistant, or advanced**
51 **practice registered nurse participating in the IATOA program may also:**
52 **(1) Engage in community education;**
53 **(2) Engage in professional education outreach programs with**
54 **local treatment providers;**
55 **(3) Serve as a liaison to courts;**
56 **(4) Serve as a liaison to addiction support organizations;**

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57 **(5) Provide educational outreach to schools;**
58 **(6) Treat physical ailments of patients in an addiction treatment**
59 **program or considering entering such a program;**
60 **(7) Refer patients to treatment centers;**
61 **(8) Assist patients with court and social service obligations;**
62 **(9) Perform other functions as authorized by the department;**
63 **and**
64 **(10) Provide mental health services in collaboration with a**
65 **qualified licensed physician.**
66 **The list of authorizations in this subsection is a nonexclusive list, and**
67 **assistant physicians, physician assistants, or advanced practice**
68 **registered nurses participating in the IATOA program may perform**
69 **other actions.**
70 **9. When an overdose survivor arrives in the emergency**
71 **department, the assistant physician, physician assistant, or advanced**
72 **practice registered nurse serving as a recovery coach or, if the**
73 **assistant physician, physician assistant, or advanced practice**
74 **registered nurse is unavailable, another properly trained recovery**
75 **coach shall, when reasonably practicable, meet with the overdose**
76 **survivor and provide treatment options and support available to the**
77 **overdose survivor. The department shall assist recovery coaches in**
78 **providing treatment options and support to overdose survivors.**
79 **10. The provisions of this section shall supersede any**
80 **contradictory statutes, rules, or regulations. The department shall**
81 **implement the improved access to treatment for opioid addictions**
82 **program as soon as reasonably possible using guidance within this**
83 **section. Further refinement to the improved access to treatment for**
84 **opioid addictions program may be done through the rules process.**
85 **11. The department shall promulgate rules to implement the**
86 **provisions of the improved access to treatment for opioid addictions act**
87 **as soon as reasonably possible. Any rule or portion of a rule, as that**
88 **term is defined in section 536.010, that is created under the authority**
89 **delegated in this section shall become effective only if it complies with**
90 **and is subject to all of the provisions of chapter 536 and, if applicable,**
91 **section 536.028. This section and chapter 536 are nonseverable, and if**
92 **any of the powers vested with the general assembly pursuant to chapter**
93 **536 to review, to delay the effective date, or to disapprove and annul a**

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94 **rule are subsequently held unconstitutional, then the grant of**
95 **rulemaking authority and any rule proposed or adopted after August**
96 **28, 2018, shall be invalid and void.**

632.005. As used in chapter 631 and this chapter, unless the context
2 clearly requires otherwise, the following terms shall mean:
3 (1) "Comprehensive psychiatric services", any one, or any combination of
4 two or more, of the following services to persons affected by mental disorders
5 other than intellectual disabilities or developmental disabilities: inpatient,
6 outpatient, day program or other partial hospitalization, emergency, diagnostic,
7 treatment, liaison, follow-up, consultation, education, rehabilitation, prevention,
8 screening, transitional living, medical prevention and treatment for alcohol abuse,
9 and medical prevention and treatment for drug abuse;
10 (2) "Council", the Missouri advisory council for comprehensive psychiatric
11 services;
12 (3) "Court", the court which has jurisdiction over the respondent or
13 patient;
14 (4) "Division", the division of comprehensive psychiatric services of the
15 department of mental health;
16 (5) "Division director", director of the division of comprehensive
17 psychiatric services of the department of mental health, or his designee;
18 (6) "Head of mental health facility", superintendent or other chief
19 administrative officer of a mental health facility, or his designee;
20 (7) "Judicial day", any Monday, Tuesday, Wednesday, Thursday or Friday
21 when the court is open for business, but excluding Saturdays, Sundays and legal
22 holidays;
23 (8) "Licensed physician", a physician licensed pursuant to the provisions
24 of chapter 334 or a person authorized to practice medicine in this state pursuant
25 to the provisions of section 334.150;
26 (9) "Licensed professional counselor", a person licensed as a professional
27 counselor under chapter 337 and with a minimum of one year training or
28 experience in providing psychiatric care, treatment, or services in a psychiatric
29 setting to individuals suffering from a mental disorder;
30 (10) "Likelihood of serious harm" means any one or more of the following
31 but does not require actual physical injury to have occurred:
32 (a) A substantial risk that serious physical harm will be inflicted by a
33 person upon his own person, as evidenced by recent threats, including verbal
34 threats, or attempts to commit suicide or inflict physical harm on

