Health Care Appropriations Committee

Meeting Packet

April 9, 2010
8:00 a.m. – 8:30 a.m.
212 Knott

Larry Cretul
Speaker

Denise Grimsley
Chair

AGENDA

Health Care Appropriations Committee
April 9, 2010
8:00 a.m. – 8:30 a.m.
212 Knott

I. Call to Order/Roll Call

II. Opening Remarks

III. Consideration of the following bills:

- CS/HB 225 — Controlled Substances by Health Care Regulation Policy Committee, Legg, Abruzzo
- PCB HCA 10-08 — Public Records by Health Care Appropriations Committee
- CS/CS/HB 355 — Public Safety Telecommunicators by Military & Local Affairs Policy Committee, Health Care Regulation Policy Committee, K. Roberson
- CS/HB 945 — Automated External Defibrillators in Assisted Living Facilities by Elder & Family Services Policy Committee, Anderson

VI. Closing Remarks/Adjournment

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 225 Controlled Substances
SPONSOR(S): Health Care Regulation Policy Committee
TIED BILLS: **IDEN./SIM. BILLS:**

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.:	Health Care Regulation Policy Committee	12 Y, 1 N, As CS	Calamas	Calamas
1)	Health Care Appropriations Committee		Clark	Massengale
2)				
3)				
4)				
5)				

SUMMARY ANALYSIS

The Committee Substitute for House Bill 225 increases regulation and provides for public-private partnerships to address prescription drug abuse.

The bill requires pharmacies to participate in a multi-state electronic prescribing network, and requires pharmacies to transmit dispensing information for controlled substances through the network. The bill makes these provisions effective July 1, 2012, and January 1, 2013, for new and existing pharmacies, respectively. The bill requires the Agency for Health Care Administration to negotiate access for law enforcement and state regulatory entities to controlled substance information through a multi-state electronic prescribing network.

The bill adds new requirements for pain clinic registration by prohibiting the Department of Health from registering pain clinics owned by non-physicians, pain clinics employing or contracting with a physician against whom regulatory action has been taken related to drug or alcohol abuse, and pain clinics with owners who have certain felony drug convictions. The bill also amends the definition of "clinics" to make it applicable to entities that are primarily engaged in the treatment pain by prescribing or dispensing controlled substances, as opposed to other methods of pain treatment.

The bill adds practitioner regulations and penalties. It makes physician advertising of controlled substances and practicing medicine in an unregistered clinic, which is required to be registered, grounds for licensure action. It prohibits dispensing practitioners from dispensing more than a 72-hour supply of controlled substances listed in Schedules II and III. Certain medication samples are exempt from the dispensing limit, and the bill does not prohibit physicians from prescribing controlled substances in any way. Under the bill's provisions, patients who receive prescriptions for controlled substances would fill them at pharmacies, rather than in physician offices or clinics. The bill makes violation of the dispensing limit a felony of the third degree.

The bill appears to have no fiscal impact on local government. The fiscal impact to the state as a result of the enforcement felony of the third degree would be insignificant. The Agency for Health Care Administration is authorized to seek private grants and donations to establish state access to the private multi-state electronic prescribing network data.

The bill provides an effective date of July 1, 2010.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Controlled Substance Dispensing

Chapter 893, Florida Statutes, sets forth the Florida Comprehensive Drug Abuse Prevention and Control Act.[1] Controlled substances are classified into five schedules to regulate the manufacture, distribution, preparation, and dispensing of the substances. Substances in Schedule I have a high potential for abuse and have no currently accepted medical use in the United States. Schedule II drugs have a high potential for abuse and a severely restricted medical use. Cocaine and morphine are examples of Schedule II drugs. Schedule III controlled substances have less potential for abuse than Schedule I or Schedule II substances and have some accepted medical use. Substances listed in Schedule III include anabolic steroids, codeine, and derivatives of barbituric acid. Schedule IV and Schedule V substances have a low potential for abuse, compared to substances in Schedules I, II, and III, and currently have accepted medical use. Substances in Schedule IV include phenobarbital, librium, and valium. Substances in Schedule V include certain stimulants and narcotic compounds.

Pharmacists and Pharmacies

Section 893.04, Florida Statutes, authorizes a pharmacist, in good faith and in the course of professional practice to dispense controlled substances upon a written or oral prescription under specified conditions:

- An oral prescription must be promptly reduced to writing by the pharmacist;
- The written prescription must be dated and signed by the prescribing practitioner on the date issued; and
- The face of the prescription or written record for the controlled substance must include:
  - The full name and address of the person for whom, or the owner of the animal for which, the controlled substance is dispensed;
  - The full name and address of the prescribing practitioner and the prescriber's federal controlled substance registry number;
  - If the prescription is for an animal, the species of animal for which the controlled substance is prescribed;
  - The name of the controlled substance prescribed and the strength, quantity, and directions for the use thereof;

[1] *See, also,* the federal Controlled Substances Act, 21 U.S.C. 812.

- The number of the prescription, as recorded in the prescription files of the pharmacy in which it is filed; and
- The initials of the pharmacist filling the prescription and the date filled.

Section 893.04(1)(d), Florida Statutes, requires the pharmacy in which a prescription for controlled substances is filled to retain the prescription on file for a period of 2 years. The original container in which a controlled substance is dispensed must bear a label with the following information:

- The name and address of the pharmacy from which the controlled substance was dispensed;
- The date on which the prescription for the controlled substance was filled;
- The number of the prescription, as recorded in the prescription files of the pharmacy in which it is filled;
- The name of the prescribing practitioner;
- The name of the patient for whom, or of the owner and species of the animal for which, the controlled substance is prescribed;
- The directions for the use of the controlled substance prescribed in the prescription; and
- A clear, concise warning that it is a crime to transfer the controlled substance to any person other than the patient for whom prescribed.

Chapter 893, Florida Statutes, imposes other limitations on controlled substance prescriptions. A prescription for a Schedule II controlled substance may be dispensed only upon a written prescription of a practitioner, except in an emergency situation, as defined by rule of the department. No prescription for a Schedule II controlled substance may be refilled.[2] No prescription for a controlled substance listed in Schedules III, IV, or V may be filled or refilled more than five times within a period of 6 months after the date on which the prescription was written unless the prescription is renewed by a practitioner.[3] A pharmacist may dispense a one-time emergency refill of up to a 72-hour supply of a prescribed medication, except for those listed in Schedule II.[4]

In addition to these requirements for dispensing controlled substances, pharmacies must comply with regulations that apply to all dispensing. A pharmacy cannot dispense a medication if the prescription is not based on a "valid practitioner-patient relationship." Such a relationship includes "a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed."[5] Department of Health rules apply this standard to controlled substances:[6]

> The following criteria shall cause a pharmacist to question whether a prescription was issued for a legitimate medical purpose:
> (a) Frequent loss of controlled substance medications;
> (b) Only controlled substance medications are prescribed for a patient;
> (c) One person presents controlled substance prescriptions with different patient names;
> (d) Same or similar controlled substance medication is prescribed by two or more prescribers at same time; and
> (e) Patient always pays cash and always insists on brand name product.

If any of those criteria are met, the pharmacy must copy the patient's photo identification for its records, and confirm the prescription with the physician. The Department of Health inspects pharmacies at least once a year to ensure compliance with statutory and regulatory requirements.[7]

---

[2] s. 893.04(1)(f), F.S.
[3] s. 893.04(1)(g), F.S.
[4] *See* 21 C.F.R. 1306.11(d)(1), which provides that in an emergency situation, a pharmacist may dispense a Schedule II controlled substance upon receiving oral authorization of a prescribing practitioner if the quantity prescribed and dispensed is limited to the amount adequate to treat the patient during the emergency period.
[5] S. 465.023(1)(h), F.S.
[6] Rule 64B16-27.831, F.A.C.
[7] Rule 64B16-28.101, F.A.C.

Physicians

Section 893.05, Florida Statutes, allows a practitioner, in good faith and in the course of professional practice only, to prescribe, administer, dispense, mix, or otherwise prepare a controlled substance. "Practitioner" means a licensed medical physician, a licensed dentist, a licensed veterinarian, a licensed osteopathic physician, a licensed naturopathic physician, or a licensed podiatrist, if such practitioner holds a valid federal controlled substance registry number.[8] Physician dispensing is regulated by the relevant medical boards within the Department of Health.

To dispense medications, rather than just prescribe them, physicians must register with the department and pay a fee of $100.[9] Physicians who only dispense complimentary medications, and who receive no direct or indirect payment or remuneration for the medications, are not required to register.[10] There are 7,108 registered dispensing practitioners in Florida.[11]

The Department must inspect any facility in which a physician dispenses medication, such as a physician office or medical clinic, with the same frequency as it inspects pharmacies, that is, at least once a year (see above).[12] Dispensing physicians are required to comply with all state and federal laws and regulations applicable to pharmacists and pharmacies (see above).[13] For example, a pharmacy is not permitted to dispense a drug if the prescription is not based on a valid practitioner-patient relationship, which requires a patient history and a physical examination adequate to establish the diagnosis. This requirement also applies to dispensing physicians.

Dispensing Prohibitions

Currently, Florida law allows registered physicians to dispense any prescribed drug. Other states have varying degrees of regulation. Twenty states allow dispensing and require some form of dispensing license.[14] Twenty-three states allow dispensing, but do not require any license. One state allows dispensing, but requires a license to dispense controlled substances.

Some states prohibit physician dispensing entirely.[15] Montana, Texas and Utah prohibit all physician dispensing; Massachusetts allows physicians to dispense only a 72-hour supply for emergencies. These states do not distinguish between controlled substances and other medications; all are included in the prohibition.

Electronic Prescribing

Electronic prescribing is the electronic generation and transmission of a patient's prescription by a health care practitioner at the point of care. It includes two major functions: two-way electronic communication between physicians and pharmacies regarding new prescriptions, refills, change requests, prescription cancellations, and patient compliance; and communication with other health care partners, like payers, related to eligibility, formularies and medication history.[16]

Electronic prescribing involves a secure, electronic connection between the physician and the pharmacy. In addition, electronic prescribing software generally allows a healthcare practitioner to not only securely access the patient's health plan formulary, but also the patient's medication history, all at the point of care. Medication history is generally available in an 11- to 24-month rolling window, and it generally includes both written and electronically transmitted prescriptions. Numerous software companies offer stand-alone

---

[8] S. 893.02, F.S.
[9] S. 465.0276(2)(a), F.S.; Rule 64B8-3.006, F.A.C.
[10] S. 465.0276(5), F.S.
[11] Provided by the Department of Health via email to committee staff, dated February 1, 2010, on file with the committee. This number includes 935 advanced registered nurse practitioners, 230 dentists, 4,925 medical doctors, 855 osteopathic physicians, 119 podiatric physicians, and 44 optometrists,
[12] S. 465.0276(3), F.S.
[13] S. 465.0276(2)(a), F.S.
[14] Dispensing Regulations by State, American Academy of Urgent Care Medicine, *see* http://aaucm.org/Professionals/MedicalClinicalNews/DispensingRegulations/default.aspx (last viewed January 30, 2010).
[15] *Id.*
[16] Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, Second Annual Florida Electronic Prescribing Report, January 2009, 2, *see* http://www.fhin.net/eprescribe/Index.shtml (last viewed February 23, 2010).

electronic prescribing products. While the cost of the product varies, some products are available at no cost to the healthcare practitioner.[17]

Section 408.0611, Florida Statutes, created in 2007, requires AHCA to work with private-sector initiatives and relevant stakeholders to create a "clearinghouse" of information on electronic prescribing for healthcare practitioners, facilities, and pharmacies. AHCA developed a website that provides information on the process and advantages of electronic prescribing, the availability of electronic prescribing software, including no-cost and low-cost software, and state and federal electronic prescribing incentive programs.[18] AHCA also reports annually to the Governor and Legislature on the implementation of electronic prescribing by health care practitioners, facilities and pharmacies.