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35 himself. Evidence of substantial risk may also include information about
36 patterns of behavior that historically have resulted in serious harm previously
37 being inflicted by a person upon himself;
38 (b) A substantial risk that serious physical harm to a person will result
39 or is occurring because of an impairment in his capacity to make decisions with
40 respect to his hospitalization and need for treatment as evidenced by his current
41 mental disorder or mental illness which results in an inability to provide for his
42 own basic necessities of food, clothing, shelter, safety or medical care or his
43 inability to provide for his own mental health care which may result in a
44 substantial risk of serious physical harm. Evidence of that substantial risk may
45 also include information about patterns of behavior that historically have resulted
46 in serious harm to the person previously taking place because of a mental
47 disorder or mental illness which resulted in his inability to provide for his basic
48 necessities of food, clothing, shelter, safety or medical or mental health care; or
49 (c) A substantial risk that serious physical harm will be inflicted by a
50 person upon another as evidenced by recent overt acts, behavior or threats,
51 including verbal threats, which have caused such harm or which would place a
52 reasonable person in reasonable fear of sustaining such harm. Evidence of that
53 substantial risk may also include information about patterns of behavior that
54 historically have resulted in physical harm previously being inflicted by a person
55 upon another person;
56 (11) "Mental health coordinator", a mental health professional who has
57 knowledge of the laws relating to hospital admissions and civil commitment and
58 who is authorized by the director of the department, or his designee, to serve a
59 designated geographic area or mental health facility and who has the powers,
60 duties and responsibilities provided in this chapter;
61 (12) "Mental health facility", any residential facility, public or private, or
62 any public or private hospital, which can provide evaluation, treatment and,
63 inpatient care to persons suffering from a mental disorder or mental illness and
64 which is recognized as such by the department or any outpatient treatment
65 program certified by the department of mental health. No correctional institution
66 or facility, jail, regional center or developmental disability facility shall be a
67 mental health facility within the meaning of this chapter;
68 (13) "Mental health professional", a psychiatrist, resident in psychiatry,
69 **psychiatric physician assistant, psychiatric assistant physician,**
70 **psychiatric advanced practice registered nurse,** psychologist, psychiatric
71 nurse, licensed professional counselor, or psychiatric social worker;

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72 (14) "Mental health program", any public or private residential facility,
73 public or private hospital, public or private specialized service or public or private
74 day program that can provide care, treatment, rehabilitation or services, either
75 through its own staff or through contracted providers, in an inpatient or
76 outpatient setting to persons with a mental disorder or mental illness or with a
77 diagnosis of alcohol abuse or drug abuse which is recognized as such by the
78 department. No correctional institution or facility or jail may be a mental health
79 program within the meaning of this chapter;

80 (15) "Ninety-six hours" shall be construed and computed to exclude
81 Saturdays, Sundays and legal holidays which are observed either by the court or
82 by the mental health facility where the respondent is detained;

83 (16) "Peace officer", a sheriff, deputy sheriff, county or municipal police
84 officer or highway patrolman;

85 (17) **"Psychiatric advanced practice registered nurse", a**
86 **registered nurse who is currently recognized by the board of nursing**
87 **as an advanced practice registered nurse, who has at least two years of**
88 **experience in providing psychiatric treatment to individuals suffering**
89 **from mental disorders;**

90 **(18) "Psychiatric assistant physician", a licensed assistant**
91 **physician under chapter 334 and who has had at least two years of**
92 **experience as an assistant physician in providing psychiatric treatment**
93 **to individuals suffering from mental health disorders;**

94 **(19)** "Psychiatric nurse", a registered professional nurse who is licensed
95 under chapter 335 and who has had at least two years of experience as a
96 registered professional nurse in providing psychiatric nursing treatment to
97 individuals suffering from mental disorders;

98 **(20) "Psychiatric physician assistant", a licensed physician**
99 **assistant under chapter 334 and who has had at least two years of**
100 **experience as a physician assistant in providing psychiatric treatment**
101 **to individuals suffering from mental health disorders or a graduate of**
102 **a postgraduate residency or fellowship for physician assistants in**
103 **psychiatry;**

104 **[**(18)**]** **(21)** "Psychiatric social worker", a person with a master's or
105 further advanced degree from an accredited school of social work, practicing
106 pursuant to chapter 337, and with a minimum of one year training or experience
107 in providing psychiatric care, treatment or services in a psychiatric setting to
108 individuals suffering from a mental disorder;

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109 [(19)] **(22)** "Psychiatrist", a licensed physician who in addition has
110 successfully completed a training program in psychiatry approved by the
111 American Medical Association, the American Osteopathic Association or other
112 training program certified as equivalent by the department;

113 [(20)] **(23)** "Psychologist", a person licensed to practice psychology under
114 chapter 337 with a minimum of one year training or experience in providing
115 treatment or services to mentally disordered or mentally ill individuals;

116 [(21)] **(24)** "Resident in psychiatry", a licensed physician who is in a
117 training program in psychiatry approved by the American Medical Association,
118 the American Osteopathic Association or other training program certified as
119 equivalent by the department;

120 [(22)] **(25)** "Respondent", an individual against whom involuntary civil
121 detention proceedings are instituted pursuant to this chapter;

122 [(23)] **(26)** "Treatment", any effort to accomplish a significant change in
123 the mental or emotional conditions or the behavior of the patient consistent with
124 generally recognized principles or standards in the mental health professions.

Section B. Because immediate action is necessary to save the lives of
2 Missouri citizens who are suffering from the opioid crisis, the repeal and
3 reenactment of sections 195.070, 334.036, and 374.426 and the enactment of
4 sections 9.192, 195.265, and 630.875 of this act are deemed necessary for the
5 immediate preservation of the public health, welfare, peace, and safety, and are
6 hereby declared to be an emergency act within the meaning of the constitution,
7 and the repeal and reenactment of sections 195.070, 334.036, and 374.426 and the
8 enactment of sections 9.192, 195.265, and 630.875 of this act shall be in full force
9 and effect upon their passage and approval.

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