According to AHCA and the Institute of Medicine, electronic prescribing offers numerous benefits, including:[19]

- Reduced health care and legal costs by preventing medication prescription errors caused by events such as illegible hand writing, look-alike or sound-alike drugs, drug-to-drug interactions, incorrect dosing, drug allergy reactions, duplication of drugs, etc.;
- Real-time communications between doctors, pharmacies and patients;
- Provision of drug pricing, payer coverage and preferred drug information;
- Improved clinical outcomes by creating complete patient medication history and providing critical drug alerts and patient specific information at the health care professionals' fingertips; and
- Reduction of fraud and crime by increasing the security of prescriptions.

According to AHCA's most recent report, E-prescribing improved prescription security by providing a complete audit trail of each transaction, from the prescribing physician's office to the dispensing pharmacy, to the patient picking up the prescription. E-prescribing requires a secure log-in process for prescribing practitioners and pharmacies, which must be credentialed and approved before they can participate.[20,21] E-prescribing provides an additional back-up for prescription records, which makes it useful in situations of natural disaster when paper records may be destroyed.[22]

The use of e-prescribing is rising. Of the 6,157 pharmacies in Florida in 2008, 71.33 percent were activated to receive electronic prescriptions, an increase from 63 percent in 2007.[23] Similarly, in 2007 the highest monthly total of e-prescribing healthcare professionals was 2,331. The highest monthly total of e-prescribing physicians in 2008 was 4,492, an increase of 92.75 percent.[24] Among e-prescribers, the number of e-prescriptions issued per month rose 72 percent between 2007 and 2008.[25]

---

[17] *See e.g.,* http://www.nationalerx.com/ and http://www.iscribe.com/ (offering free web-based electronic prescribing software) (last viewed February 23, 2010); Florida ePrescribe Clearinghouse, Products and Services, *see* http://www.fhin.net/eprescribe/Technology/products.shtml (last viewed February 23, 2010).

[18] Florida E-Prescribe Clearinghouse, *see* http://www.fhin.net/eprescribe/Index.shtml (last viewed February 23, 2010); Agency for Health Care Administration, *see* http://ahca.myflorida.com/dhit/ElectronicPrescribing/ePrescribeIndex.shtml (last viewed February 23, 2010).

[19] Agency for Health Care Administration, Advantages of ePrescribing, *see* http://www.fhin.net/eprescribe/Benefits/Benefits.shtml (last viewed February 23, 2010), *citing* Institute of Medicine, Committee on Identifying and Preventing Medication Errors, "Preventing Medication Errors: Quality Chasm Series" (2006).

[20] Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, Second Annual Florida Electronic Prescribing Report, January 2009, *see* http://www.fhin.net/eprescribe/Index.shtml (last viewed February 23, 2010): "Secure access is possible using a virtual private network (VPN) connection over the Internet, which creates a protected electronic channel for the safe transmission of encrypted medication information. Infrastructure technology partners, vendors and others are bound through strong contracts to ensure the authentication of users, the integrity of prescriptions, and the privacy and security of personal health information that passes through the secure networks. Unwarranted prescription activity can be identified much more readily in the electronic system through the use of embedded auditing features."

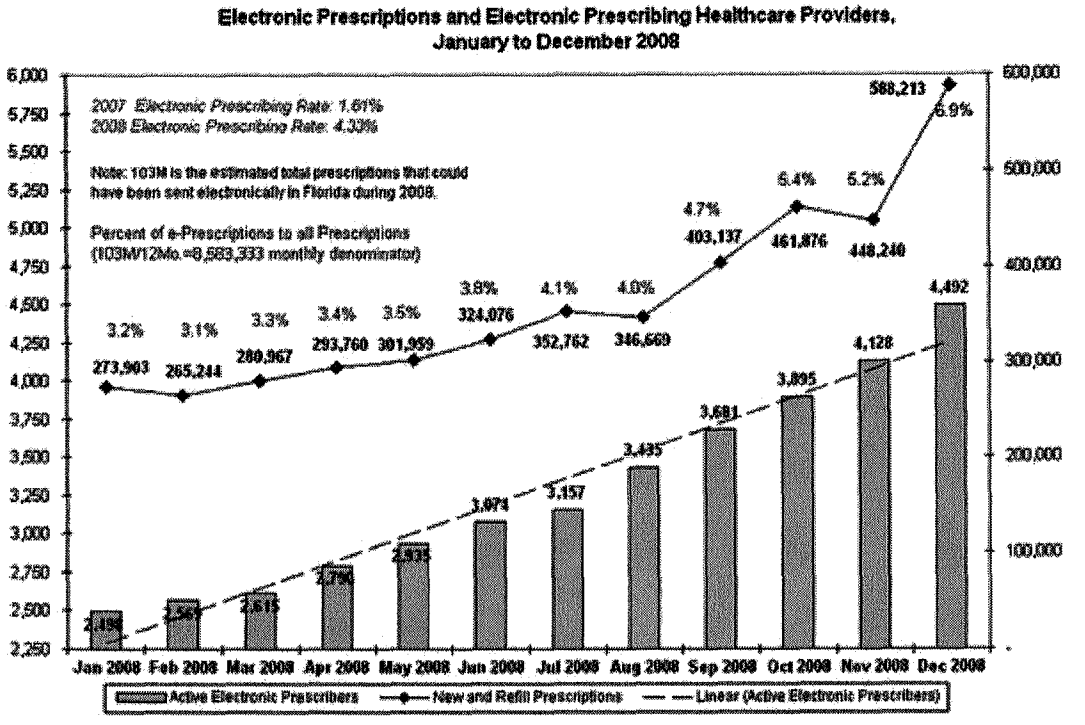
[21] *Id.* at 7.

[22] *Id.*

[23] Agency for Health Care Administration, ePrescribing Clearinghouse, ePrescribing Dashboard 2008 Metrics, *see* http://www.fhin.net/eprescribe/Dashboard/FLmetrics.shtml (last viewed February 23, 2010).

[24] *Id.*

[25] *Id.*



Source: SureScripts-RxHub, *cited in*, Agency for Health Care Administration, ePrescribing Clearinghouse, ePrescribing Dashboard 2008 Metrics.

Controlled Substance E-Prescribing

The Drug Enforcement Administration (DEA) requires every person who dispenses controlled substances to register with the DEA and obtain a unique registration number.[26] All prescriptions for controlled substances must include the DEA registration number of the prescribing practitioner.[27] The DEA prohibits the use of electronic prescribing for controlled substances.[28] On June 27, 2008, the DEA proposed rules that would allow practitioners to issue electronic prescriptions for controlled substances.[29] The proposed rules delineate system requirements for prescribing practitioners e-prescribing vendors, pharmacies, pharmacists, and others. Public comments on the proposed rules were due September 25, 2008, and the DEA received more than 500 comments.[30]

Federal Incentives and Penalties

The 2008 Medicare Improvements for Patients and Providers Act created a Medicare program to encourage physicians to adopt e-prescribing systems.[31] From 2009 through 2014, Medicare will provide incentive payments to eligible health care practitioners who demonstrate "meaningful use" of electronic prescribing. Practitioners will receive a 2 percent incentive payment in 2009 and 2010; a 1 percent incentive payment in 2011 and 2012; and a .5 percent incentive payment in 2013.

Beginning in 2012, Medicare health care practitioners not using electronic prescribing will receive reduced payments for Medicare-covered services: Reimbursements will be reduced 1 percent in 2012, 1.5 percent in 2013, and 2 percent in 2014 and ongoing.[32] Exemptions may be awarded on a case-by-case basis if it is determined that compliance would result in significant hardship for the practitioner.[33]

---

[26] 21 C.F.R. 1301.11 (2010).
[27] 21 C.F.R. 1306.05 (2010).
[28] 21 C.F.R. 1306.05 (2010).
[29] Electronic Prescriptions for Controlled Substances, 73 Fed. Reg. 125 (June 27, 2008), (to be codified at 21 C.F.R. pts. 1300, 1304, 1306, 1311), *see* http://www.gpoaccess.gov/fr/index.html, last viewed February 23, 2010.
[30] Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, Second Annual Florida Electronic Prescribing Report, January 2009, *see* http://www.fhin.net/eprescribe/Index.shtml (last viewed February 23, 2010).
[31] Pub. L. No. 110-275 (2008).
[32] *Id.*
[33] Agency for Health Care Administration, ePrescribing Clearinghouse, ePrescribing Initiatives and Incentive Programs, *see* http://www.fhin.net/eprescribe/ePrescribingInitiatives/NationalIncentivePrograms.shtml (last viewed February 23, 2010).

The 2009 American Recovery and Investment Act (ARRA)[34] authorized approximately $19 billion for additional Medicare and Medicaid incentives to assist providers in adopting health information technology, and for state loan programs. The incentives will be available for five years, starting in 2011.

Electronic Prescribing Networks

To manage health care costs, private sector health care entities established secure internet-based networks for electronically connecting prescribers, dispensers, payers, and pharmacy benefits managers across the country. These e-prescribing networks use private contracting mechanisms to ensure that their technology partners and other affiliates properly authenticate users, maintain prescription integrity, and protect the privacy and security of the health information transmitted through the network. E-prescribing networks use national standards to certify e-prescribing software for use by physicians and pharmacies to participate in the networks.[35]

Until 2008, the two largest e-prescribing networks were RxHub and Surescripts. Both companies were established in 2001. RxHub was founded by three pharmacy benefits management companies, CVS Caremark Corporation, Express Scripts, Inc., and Medco Health Solutions.[36] RxHub focused on providing services related to the delivery of medication information to e-prescribing physicians.[37] Surescripts was created by the National Association of Chain Drug Stores and the National Community Pharmacists Association.[38] Surescripts focused on the provision of services related to electronic communication of prescription information between physicians and pharmacies.[39] In 2008, the two companies merged under the name Surescripts-RxHub, later Surescripts, and became the single largest e-prescribing network, nationally.

According to AHCA, Surescripts does not develop or endorse specific e-prescribing software. Rather, it works with vendors that supply electronic health record and e-prescribing applications to connect their applications to the network.[40] Both stand-alone e-prescribing systems and full electronic medical records systems can be used to connect to the network. There are more than 30 Surescripts-certified technology partners available in Florida.[41]

According to 2009 Surescripts' data, the network has access to 27 payer sources, 49 states have patient accessibility rates of 50 percent or more, and the network accesses more than 220 million patient records annually.[42] Nationally, the network includes major chain pharmacies like Walgreens, CVS, and Wal-Mart, and over 10,000 independent pharmacies.[43] In Florida, more than 8,000 physicians have access to the network, as do the majority of pharmacies. By agreement with AHCA, Florida Medicaid prescription drug data will be added this year.[44] According to Surescripts, the network now includes cash and paper transactions, rather than just electronic and third-party-paid transactions, if the prescribing or dispensing entity uses the network for that purpose.

Prescription Drug Diversion and Abuse

According to the Substance Abuse and Mental Health Services Administration, more than 6.3 million Americans reported using prescription drugs for nonmedical reasons in 2003.[45] Most people who take prescription medications take them responsibly; however, the nonmedical use or abuse of prescription

---

[34] Public Law 111-05 (2009).
[35] Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, Second Annual Florida Electronic Prescribing Report, January 2009, 7, *see* http://www.fhin.net/eprescribe/Index.shtml (last viewed February 23, 2010).
[36] *See*, http://www.surescripts.com/the-company.html.
[37] Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, Second Annual Florida Electronic Prescribing Report, January 2009, 24 *see* http://www.fhin.net/eprescribe/Index.shtml (last viewed February 23, 2010).
[38] *See,* http://www.surescripts.com/the-company.html.
[39] Agency for Health Care Administration, Florida Center for Health Information and Policy Analysis, Second Annual Florida Electronic Prescribing Report, January 2009, 24 *see* http://www.fhin.net/eprescribe/Index.shtml (last viewed February 23, 2010).
[40] *Id* at 2.
[41] Presentation by Tom Groom, Senior Vice President, Surescripts, to the Health Regulation Policy Committee, March 25, 2009.
[42] Presentation by Tom Groom, Senior Vice President, Surescripts, to the Health Regulation Policy Committee, March 25, 2009.
[43] See, http://www.surescripts.com/the-company.html; http://www.surescripts.com/connected-pharmacies.html.
[44] Presentation by Tom Groom, Senior Vice President, Surescripts, to the Health Regulation Policy Committee, March 25, 2009.
[45] Overview of Findings from the 2003 National Survey on Drug Use and Health, *see* http://oas.samhsa.gov/nhsda/2k3nsduh/2k3Overview.htm (last viewed January 30, 2010).

drugs remains a serious public health concern in the United States. Certain prescription drugs—opioid substances, central nervous system depressants, and stimulants—when abused can alter the brain's activity and lead to dependence and possible addiction.

Prescription drug abuse also occurs when a person illegally obtains a legal prescription drug for nonmedical use. People obtain these drugs in a variety of ways, including "doctor shopping," in which the person continually switches physicians so that they can obtain enough of the drug to feed their addiction. By frequently switching physicians, the doctors are unaware that the patient has already been prescribed the same drug and may be abusing it. Some physicians prescribe and dispense medically unjustifiable amounts of controlled substances, and are aware of their patients' abuse.[46]

Use of prescription pain relievers without a doctor's prescription or only for the experience or feeling they cause ("nonmedical" use) is, after marijuana use, the second most common form of illicit drug use in the United States.[47] According to the Drug Abuse Warning Network (DAWN), approximately 324,000 emergency department visits in 2006 involved the nonmedical use of pain relievers (including both prescription and over-the-counter pain medications).[48]

According to research by the National Institute on Drug Abuse,[49] the three most abused classes of prescription drugs are:

- Opioids, used to treat pain. Examples include codeine (Schedules II, III, V), oxycodone (OxyContin, Percocet – Schedule II), and morphine (Kadian, Avinza -Schedule II);
- Central nervous system depressants, used to treat anxiety and sleep disorders. Examples include barbiturates (Mebaral, Nembutal) and benzodiazepines (Valium, Xanax) (all in Schedule IV); and
- Stimulants, used to treat ADHD, narcolepsy, and obesity. Examples include dextroamphetamine (Dexedrine, Adderall) and methylphenidate (Ritalin, Concerta) (all in Schedule II).

The most commonly abused drugs (highlighted below) are found in all four prescribable controlled substance Schedules.[50]

Substance	Other Names
Schedule II - high potential for abuse; severely restricted medical use	
1-Phenylcyclohexylamine	Precursor of PCP
1-Piperidinocyclohexanecarbonitrile	PCC, precursor of PCP
Alfentanil	Alfenta
Alphaprodine	Nisentil
Amobarbital	Amytal, Tuinal
Amphetamine	Dexedrine, Biphetamine
Anileridine	Leritine
Benzoylecgonine	Cocaine metabolite
Bezitramide	Burgodin
Carfentanil	Wildnil

[46] *See*, Press Release, U.S. Att'y No. Dist. Fla., Destin Physician Sentenced to Life Imprisonment for Illegal Distribution of Controlled Substances, *see* http://www.justice.gov/usao/fln/press%20releases/2010/jan/webb.html (last viewed January 30, 2010); The Oxycontin Express (Vanguard, 2009) *see* http://www.hulu.com/watch/100279/vanguard-the-oxycontin-express (last viewed January 30, 2010).

[47] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, Results from the 2007 National Survey on Drug Use and Health: National findings (DHHS Publication No. SMA 08-4343, NSDUH Series H-34) (2008), *see* http://oas.samhsa.gov/p0000016.htm (last viewed January 30, 2010); *cited in*, The NSDUH Report, Trends in Nonmedical Use of Prescription Pain Relievers: 2002 to 2007, Feb. 5, 2009, *see* http://www.oas.samhsa.gov/2k9/painRelievers/nonmedicalTrends.cfm (last viewed January 30, 2010).

[48] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, Drug Abuse Warning Network, 2006: National Estimates of Drug-Related Emergency Department Visits, (August 2008), *see* http://dawninfo.samhsa.gov/files/ED2006/DAWN2K6ED.pdf (last viewed January 30, 2010), *cited in*, The NSDUH Report, Trends in Nonmedical Use of Prescription Pain Relievers: 2002 to 2007, Feb. 5, 2009, *see* http://www.oas.samhsa.gov/2k9/painRelievers/nonmedicalTrends.cfm (last viewed January 30, 2010).

[49] National Institutes of Health, National Institute on Drug Abuse, *see*, http://www.drugabuse.gov/Researchreports/Prescription/prescription2.html.

[50] National Institutes of Health, National Institute on Drug Abuse, *see*, http://www.drugabuse.gov/DrugPages/DrugsofAbuse.html (last viewed January 30, 2010); U.S. Drug Enforcement Administration, *see*, http://www.justice.gov/dea/pubs/scheduling.html (last viewed January 30, 2010). This is a very basic list which describes the parent chemicals, not the salts, isomers and salts of isomers, esters, ethers and derivatives which may also be controlled substances.

Coca Leaves	
Cocaine	Methyl benzoylecgonine, Crack
Codeine	Morphine methyl ester, methyl morphine
Dextropropoxyphene, bulk (non-dosage forms)	Propoxyphene
Dihydrocodeine	Didrate, Parzone
Diphenoxylate	
Diprenorphine	M50-50
Ecgonine	Cocaine precursor, in Coca leaves
Ethylmorphine	Dionin
Etorphine HCl	M 99
Fentanyl	Innovar, Sublimaze, Duragesic
Glutethimide	Doriden, Dorimide
Hydrocodone	dihydrocodeinone
Hydromorphone	Dilaudid, dihydromorphinone
Isomethadone	Isoamidone
Levo-alphacetylmethadol	LAAM, long acting methadone, levomethadyl acetate
Levomethorphan	
Levorphanol	Levo-Dromoran
Meperidine	Demerol, Mepergan, pethidine
Meperidine intermediate-A	Meperidine precursor
Meperidine intermediate-B	Meperidine precursor
Meperidine intermediate-C	Meperidine precursor
Metazocine	
Methadone	Dolophine, Methadose, Amidone
Methadone intermediate	Methadone precursor
Methamphetamine	Desoxyn, D-desoxyephedrine, ICE, Crank, Speed
Methylphenidate	Ritalin
Metopon	
Moramide-intermediate	
Morphine	MS Contin, Roxanol, Duramorph, RMS, MSIR
Nabilone	Cesamet
Opium extracts	
Opium fluid extract	
Opium poppy	Papaver somniferum
Opium tincture	Laudanum
Opium, granulated	Granulated opium
Opium, powdered	Powdered Opium
Opium, raw	Raw opium, gum opium
Oxycodone	OxyContin, Percocet, Tylox, Roxicodone, Roxicet,
Oxymorphone	Numorphan
Pentobarbital	Nembutal
Phenazocine	Narphen, Prinadol
Phencyclidine	PCP, Sernylan
Phenmetrazine	Preludin
Phenylacetone	P2P, phenyl-2-propanone, benzyl methyl ketone
Piminodine	
Poppy Straw	Opium poppy capsules, poppy heads
Poppy Straw Concentrate	Concentrate of Poppy Straw, CPS
Racemethorphan	
Racemorphan	Dromoran
Remifentanil	Ultiva

Secobarbital	Seconal, Tuinal
Sufentanil	Sufenta
Thebaine	Precursor of many narcotics
Schedule III - (less potential for abuse than Schedules I or II substances; some accepted medical use)	
Amobarbital & noncontrolled active ingred.	Amobarbital/ephedrine capsules
Amobarbital suppository dosage form	
Anabolic steroids	"Body Building" drugs
Aprobarbital	Alurate
Barbituric acid derivative	Barbiturates not specifically listed
Benzphetamine	Didrex, Inapetyl
Boldenone	Equipoise, Parenabol, Vebonol, dehydrotestosterone
Buprenorphine	Buprenex, Temgesic
Butabarbital	Butisol, Butibel
Butalbital	Fiorinal, Butalbital with aspirin
Chlorhexadol	Mechloral, Mecoral, Mededorm, Chloralodol
Chlorotestosterone (same as clostebol)	if 4-chlorotestosterone then clostebol
Chlorphentermine	Pre-Sate, Lucofen, Apsedon, Desopimon
Clortermine	Voranil
Clostebol	Alfa-Trofodermin, Clostene, 4-chlorotestosterone
Codeine & isoquinoline alkaloid 90 mg/du	Codeine with papaverine or noscapine
Codeine combination product 90 mg/du	Empirin, Fiorinal, Tylenol, ASA or APAP w/codeine
Dehydrochlormethyltestosterone	Oral-Turinabol
Dihydrocodeine combination product 90 mg/du	Synalgos-DC, Compal
Dihydrotestosterone (same as stanolone)	see stanolone
Dronabinol in sesame oil in soft gelatin capsule	Marinol, synthetic THC in sesame oil/soft gelatin
Drostanolone	Drolban, Masterid, Permastril
Ethylestrenol	Maxibolin, Orabolin, Durabolin-O, Duraboral
Ethylmorphine combination product 15 mg/du	
Fluoxymesterone	Anadroid-F, Halotestin, Ora-Testryl
Formebolone (incorrect spelling in law)	Esiclene, Hubernol
Hydrocodone & isoquinoline alkaloid 15 mg/du	Dihydrocodeinone+papaverine or noscapine
Hydrocodone combination product 15 mg/du	Tussionex, Tussend, Lortab, Vicodin, Hycodan, Anexsia ++
Ketamine	Ketaset, Ketalar, Special K, K
Lysergic acid	LSD precursor
Lysergic acid amide	LSD precursor
Mesterolone	Proviron
Methandienone (see Methandrostenolone)	
Methandranone	
Methandriol	Sinesex, Stenediol, Troformone
Methandrostenolone	Dianabol, Metabolina, Nerobol, Perbolin
Methenolone	Primobolan, Primobolan Depot, Primobolan S
Methyltestosterone	Android, Oreton, Testred, Virilon
Methyprylon	Noludar
Mibolerone	Cheque
Morphine combination product/50 mg/100 ml or gm	
Nalorphine	Nalline
Nandrolone	Deca-Durabolin, Durabolin, Durabolin-50
Norethandrolone	Nilevar, Solevar
Opium combination product 25 mg/du	Paregoric, other combination products
Oxandrolone	Anavar, Lonavar, Provitar, Vasorome
Oxymesterone	Anamidol, Balnimax, Oranabol, Oranabol 10
Oxymetholone	Anadrol-50, Adroyd, Anapolon, Anasteron, Pardroyd

Pentobarbital & noncontrolled active ingred.	FP-3
Pentobarbital suppository dosage form	WANS
Phendimetrazine	Plegine, Prelu-2, Bontril, Melfiat, Statobex
Secobarbital & noncontrolled active ingred	various
Secobarbital suppository dosage form	various
Stanolone	Anabolex, Andractim, Pesomax, dihydrotestosterone
Stanozolol	Winstrol, Winstrol-V
Stimulant compounds previously excepted	Mediatric
Sulfondiethylmethane	
Sulfonethylmethane	
Sulfonmethane	
Talbutal	Lotusate
Testolactone	Teslac
Testosterone	Android-T, Androlan, Depotest, Delatestryl
Thiamylal	Surital
Thiopental	Pentothal
Tiletamine & Zolazepam Combination Product	Telazol
Trenbolone	Finaplix-S, Finajet, Parabolan
Vinbarbital	Delvinal, vinbarbitone
Schedule IV - (less potential for abuse than Schedules I, II, or III substances; some accepted medical use)	
Alprazolam	Xanax
Barbital	Veronal, Plexonal, barbitone
Bromazepam	Lexotan, Lexatin, Lexotanil
Butorphanol	Stadol, Stadol NS, Torbugesic, Torbutrol
Camazepam	Albego, Limpidon, Paxor
Cathine	Constituent of "Khat" plant
Chloral betaine	Beta Chlor
Chloral hydrate	Noctec
Chlordiazepoxide	Librium, Libritabs, Limbitrol, SK-Lygen
Clobazam	Urbadan, Urbanyl
Clonazepam	Klonopin, Clonopin
Clorazepate	Tranxene
Clotiazepam	Trecalmo, Rize
Cloxazolam	Enadel, Sepazon, Tolestan
Delorazepam	
Dexfenfluramine	Redux
Dextropropoxyphene dosage forms	Darvon, propoxyphene, Darvocet, Dolene, Propacet
Diazepam	Valium, Valrelease
Dichloralphenazone	Midrin, dichloralantipyrine
Diethylpropion	Tenuate, Tepanil
Difenoxin 1 mg/25 ug AtSO4/du	Motofen
Estazolam	ProSom, Domnamid, Eurodin, Nuctalon
Ethchlorvynol	Placidyl
Ethinamate	Valmid, Valamin
Ethyl loflazepate	
Fencamfamin	Reactivan
Fenfluramine	Pondimin, Ponderal
Fenproporex	Gacilin, Solvolip
Fludiazepam	
Flunitrazepam	Rohypnol, Narcozep, Darkene, Roipnol
Flurazepam	Dalmane
Halazepam	Paxipam

Haloxazolam	
Ketazolam	Anxon, Loftran, Solatran, Contamex
Loprazolam	
Lorazepam	Ativan
Lormetazepam	Noctamid
Mazindol	Sanorex, Mazanor
Mebutamate	Capla
Medazepam	Nobrium
Mefenorex	Anorexic, Amexate, Doracil, Pondinil
Meprobamate	Miltown, Equanil, Deprol, Equagesic, Meprospan
Methohexital	Brevital
Methylphenobarbital (mephobarbital)	Mebaral, mephobarbital
Midazolam	Versed
Modafinil	Provigil
Nimetazepam	Erimin
Nitrazepam	Mogadon
Nordiazepam	Nordazepam, Demadar, Madar
Oxazepam	Serax, Serenid-D
Oxazolam	Serenal, Convertal
Paraldehyde	Paral
Pemoline	Cylert
Pentazocine	Talwin, Talwin NX, Talacen, Talwin Compound
Petrichloral	Pentaerythritol chloral, Periclor
Phenobarbital	Luminal, Donnatal, Bellergal-S
Phentermine	Ionamin, Fastin, Adipex-P, Obe-Nix, Zantryl
Pinazepam	Domar
Pipradrol	Detaril, Stimolag Fortis
Prazepam	Centrax
Quazepam	Doral, Dormalin
Sibutramine	Meridia
SPA	1-dimethylamino-1,2-diphenylethane, Lefetamine
Temazepam	Restoril
Tetrazepam	
Triazolam	Halcion
Zaleplon	Sonata
Zolpidem	Ambien, Stilnoct,Ivadal
Schedule V - (low potential for abuse compared to Schedule IV substances; some accepted medical use)	
Codeine preparations - 200 mg/100 ml or 100 gm	Cosanyl, Robitussin A-C, Cheracol, Cerose, Pediacof
Difenoxin preparations - 0.5 mg/25 ug AtSO4/du	Motofen
Dihydrocodeine preparations 10 mg/100 ml or 100 gm	Cophene-S, various others
Diphenoxylate preparations 2.5 mg/25 ug AtSO4	Lomotil, Logen
Ethylmorphine preparations 100 mg/100 ml or 100 gm	
Opium preparations - 100 mg/100 ml or gm	Parepectolin, Kapectolin PG, Kaolin Pectin P.G.
Pyrovalerone	Centroton, Thymergix

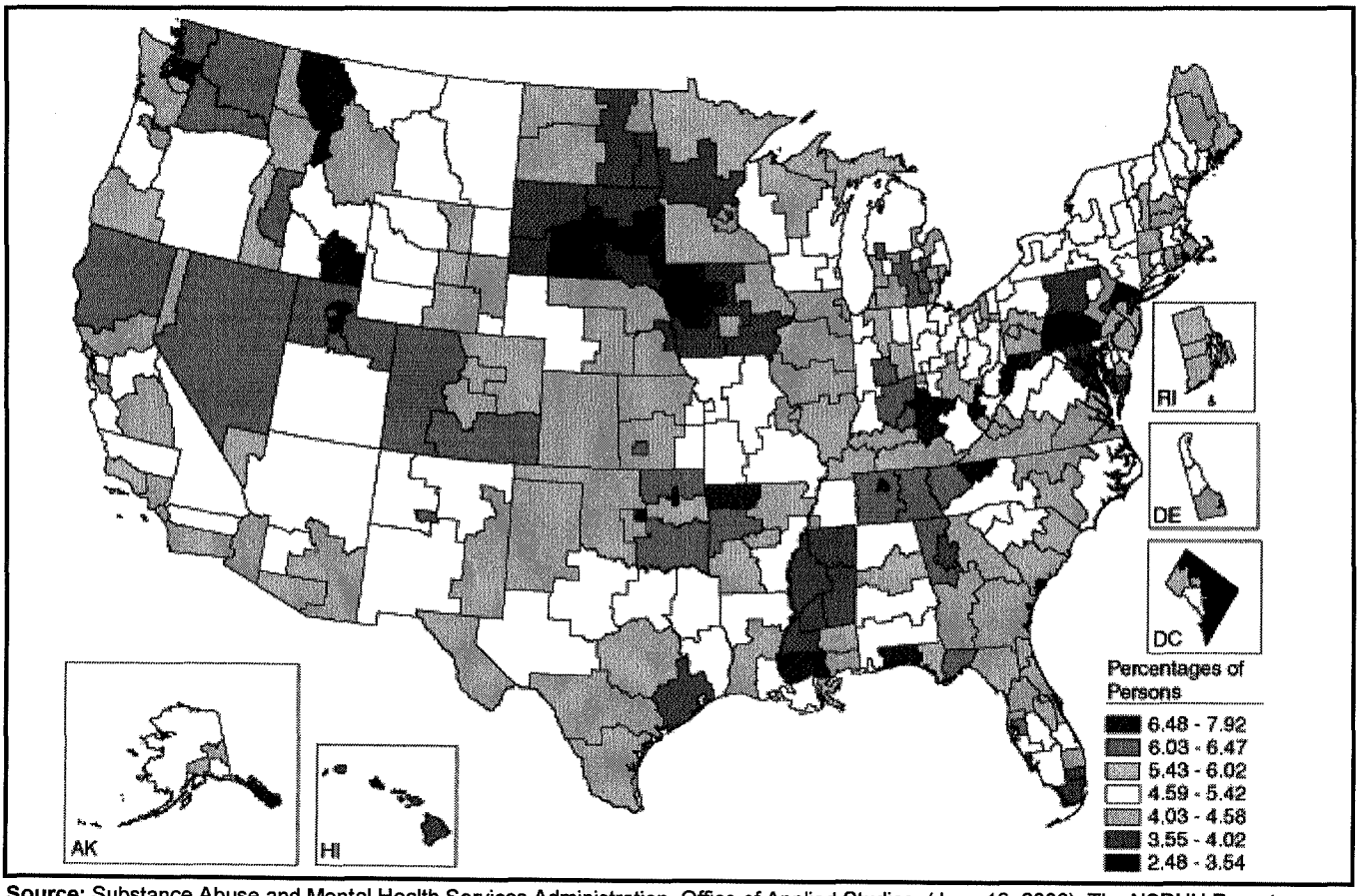
The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors an annual national survey on drug use and health. The most recent survey[51] indicates there are 7.0 million (2.8 percent) persons aged 12 or older who used prescription-type psychotherapeutic drugs nonmedically in the past month. Of these, 5.2 million used pain relievers, an increase from 4.7 million in 2005.

[51] 2006 National Survey on Drug Use and Health, U.S. Substance Abuse and Mental Health Services Administration, *see* http://www.oas.samhsa.gov/nsduh/2k6nsduh/2k6Results.cfm#High (last viewed January 30, 2010).

Of those 7 million people who used pain relievers nonmedically in a 12-month period, 55.7 percent reported they received the drug from a friend or relative for free. Another 9.3 percent bought the drugs from a friend or family member. Another 19.1 percent reported they obtained the drug through just one doctor. Only 3.9 percent got the pain relievers from a drug dealer or other stranger, and only 0.1 percent reported buying the drug on the Internet. Among those who reported getting the pain reliever from a friend or relative for free, 80.7 percent reported in a follow-up question that the friend or relative had obtained the drugs from just one doctor, while only 1.6 percent reported that the friend or relative had bought the drug from a drug dealer or other stranger.[52]

National data indicate that the percent of the population using prescription pain relievers for nonmedical purposes in the past year ranged from a low of 2.48 percent in area of the District of Columbia to a high of 7.92 percent in northwest Florida. In Florida, for example, Palm Beach County measured 4.53 percent; Broward County measured 3.82 percent; Miami-Dade and Monroe Counties measured 3.59 percent; and Escambia, Okaloosa, Santa Rosa and Walton Counties combined measured 7.92 percent.[53]

Figure 1. Nonmedical Use of Pain Relievers in the Past Year among Persons Aged 12 or Older, by Substate Region*: Percentages, Annual Averages Based on 2004, 2005, and 2006 NSDUHs



Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (June 19, 2008). The NSDUH Report: Nonmedical Use of Pain Relievers in Substate Regions: 2004 to 2006.

The Florida Medical Examiners Commission reports on drug-related deaths in Florida, and specifically tracks deaths caused by abuse of prescriptions drugs[54]. According to the commission, prescription drugs are found in deceased persons in lethal amounts more often than illicit drugs.[55] According to the

[52] *Id.*
[53] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, The NSDUH Report: Nonmedical Use of Pain Relievers in Substate Regions: 2004 to 2006, June 19, 2008, *see* http://www.oas.samhsa.gov/2k8/pain/substate.cfm (last viewed January 30, 2010).
[54] Florida Department of Law Enforcement, Medical Examiners Commission, Drugs Identified in Deceased Persons Interim Report, November 2009, *see* http://www.fdle.state.fl.us/content/getdoc/036671bc-4148-4749-a891-7e3932e0a483/Publications.aspx (last viewed January 30, 2010).
[55] *Id.*

commission's data, 1,157 deaths in Florida from January 2009 through June 2009 were caused by prescription drugs, or about 6.3 deaths per day.[56]

According to recent U.S. DEA statistics, the top 25 pain management clinics for dispensing of time release opioids and other pain relievers are all located in Florida.[57] The U.S. Drug Enforcement Administration identified the 50 practitioners who dispense the most Oxycodone in the country. All 50 top-dispensing practitioners are in Florida, and 33 are in Broward County.[58]

Physician Dispensing of Oxycodone, by County[59]

County	Units Oxycodone
Broward	6,584,200
Palm Beach	1,809,400
Miami-Dade	450,000
Pinellas	308,400
Hillsborough	277,300
Lake	220,400
Orange	111,200
Seminole	109,760

Physician Dispensing of Oxycodone in Palm Beach, Broward, Miami-Dade Counties, by Zip Code[60]

Zip Code	Units Oxycodone
33311	1,235,700
33309	775,400
33334	727,600
33407	575,100
33313	442,800
33324	436,600
33009	396,000
33312	340,900
33020	329,000
33162	314,800
33301	285,900
33463	277,500
33417	241,700
33431	227,600
33325	198,800
33483	193,600
33323	186,800
33021	153,600
33487	151,200
33321	143,200
33445	142,700
33016	135,200
33024	130,200
33069	126,600
33023	122,800
33063	118,000
33073	111,900
33317	109,100
33308	107,000
33064	106,300

[56] *Id.*
[57] Data drawn from the Automation of Reports and Consolidated Orders System, U.S. Department of Justice Drug Enforcement Administration, provided by the Florida Office of Drug Control via email March 22, 2009, on file with the Health Regulation Policy Committee, *see* http://www.deadiversion.usdoj.gov/arcos/index.html (last viewed January 30, 2010).
[58] Data drawn from the Automation of Reports and Consolidated Orders System, July-December 2008, U.S. Department of Justice Drug Enforcement Administration, provided by the Florida Office of Drug Control via email March 22, 2009, on file with the Health Regulation Policy Committee, *see* http://www.deadiversion.usdoj.gov/arcos/index.html (last viewed January 30, 2010)
[59] *Id.*
[60] *Id.*

In 2009, the State Attorney for the Seventeenth Judicial Circuit (Broward County) empanelled a grand jury to consider the proliferation of pain clinics in Broward County and their effect on the community, and to make recommendations on what can be done to protect the public from the dangers of pain clinics. The grand jury interim report found that physicians in pain clinics dispense controlled substances directly to patients, rather than the patient going to a pharmacy to fill the prescription. Among other things, the grand jury recommended the state prohibit dispensing prescription drugs in pain clinics.[61]

Prescription Drug Monitoring Program and Pain Clinic Regulation

In the 2009 Regular Session, the Legislature passed Senate bill 462 (chapter 2009-198, Laws of Florida) to address the problem of prescription drug abuse. The bill:

- required the Department of Health to establish a database of controlled substances dispensed to all patients in Florida;
- required all pharmacies and all dispensing physicians to report all controlled substance dispensing to the department within 15 days of dispensing;
- required the department to load the reported dispensing information into the database, and make it available to practitioners, regulators, and criminal justice entities upon their request;
- required all pain clinics, defined as entities that advertise for pain management services or employ a physician who is primarily engaged in the treatment of pain by prescribing or dispensing controlled substances, to register with the department;
- required the medical boards to adopt rules for the standards of medical practice in pain clinics;
- created a task force within the Executive Office of the Governor, chaired by the Office of Drug Control, to monitor and report on the implementation of the database; and
- authorized the Office of Drug Control within the Executive Office of the Governor to establish a direct support organization to solicit public and private funding for the database.

As of January 2010, the department has implemented the clinic registration requirement, and the boards have begun rulemaking on the standards of practice.[62] The Office of Drug Control has established the direct support organization. To date, $400,000 has been generated to fund the database, via a grant from the U.S. Department of Justice awarded to the Department of Children and Families prior to the passage of the bill. Current cost projections for the program are $449,665 in nonrecurring first year costs, and $480,486 in recurring annual costs.[63]

Effect of Proposed Changes

The Committee Substitute for House Bill 225 makes several regulatory changes to address the problem of prescription drug abuse, related to pharmacies, physicians, pain clinics, and access to controlled substance dispensing information.

The bill amends sections 465.018 and 465.023, Florida Statutes, to require pharmacies to participate in a multi-state electronic prescribing network, and require pharmacies to transmit dispensing information for controlled substances through the network. The bill also makes failure to so transmit controlled substance dispensing information grounds for pharmacy permit disciplinary action. The bill makes these provisions effective July 1, 2012, for new pharmacies and January 1, 2013, for existing pharmacies.

The bill creates section 408.0513, Florida Statutes, which requires the Agency for Health Care Administration to negotiate access to controlled substance information through a multi-state electronic prescribing network for law enforcement and state regulatory entities. Access to the information available in the network is limited to criminal justice agencies, as defined in section 119.011, Florida Statutes, engaged in an active investigation involving a specific violation of law, and the department or relevant

[61] The Proliferation of Pain Clinics in South Florida, Interim Report of the Broward County Grand Jury, Circuit Court of the Seventeenth Judicial Circuit, November 19, 2009.
[62] *See,* Rules 64B8-9.0131, 64B8-9.0132, 64B8-9.0133, F.A.C., under development.
[63] PL2009-198 Implementation of the Prescription Drug Monitoring Program & Pain Clinic Registration Florida Department of Health, Florida Department of Health, presentation to the House Health Regulation Policy Committee, January 12, 2010; Prescription Drug Monitoring Program PL2009 – 198 Implementation Status Plan, Florida Office of Drug Control, Executive Office of the Governor, presentation to the House Health Regulation Policy Committee, January 12, 2010.

regulatory board involved in a specific investigation involving a regulated person. Section 119.011 defines "criminal justice agency" as:

- Any law enforcement agency, court, or prosecutor;
- Any other agency charged by law with criminal law enforcement duties;
- Any agency having custody of criminal intelligence information or criminal investigative information for the purpose of assisting law enforcement agencies in the conduct of certain investigations; and
- The Department of Corrections.

The bill amends sections 458.309 and 459.005, Florida Statutes, to add pain clinic registration requirements. It prohibits the Department of Health from registering pain clinics owned by non-physicians, pain clinics employing or contracting with a physician against whom regulatory action has been taken related to drug or alcohol abuse, and pain clinics with owners who have certain felony drug convictions. The bill also amends the definition of "clinics" to make it applicable only to entities that are primarily engaged in the treatment pain by prescribing or dispensing controlled substances, as opposed to other methods of pain treatment.

The bill amends sections 458.331, 459.015 and 465.0276, Florida Statutes, to add practitioner regulations and penalties. It makes advertising controlled substances and practicing medicine in an unregistered clinic which is required to be registered grounds for physician licensure action. It prohibits dispensing practitioners from dispensing more than a 72-hour supply of controlled substances listed in Schedules II and III. The bill exempts medication samples from the dispensing limit, if they are provided with no direct or indirect remuneration. The bill does not prohibit physicians from prescribing controlled substances in any way. Under the bill's provisions, patients who receive prescriptions for controlled substances would fill them at pharmacies, rather than in physician offices or clinics. The bill makes violation of the dispensing limit a felony of the third degree.[64]

The bill authorizes the Agency for Health Care Administration to adopt rules to implement section 408.0513, Florida Statutes.

The bill appears to have no fiscal impact on state or local government. The Agency for Health Care Administration is authorized to seek private grants and donations to implement section 408.0513, Florida Statutes.

The bill provides an effective date of July 1, 2010.

B. SECTION DIRECTORY:

Section 1. Creates s. 408.0513 related to access to prescription drug medication history.
Section 2. Amends s. 458.309, F.S., related to rulemaking authority.
Section 2. Amends s. 458.331, F.S., related to grounds for disciplinary action and action by the board and department.
Section 3. Amends s. 459.005, F.S., related to rulemaking authority.
Section 4. Amends s. 459.015, F.S., related to grounds for disciplinary action and action by the board and department.
Section 5. Amends s. 465.018, F.S., related to community pharmacies and permits.
Section 6. Amends s. 465.023, F.S., related to pharmacy permittees and disciplinary action.
Section 7. Amends s. 465.0276, F.S., related to dispensing practitioners.
Section 8. Provides an effective date of July 1, 2010.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[64] Third degree felonies are punishable by up to 5 years in prison or up to a $5,000 fine (ss. 775.082 and 775.083, F.S.).

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments. According to the Department of Health, which regulates dispensing practitioners, the dispensing limit provisions of the bill have no fiscal impact on the department.

   The fiscal impact to the Department of Corrections as a result of the third degree felony for physicians that dispense Schedule II or III controlled substances beyond the 72-hour limit is indeterminate at this time. This is a likely low volume offense and is therefore anticipated to have an insignificant fiscal effect.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill requires pharmacies to participate in, and transmit controlled substance dispensing information through, a multi-state electronic prescribing network as a condition of permitting. According to the Agency for Health Care Administration, more than 70 percent of pharmacies in Florida are activated to receive electronic prescriptions. Such pharmacies may incur transmission transaction costs if they do not currently use these systems for controlled substance prescriptions. The approximately 30 percent of pharmacies in Florida that0 are not activated to participate in a multi-state e-prescribing network will incur activation costs, which may include computer upgrades, software purchases, licensing agreements, and the above-mentioned transaction costs. These costs will vary with each pharmacy.

D. FISCAL COMMENTS:

The costs of access to information contained in an existing multi-state network are unknown, and are subject to negotiation by the Agency for Health Care Administration. The agency is authorized to seek private grants and donations to implement this provision.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULEMAKING AUTHORITY:

No additional rulemaking authority is required to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

On March 1, 2010, the Health Care Regulation Policy Committee adopted a proposed committee substitute for House Bill 225. The proposed committee substitute made the following changes to HB 225:

- Amended current law to clarify that the pain management clinic registration requirement only applies to clinics that primarily treat pain by prescribing or dispensing controlled substances;
- Deleted the requirement that medical directors of pain management clinics be board-certified in pain management in order to register the clinic with the Department of Health;
- Deleted Schedule IV controlled substances from the list of controlled substances banned from physician dispensing by the bill;
- Made it a felony of the third degree for physicians to dispense Schedule II or III controlled substances beyond the 72-hour limit;
- Excepted unremunerated medication samples from the dispensing prohibition;
- Deleted the requirement for pharmacies not using the multi-state electronic prescribing network for controlled substance dispensing to report that dispensing to the Agency for Health Care Administration;
- Required pharmacies to use the multi-state electronic prescribing network to transmit information on all controlled substance dispensing as a condition of licensure;
- Delayed the effective date for new pharmacies to demonstrate the ability to participate in and transmit information through a multi-state electronic prescribing network to July 1, 2012; and
- Delayed the effective date for existing pharmacies to transmit dispensing information on Schedule II and III controlled substances to January 1, 2013.

The bill was reported favorably as a committee substitute. The analysis reflects the committee substitute.

A bill to be entitled

An act relating to controlled substances; creating s. 408.0513, F.S.; requiring the Agency for Health Care Administration to contract with a multistate electronic prescribing network to provide certain agencies with access to certain controlled substance information; requiring the Agency for Health Care Administration to adopt rules and seek grants and donations; amending ss. 458.309 and 459.005, F.S.; revising requirements for the registration of pain-management clinics; requiring the Department of Health to refuse to register pain-management clinics under certain circumstances; amending ss. 458.331 and 459.015, F.S.; specifying additional grounds for disciplinary action against practitioners licensed under ch. 458 or ch. 459, F.S.; amending s. 465.018, F.S.; requiring community pharmacy permit applicants to demonstrate the ability to participate in and transmit dispensing information through a multistate electronic prescribing network; requiring community pharmacy permittees to transmit dispensing information through such a network for prescriptions of certain controlled substances; amending s. 465.023, F.S.; specifying an additional ground for disciplinary action against community pharmacy permittees; amending s. 465.0276, F.S.; prohibiting registered dispensing practitioners from dispensing more than a specified amount of certain controlled substances; providing penalties; providing exceptions; reenacting ss. 458.303, 458.311(1)(d) and (5),

458.313(6), 458.3135(2)(d), 458.3137(2)(e), 458.3145(1)(g), and 458.345(1)(b) and (2), F.S., relating to provisions not applicable to certain practitioners, licensure of physicians by examination, licensure of physicians by endorsement, temporary certificates for visiting physicians practicing in approved cancer centers, temporary certificates for visiting physicians in conjunction with certain plastic surgery training programs and educational symposiums, medical faculty certificates, and registration of resident physicians, interns, and fellows, respectively, to incorporate the amendment made by this act to s. 458.331, F.S., in references thereto; reenacting s. 459.021(8), F.S., relating to the registration of resident osteopathic physicians, interns, and fellows, to incorporate the amendment made by this act to s. 459.015, F.S., in a reference thereto; providing an effective date.

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

Section 1. Section 408.0513, Florida Statutes, is created to read:

408.0513 Access to prescription drug medication history.—

(1) By December 1, 2010, the agency shall contract with an entity that operates a multistate electronic prescribing network to provide the following agencies with access to the controlled substance information available on such network for the controlled substances listed in Schedules II and III of s.

893.03:

(a) A criminal justice agency as defined in s. 119.011 that enforces the laws of this state or the United States and that initiates an active investigation involving a specific violation of law.

(b) The Department of Health or the relevant health regulatory board responsible for the licensure, regulation, or discipline of practitioners, pharmacists, or other persons who are authorized to prescribe, administer, or dispense controlled substances and who are involved in a specific investigation involving a designated person.

(2) The agency shall adopt rules under ss. 120.536(1) and 120.54 to administer this section, including the method and terms of access to the information provided under subsection (1).

(3) The agency shall seek federal grants and donations from private entities to implement this section.

Section 2. Subsection (4) of section 458.309, Florida Statutes, is amended to read:

458.309 Rulemaking authority.—

(4) All privately owned pain-management clinics, facilities, or offices, hereinafter referred to as "clinics," primarily engaged in the treatment of pain by prescribing or dispensing controlled substances, which advertise in any medium for any type of pain-management services~~,~~ or employ a physician who is primarily engaged in the treatment of pain by prescribing or dispensing controlled substance medications, must register with the department by January 4, 2010, unless that clinic is

licensed as a facility pursuant to chapter 395. The department shall refuse to register any clinic not wholly owned by a physician or group of physicians; any clinic owned by or having any contractual or employment relationship with a physician whose federal Drug Enforcement Administration registration number has ever been suspended or revoked or against whom the board has taken final administrative action relating to the physician's impairment due to the misuse or abuse of alcohol or drugs; or any clinic the ownership or any controlling interest of which is held by any person who has been convicted of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 893. A physician may not practice medicine in a pain-management clinic that is required to register but has not registered with the department. Each clinic location shall be registered separately regardless of whether the clinic is operated under the same business name or management as another clinic. If the clinic is licensed as a health care clinic under chapter 400, the medical director is responsible for registering the facility with the department. If the clinic is not registered pursuant to chapter 395 or chapter 400, the clinic shall, upon registration with the department, designate a physician who is responsible for complying with all requirements related to registration of the clinic. The designated physician shall be licensed under this chapter or chapter 459 and shall practice at the office location for which the physician has assumed responsibility. The department shall inspect the clinic annually to ensure that it complies with rules of the Board of Medicine adopted pursuant to this

subsection and subsection (5) unless the office is accredited by a nationally recognized accrediting agency approved by the Board of Medicine. The actual costs for registration and inspection or accreditation shall be paid by the physician seeking to register the clinic.

Section 3. Paragraph (nn) of subsection (1) of section 458.331, Florida Statutes, is redesignated as paragraph (pp), and new paragraphs (nn) and (oo) are added to that subsection to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(nn) Practicing medicine in a clinic that is required to register but has not registered with the department pursuant to s. 458.309.

(oo) Promoting or advertising through any communication media the use, sale, or dispensing of any controlled substance appearing on any schedule in chapter 893.

Section 4. Subsection (3) of section 459.005, Florida Statutes, is amended to read:

459.005 Rulemaking authority.—

(3) All privately owned pain-management clinics, facilities, or offices, hereinafter referred to as "clinics," primarily engaged in the treatment of pain by prescribing or dispensing controlled substances, which advertise in any medium for any type of pain-management services~~,~~ or employ a physician who is licensed under this chapter and who is primarily engaged

in the treatment of pain by prescribing or dispensing controlled substance medications, must register with the department by January 4, 2010, unless that clinic is licensed as a facility under chapter 395. The department shall refuse to register any clinic not wholly owned by a physician or group of physicians; any clinic owned by or having any contractual or employment relationship with a physician whose federal Drug Enforcement Administration registration number has ever been suspended or revoked or against whom the board has taken final administrative action relating to the physician's impairment due to the misuse or abuse of alcohol or drugs; or any clinic the ownership or any controlling interest of which is held by any person who has been convicted of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 893. A physician may not practice osteopathic medicine in a pain-management clinic that is required to register but has not registered with the department. Each clinic location shall be registered separately regardless of whether the clinic is operated under the same business name or management as another clinic. If the clinic is licensed as a health care clinic under chapter 400, the medical director is responsible for registering the facility with the department. If the clinic is not registered under chapter 395 or chapter 400, the clinic shall, upon registration with the department, designate a physician who is responsible for complying with all requirements related to registration of the clinic. The designated physician shall be licensed under chapter 458 or this chapter and shall practice at the office location for which the physician has assumed

responsibility. The department shall inspect the clinic annually to ensure that it complies with rules of the Board of Osteopathic Medicine adopted pursuant to this subsection and subsection (4) unless the office is accredited by a nationally recognized accrediting agency approved by the Board of Osteopathic Medicine. The actual costs for registration and inspection or accreditation shall be paid by the physician seeking to register the clinic.

Section 5. Paragraph (pp) of subsection (1) of section 459.015, Florida Statutes, is redesignated as paragraph (rr), and new paragraphs (pp) and (qq) are added to that subsection to read:

459.015 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(pp) Practicing osteopathic medicine in a clinic that is required to register but has not registered with the department pursuant to s. 459.005.

(qq) Promoting or advertising through any communication media the use, sale, or dispensing of any controlled substance appearing on any schedule in chapter 893.

Section 6. Section 465.018, Florida Statutes, is amended to read:

465.018 Community pharmacies; permits.—Any person desiring a permit to operate a community pharmacy shall apply to the department. If the board office certifies that the application complies with the laws of the state and the rules of the board

governing pharmacies, the department shall issue the permit. A ~~No~~ permit may not ~~shall~~ be issued unless a licensed pharmacist is designated as the prescription department manager responsible for maintaining all drug records, providing for the security of the prescription department, and following such other rules as relate to the practice of the profession of pharmacy. The permittee and the newly designated prescription department manager shall notify the department within 10 days of any change in prescription department manager. Effective July 1, 2012, a permit may not be issued unless the applicant demonstrates the ability to participate in and transmit dispensing information through a multistate electronic prescribing network. Effective January 1, 2013, a permittee must transmit dispensing information through a multistate electronic prescribing network for each prescription of a controlled substance listed in Schedule II or Schedule III of s. 893.03.

Section 7. Subsection (1) of section 465.023, Florida Statutes, is amended to read:

465.023 Pharmacy permittee; disciplinary action.—

(1) The department or the board may revoke or suspend the permit of any pharmacy permittee, and may fine, place on probation, or otherwise discipline any pharmacy permittee if the permittee, or any affiliated person, partner, officer, director, or agent of the permittee, including a person fingerprinted under s. 465.022(3), has:

(a) Obtained a permit by misrepresentation or fraud or through an error of the department or the board;

(b) Attempted to procure, or has procured, a permit for

any other person by making, or causing to be made, any false representation;

(c) Violated any of the requirements of this chapter or any of the rules of the Board of Pharmacy; of chapter 499, known as the "Florida Drug and Cosmetic Act"; of 21 U.S.C. ss. 301-392, known as the "Federal Food, Drug, and Cosmetic Act"; of 21 U.S.C. ss. 821 et seq., known as the Comprehensive Drug Abuse Prevention and Control Act; or of chapter 893;

(d) Been convicted or found guilty, regardless of adjudication, of a felony or any other crime involving moral turpitude in any of the courts of this state, of any other state, or of the United States;

(e) Been convicted or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for any offense that would constitute a violation of this chapter;

(f) Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy;

(g) Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud; ~~or~~

(h) Dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a

documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466; or

(i) Failed to transmit dispensing information through a multistate electronic prescribing network pursuant to s. 465.018 for any prescription of a controlled substance listed in Schedule II or Schedule III of s. 893.03.

Section 8. Subsection (1) of section 465.0276, Florida Statutes, is amended to read:

465.0276 Dispensing practitioner.—

(1)(a) A person may not dispense medicinal drugs unless licensed as a pharmacist or otherwise authorized under this chapter to do so, except that a practitioner authorized by law to prescribe drugs may dispense such drugs to her or his patients in the regular course of her or his practice in compliance with this section.

(b) A practitioner registered under this section may not dispense more than a 72-hour supply of a controlled substance listed in Schedule II or Schedule III of s. 893.03. A practitioner who violates this paragraph commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. This paragraph does not apply to the dispensing of complimentary packages of medicinal drugs to the practitioner's own patients in the regular course of her or his practice without the payment of a fee or remuneration of any kind, whether direct or indirect, as provided in subsection (5).

This paragraph does not apply to a controlled substance dispensed in the health care system of the Department of Corrections.

Section 9. For the purpose of incorporating the amendment made by this act to section 458.331, Florida Statutes, in references thereto, section 458.303, Florida Statutes, is reenacted to read:

458.303 Provisions not applicable to other practitioners; exceptions, etc.—

(1) The provisions of ss. 458.301, 458.303, 458.305, 458.307, 458.309, 458.311, 458.313, 458.315, 458.317, 458.319, 458.321, 458.327, 458.329, 458.331, 458.337, 458.339, 458.341, 458.343, 458.345, and 458.347 shall have no application to:

(a) Other duly licensed health care practitioners acting within their scope of practice authorized by statute.

(b) Any physician lawfully licensed in another state or territory or foreign country, when meeting duly licensed physicians of this state in consultation.

(c) Commissioned medical officers of the Armed Forces of the United States and of the Public Health Service of the United States while on active duty and while acting within the scope of their military or public health responsibilities.

(d) Any person while actually serving without salary or professional fees on the resident medical staff of a hospital in this state, subject to the provisions of s. 458.321.

(e) Any person furnishing medical assistance in case of an emergency.

(f) The domestic administration of recognized family

remedies.

(g) The practice of the religious tenets of any church in this state.

(h) Any person or manufacturer who, without the use of drugs or medicine, mechanically fits or sells lenses, artificial eyes or limbs, or other apparatus or appliances or is engaged in the mechanical examination of eyes for the purpose of constructing or adjusting spectacles, eyeglasses, or lenses.

(2) Nothing in s. 458.301, s. 458.303, s. 458.305, s. 458.307, s. 458.309, s. 458.311, s. 458.313, s. 458.319, s. 458.321, s. 458.327, s. 458.329, s. 458.331, s. 458.337, s. 458.339, s. 458.341, s. 458.343, s. 458.345, or s. 458.347 shall be construed to prohibit any service rendered by a registered nurse or a licensed practical nurse, if such service is rendered under the direct supervision and control of a licensed physician who provides specific direction for any service to be performed and gives final approval to all services performed. Further, nothing in this or any other chapter shall be construed to prohibit any service rendered by a medical assistant in accordance with the provisions of s. 458.3485.

Section 10. For the purpose of incorporating the amendment made by this act to section 458.331, Florida Statutes, in references thereto, paragraph (d) of subsection (1) and subsection (5) of section 458.311, Florida Statutes, are reenacted to read:

458.311 Licensure by examination; requirements; fees.—

(1) Any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply to the

department on forms furnished by the department. The department shall license each applicant who the board certifies:

(d) Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331.

(5) The board may not certify to the department for licensure any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter until such investigation is completed. Upon completion of the investigation, the provisions of s. 458.331 shall apply. Furthermore, the department may not issue an unrestricted license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331. When the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331, then the board may enter an order imposing one or more of the terms set forth in subsection (8).

Section 11. For the purpose of incorporating the amendment made by this act to section 458.331, Florida Statutes, in references thereto, subsection (6) of section 458.313, Florida Statutes, is reenacted to read:

458.313 Licensure by endorsement; requirements; fees.—

(6) The department shall not issue a license by endorsement to any applicant who is under investigation in any jurisdiction for an act or offense which would constitute a violation of this chapter until such time as the investigation

is complete, at which time the provisions of s. 458.331 shall apply. Furthermore, the department may not issue an unrestricted license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331. When the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331, the board may enter an order imposing one or more of the terms set forth in subsection (7).

Section 12. For the purpose of incorporating the amendment made by this act to section 458.331, Florida Statutes, in a reference thereto, paragraph (d) of subsection (2) of section 458.3135, Florida Statutes, is reenacted to read:

458.3135 Temporary certificate for visiting physicians to practice in approved cancer centers.—

(2) A temporary certificate for practice in an approved cancer center may be issued without examination to an individual who:

(d) Has not committed any act in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 456.072 or s. 458.331;

Section 13. For the purpose of incorporating the amendment made by this act to section 458.331, Florida Statutes, in a reference thereto, paragraph (e) of subsection (2) of section 458.3137, Florida Statutes, is reenacted to read:

458.3137 Temporary certificate for visiting physicians to obtain medical privileges for instructional purposes in conjunction with certain plastic surgery training programs and

plastic surgery educational symposiums.—

(2) A temporary certificate to practice medicine for educational purposes to help teach plastic surgery residents of a medical school within this state in conjunction with a nationally sponsored educational symposium may be issued without examination, upon verification by the board that the individual meets all of the following requirements:

(e) Has not committed an act in this or any other jurisdiction that would constitute a basis for disciplining a physician under s. 456.072 or s. 458.331.

Section 14. For the purpose of incorporating the amendment made by this act to section 458.331, Florida Statutes, in a reference thereto, paragraph (g) of subsection (1) of section 458.3145, Florida Statutes, is reenacted to read:

458.3145 Medical faculty certificate.—

(1) A medical faculty certificate may be issued without examination to an individual who:

(g) Has not committed any act in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331;

Section 15. For the purpose of incorporating the amendment made by this act to section 458.331, Florida Statutes, in references thereto, paragraph (b) of subsection (1) and subsection (2) of section 458.345, Florida Statutes, are reenacted to read:

458.345 Registration of resident physicians, interns, and fellows; list of hospital employees; prescribing of medicinal drugs; penalty.—

(1) Any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training which leads to subspecialty board certification in this state, or any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training in a teaching hospital in this state as defined in s. 408.07(45) or s. 395.805(2), who does not hold a valid, active license issued under this chapter shall apply to the department to be registered and shall remit a fee not to exceed $300 as set by the board. The department shall register any applicant the board certifies has met the following requirements:

(b) Has not committed any act or offense within or without the state which would constitute the basis for refusal to certify an application for licensure pursuant to s. 458.331.

(2) The board shall not certify to the department for registration any applicant who is under investigation in any state or jurisdiction for an act which would constitute grounds for disciplinary action under s. 458.331 until such time as the investigation is completed, at which time the provisions of s. 458.331 shall apply.

Section 16. For the purpose of incorporating the amendment made by this act to section 459.015, Florida Statutes, in a reference thereto, subsection (8) of section 459.021, Florida Statutes, is reenacted to read:

459.021 Registration of resident physicians, interns, and fellows; list of hospital employees; penalty.—

(8) Notwithstanding any provision of this section or s.

120.52 to the contrary, any person who is registered under this section is subject to the provisions of s. 459.015.

Section 17. This act shall take effect July 1, 2010.

Amendment No. 1

COUNCIL/COMMITTEE ACTION

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

Council/Committee hearing bill: Health Care Appropriations Committee

Representative(s) Legg offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 408.0513, Florida Statutes, is created to read:

408.0513 Access to prescription drug medication history.—

(1) By December 1, 2010, the agency shall contract with an entity that operates a multistate electronic prescribing network to provide the following agencies with access to the controlled substance information available on such network for the controlled substances listed in Schedules II and III of s. 893.03:

(a) A criminal justice agency as defined in s. 119.011 that enforces the laws of this state or the United States and that initiates an active investigation involving a specific violation of law.

(b) The Department of Health or the relevant health regulatory board responsible for the licensure, regulation, or discipline of practitioners, pharmacists, or other persons who are authorized to prescribe, administer, or dispense controlled substances and who are involved in a specific investigation involving a designated person.

(2) The agency shall adopt rules under ss. 120.536(1) and 120.54 to administer this section, including the method and terms of access to the information provided under subsection (1).

(3) The agency shall seek federal grants and donations from private entities to implement this section.

Section 2. Subsection (4) of section 458.309, Florida Statutes, is amended to read:

458.309 Rulemaking authority.—

(4) All privately owned pain-management clinics, facilities, or offices, primarily engaged in the treatment of pain by prescribing or dispensing controlled substances, hereinafter referred to as "clinics," which advertise in any medium for any type of pain-management services~~,~~ or employ a physician who is primarily engaged in the treatment of pain by prescribing or dispensing controlled substance medications, must register with the department by January 4, 2010, unless that clinic is licensed as a facility pursuant to chapter 395. The department shall refuse to register any clinic owned by or having any contractual or employment relationship with a physician whose federal Drug Enforcement Administration registration number has ever been suspended or revoked or

against whom the board has taken final administrative action relating to the physician's impairment due to the misuse or abuse of alcohol or drugs; or any clinic the ownership or any controlling interest of which is held by any person who has been convicted of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 893. A physician may not practice medicine in a pain-management clinic that is required to register but has not registered with the department. Each clinic location shall be registered separately regardless of whether the clinic is operated under the same business name or management as another clinic. If the clinic is licensed as a health care clinic under chapter 400, the medical director is responsible for registering the facility with the department. If the clinic is not registered pursuant to chapter 395 or chapter 400, the clinic shall, upon registration with the department, designate a physician who is responsible for complying with all requirements related to registration of the clinic. The designated physician shall be licensed under this chapter or chapter 459 and shall practice at the office location for which the physician has assumed responsibility. The department shall inspect the clinic annually to ensure that it complies with rules of the Board of Medicine adopted pursuant to this subsection and subsection (5) unless the office is accredited by a nationally recognized accrediting agency approved by the Board of Medicine. The actual costs for registration and inspection or accreditation shall be paid by the physician seeking to register the clinic.

Amendment No. 1

Section 3. Paragraph (nn) of subsection (1) of section 458.331, Florida Statutes, is redesignated as paragraph (qq), and new paragraphs (nn), (oo), and (pp) are added to that subsection to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(nn) Practicing medicine in a clinic that is required to register but has not registered with the department pursuant to s. 458.309.

(oo) Promoting or advertising through any communication media the use, sale, or dispensing of any controlled substance appearing on any schedule in chapter 893.

(pp) Dispensing controlled substances in Schedules II, III, IV or V of s. 893.03 without being registered with the Board of Pharmacy as a controlled substance dispensing practitioner pursuant to s. 465.0276(3).

Section 4. Subsection (3) of section 459.005, Florida Statutes, is amended to read:

459.005 Rulemaking authority.—

(3) All privately owned pain-management clinics, facilities, or offices, primarily engaged in the treatment of pain by prescribing or dispensing controlled substances, hereinafter referred to as "clinics," which advertise in any medium for any type of pain-management services, or employ a physician who is licensed under this chapter and who is primarily engaged in the treatment of pain by prescribing or

dispensing controlled substance medications, must register with the department by January 4, 2010, unless that clinic is licensed as a facility under chapter 395. The department shall refuse to register any clinic owned by or having any contractual or employment relationship with a physician whose federal Drug Enforcement Administration registration number has ever been suspended or revoked or against whom the board has taken final administrative action relating to the physician's impairment due to the misuse or abuse of alcohol or drugs; or any clinic the ownership or any controlling interest of which is held by any person who has been convicted of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 893. A physician may not practice osteopathic medicine in a pain-management clinic that is required to register but has not registered with the department. Each clinic location shall be registered separately regardless of whether the clinic is operated under the same business name or management as another clinic. If the clinic is licensed as a health care clinic under chapter 400, the medical director is responsible for registering the facility with the department. If the clinic is not registered under chapter 395 or chapter 400, the clinic shall, upon registration with the department, designate a physician who is responsible for complying with all requirements related to registration of the clinic. The designated physician shall be licensed under chapter 458 or this chapter and shall practice at the office location for which the physician has assumed responsibility. The department shall inspect the clinic annually to ensure that it complies with

rules of the Board of Osteopathic Medicine adopted pursuant to this subsection and subsection (4) unless the office is accredited by a nationally recognized accrediting agency approved by the Board of Osteopathic Medicine. The actual costs for registration and inspection or accreditation shall be paid by the physician seeking to register the clinic.

Section 5. Paragraph (pp) of subsection (1) of section 459.015, Florida Statutes, is redesignated as paragraph (ss), and new paragraphs (pp), (qq), and (rr) are added to that subsection to read:

459.015 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(pp) Practicing osteopathic medicine in a clinic that is required to register but has not registered with the department pursuant to s. 459.005.

(qq) Promoting or advertising through any communication media the use, sale, or dispensing of any controlled substance appearing on any schedule in chapter 893.

(rr) Dispensing controlled substances in Schedules II, III, IV or V of s. 893.03 without being registered with the Board of Pharmacy as a controlled substance dispensing practitioner pursuant to s. 465.0276(3).

Section 6. Section 465.018, Florida Statutes, is amended to read:

465.018 Community pharmacies; permits.—Any person desiring a permit to operate a community pharmacy shall apply to the

department. If the board office certifies that the application complies with the laws of the state and the rules of the board governing pharmacies, the department shall issue the permit. A ~~No~~ permit may not ~~shall~~ be issued unless a licensed pharmacist is designated as the prescription department manager responsible for maintaining all drug records, providing for the security of the prescription department, and following such other rules as relate to the practice of the profession of pharmacy. The permittee and the newly designated prescription department manager shall notify the department within 10 days of any change in prescription department manager. Effective July 1, 2012, a permit may not be issued unless the applicant demonstrates the ability to participate in and transmit dispensing information through a multistate electronic prescribing network. Effective January 1, 2013, a permittee must transmit dispensing information through a multistate electronic prescribing network for each prescription of a controlled substance listed in Schedule II or Schedule III of s. 893.03.

Section 7. Subsection (1) of section 465.023, Florida Statutes, is amended to read:

465.023 Pharmacy permittee; disciplinary action.—

(1) The department or the board may revoke or suspend the permit of any pharmacy permittee, and may fine, place on probation, or otherwise discipline any pharmacy permittee if the permittee, or any affiliated person, partner, officer, director, or agent of the permittee, including a person fingerprinted under s. 465.022(3), has:

(a) Obtained a permit by misrepresentation or fraud or through an error of the department or the board;

(b) Attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation;

(c) Violated any of the requirements of this chapter or any of the rules of the Board of Pharmacy; of chapter 499, known as the "Florida Drug and Cosmetic Act"; of 21 U.S.C. ss. 301-392, known as the "Federal Food, Drug, and Cosmetic Act"; of 21 U.S.C. ss. 821 et seq., known as the Comprehensive Drug Abuse Prevention and Control Act; or of chapter 893;

(d) Been convicted or found guilty, regardless of adjudication, of a felony or any other crime involving moral turpitude in any of the courts of this state, of any other state, or of the United States;

(e) Been convicted or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for any offense that would constitute a violation of this chapter;

(f) Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy;

(g) Been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud; ~~or~~

(h) Dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by

s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466; or

(i) Failed to transmit dispensing information through a multistate electronic prescribing network pursuant to s. 465.018 for any prescription of a controlled substance listed in Schedule II or Schedule III of s. 893.03.

Section 8. Subsections (3) and (4) of section 465.0276, Florida Statutes, are amended, and subsequent subsections are renumbered to read:

465.0276 Dispensing practitioner.—

(1) A person may not dispense medicinal drugs unless licensed as a pharmacist or otherwise authorized under this chapter to do so, except that a practitioner authorized by law to prescribe drugs may dispense such drugs to her or his patients in the regular course of her or his practice in compliance with this section.

(2) A practitioner who dispenses medicinal drugs for human consumption for fee or remuneration of any kind, whether direct or indirect, must:

(a) Register with her or his professional licensing board as a dispensing practitioner and pay a fee not to exceed $100 at the time of such registration and upon each renewal of her or

his license. Each appropriate board shall establish such fee by rule.

(b) Comply with and be subject to all laws and rules applicable to pharmacists and pharmacies, including, but not limited to, this chapter and chapters 499 and 893 and all federal laws and federal regulations.

(c) Before dispensing any drug, give the patient a written prescription and orally or in writing advise the patient that the prescription may be filled in the practitioner's office or at any pharmacy.

(3) To dispense controlled substances in Schedules II, III, IV or V of s. 893.03, practitioners authorized by law to prescribe controlled substances shall register with the Board of Pharmacy as a controlled substance dispensing practitioner and pay a fee not to exceed $100. The department shall adopt rules establishing procedures for quadrennial renewal of registration.

(a) The department shall establish a statement of reference which shall inquire whether the referring entity:

1. Has personal knowledge of the practitioner;

2. Has had an opportunity to form an opinion of the practitioner's medical skills and ethics;

3. Is aware of any incidents in the practitioner's medical practice which reflect insufficient skill or medical ethics to properly dispense controlled substances;

4. Is aware of any facts or circumstances which indicate the practitioner is likely to dispense controlled substances without clinical justification; and

5. Recommends the practitioner for controlled substance dispensing registration.

(b) Upon receiving a request for registration, the department shall send the statement of reference to the following persons:

1. The president of the Florida Medical Association.

2. The president of the Florida Osteopathic Medical Association.

3. The dean of any Florida medical school.

4. The hospital medical chief of every licensed hospital within 50 miles of the practitioner's practice location.

5. The president of the practitioner's state specialty society, if any.

6. The president of every county medical association geographically located in the practitioner's practice area.

The department shall establish and maintain an accurate listing of the persons described above. Persons receiving the statement of reference may decline to complete or return it. Completed statements must be notarized and returned to the department.

(c) The persons listed in paragraph (b) are immune from civil liability for the information conveyed in a statement of reference, if provided in good faith.

(d) The Board of Pharmacy shall not register practitioners for which any statement of reference contains a negative recommendation, or for which no positive recommendation is returned to the department. The Board shall not consider any statement of reference which is not notarized. Administrative

challenges made pursuant to ch. 120 for registration denials and renewal denials shall be to the practitioner's professional licensing board.

(d) The requirements of this subsection apply to physicians practicing in Broward, Dade and Palm Beach Counties on September 1, 2010. For all other physicians, the requirements of this subsection apply at the time of the next licensure renewal.

(4) Effective July 1, 2012, the department may not register a controlled substance dispensing practitioner unless the practitioner demonstrates the ability to participate in and transmit dispensing information through a multistate electronic prescribing network. Effective January 1, 2013, controlled substance dispensing practitioners must transmit dispensing information through a multistate electronic prescribing network for each prescription of a controlled substance listed in Schedules II, III, IV or V of s. 893.03.

(5~~3~~) The department shall inspect any facility where a practitioner dispenses medicinal drugs pursuant to subsection (2) in the same manner and with the same frequency as it inspects pharmacies for the purpose of determining whether the practitioner is in compliance with all statutes and rules applicable to her or his dispensing practice.

(6~~4~~) The registration of any practitioner who has been found by her or his respective board to have dispensed medicinal drugs in violation of this chapter shall be subject to suspension or revocation.

(7~~5~~) A practitioner who confines her or his activities to the dispensing of complimentary packages of medicinal drugs to

the practitioner's own patients in the regular course of her or his practice, without the payment of fee or remuneration of any kind, whether direct or indirect, and who herself or himself dispenses such drugs is not required to register pursuant to this section. The practitioner must dispense such drugs in the manufacturer's labeled package with the practitioner's name, patient's name, and date dispensed, or, if such drugs are not dispensed in the manufacturer's labeled package, they must be dispensed in a container which bears the following information:

(a) Practitioner's name;

(b) Patient's name;

(c) Date dispensed;

(d) Name and strength of drug; and

(e) Directions for use.

Section 17. This act shall take effect July 1, 2010.

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

Remove the entire title and insert:

An act relating to controlled substances; creating s. 408.0513, F.S.; requiring the Agency for Health Care Administration to contract with a multistate electronic prescribing network to provide certain agencies with access to certain controlled substance information; requiring the Agency for Health Care Administration to adopt rules and seek grants and donations; amending ss. 458.309 and 459.005, F.S.; revising requirements for the registration of pain-management clinics; requiring the

Department of Health to refuse to register pain-management clinics under certain circumstances; amending ss. 458.331 and 459.015, F.S.; specifying additional grounds for disciplinary action against practitioners licensed under ch. 458 or ch. 459, F.S.; amending s. 465.018, F.S.; requiring community pharmacy permit applicants to demonstrate the ability to participate in and transmit dispensing information through a multistate electronic prescribing network; requiring community pharmacy permittees to transmit dispensing information through such a network for prescriptions of certain controlled substances; amending s. 465.023, F.S.; specifying an additional ground for disciplinary action against community pharmacy permittees; amending s. 465.0276, F.S.; requiring registration by the Board of Pharmacy for dispensing certain controlled substances; requiring a fee; providing for quadrennial registration renewal; requiring the department to establish a statement of reference with certain inquiries; requiring the department to send the statement of reference to certain persons upon receiving a registration application; requiring the department to establish and maintain a list of such persons; providing for certain civil immunity; prohibiting the department from registering certain practitioners; specifying that administrative appeals under chapter 120 are to the professional licensing board; providing applicability for practitioners in Broward, Palm Beach and Miami-Dade Counties on September 1, 2010; providing applicability for other practitioners upon license renewal; prohibiting the department from registering practitioners who cannot demonstrate ability to transmit certain information

through a multi-state prescribing network, effective July 1, 2012; requiring controlled substance dispensing practitioners to transmit certain information through a multi-state prescribing network effective January 1, 2013; providing an effective date.

PCB HCA 10-08

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCA 10-08 Public Records
SPONSOR(S): Health Care Appropriations Committee
TIED BILLS: **IDEN./SIM. BILLS:**

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.:	Health Care Appropriations Committee		Calamas	Massengale
1)				
2)				
3)				
4)				
5)				

SUMMARY ANALYSIS

Proposed Committee Bill HCA 10-08 creates a public records exemption for reference statements made to the Florida Department of Health, Board of Pharmacy during the board's registration process for practitioners authorized to prescribe controlled substances in Schedules II, II, IV or V. The board is required to register all controlled substance prescribing practitioners pursuant section 465.0276(3), Florida Statutes, as amended by Committee Substitute for House Bill 225, and must solicit reference statements from specified individuals during the registration process. The public records exemption makes the reference statement confidential and exempt from public records requests, except in investigations in which a finding of probable cause is made.

The bill provides for repeal of the exemption on October 2, 2015, unless reviewed and saved from repeal by the Legislature. It also provides a statement of public necessity as required by the Florida Constitution.

Section 24(c) of Article I of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created public record or public meeting exemption. The bill creates a new exemption; thus, it requires two-thirds vote for final passage.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Public Records Law

Section 24(a) of Article I of the Florida Constitution sets forth the state's public policy regarding access to government records. The section guarantees every person a right to inspect or copy any public record of the legislative, executive, and judicial branches of government. The Legislature, however, may provide by general law for the exemption of records from the requirements of Section 24(a) of Article I of the Florida Constitution. The general law must state with specificity the public necessity justifying the exemption (public necessity statement) and must be no broader than necessary to accomplish its purpose.[1]

Public policy regarding access to government records is addressed further in the Florida Statutes. Section 119.07(1), Florida Statutes, guarantees every person a right to inspect and copy any state, county, or municipal record. Furthermore, the Open Government Sunset Review Act[2] provides that a public record or public meeting exemption may be created or maintained only if it serves an identifiable public purpose. In addition, it may be no broader that is necessary to meet one of the following purposes:[3]

- Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption.
- Protects sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety; however, only the identity of an individual may be exempted under this provision.
- Protects trade or business secrets.

[1] Article I, s. 24(c), of the Florida Constitution.
[2] s. 119.15, F.s.
[3] *Id.*

Public Records Exemption for Health Care Practitioner Investigations

Current law provides a public records exemption for materials related to the investigation of a complaint filed with the Department of Health against a health care practitioner.[4] The appropriate practitioner regulatory board conducts an investigation after a complaint is filed. Investigative materials and the probable cause report used by the regulatory board are confidential and exempt[5] from section 119.07(1), Florida Statutes, until and unless the practitioner waives his privilege of confidentiality or ten days after probable cause has been found to exist.[6]

Effect of Proposed Changes

Proposed Committee Bill HCA 10-08 creates a public record exemption for reference statements made to the Florida Department of Health, Board of Pharmacy during the board's registration process for practitioners authorized to prescribe controlled substances in Schedules II, II, IV or V. The board is required to register all controlled substance prescribing practitioners pursuant section 465.0276(3), Florida Statutes, as amended by Committee Substitute for House Bill 225, and must solicit reference statements from specified individuals during the registration process. The public records exemption makes the reference statement confidential and exempt from public records requests, except in investigations in which a finding of probable cause is made. The public records exemption protects the reference statement, which requests from a referring person whether, the person:

- Has personal knowledge of the practitioner;
- Has had an opportunity to form an opinion of the practitioner's medical skills and ethics;
- Is aware of any incidents in the practitioner's medical practice which reflect insufficient skill or medical ethics to properly dispense controlled substances;
- Is aware of any facts or circumstances which indicate the practitioner is likely to dispense controlled substances without clinical justification; and
- Recommends the practitioner for controlled substance dispensing registration.

The bill provides for repeal of the exemption on October 2, 2015, unless reviewed and saved from repeal by the Legislature. It also provides a statement of public necessity as required by the Florida Constitution.[7]

B. SECTION DIRECTORY:

Section 1: Provides an unnumbered section of law to create a public record exemption for statements of reference made to the Board of Pharmacy regarding controlled substance prescribing practitioners.

Section 2: Provides a public necessity statement.

Section 3: Provides an effective date dependent upon the adoption of House Bill 225 or similar legislation in the same legislative session or an extension thereof.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

[4] s. 456.073, F.S.

[5] There is a difference between records the Legislature designates as exempt from public record requirements and those the Legislature deems confidential and exempt. A record classified as exempt from public disclosure may be disclosed under certain circumstances. (*See WFTV, Inc. v. The School Board of Seminole*, 874 So.2d 48, 53 (Fla. 5th DCA 2004), review denied 892 So.2d 1015 (Fla. 2004); *City of Rivera Beach v. Barfield*, 642 So.2d 1135 (Fla. 4th DCA 1994; *Williams v. City of Minneola*, 575 So.2d 687 (Fla. 5th DCA 1991). If the Legislature designate a record as confidential and exempt from public disclosure, such record may not be released, by the custodian of public records, to anyone other than the persons or entities specifically designated in the statutory scheme. (*See* Attorney General Opinion 85-62, August 1, 1985).

[6] s. 456.073(10), F.S.

[7] Section 24(c), Art. I, Florida Constitution.

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill may have an indeterminate, insignificant fiscal impact on the Department of Health because staff responsible for complying with public records requests could require training related to creation of the public records exemption. In addition, the department could incur costs associated with redacting the exempt information prior to releasing a record. The costs, however, would be absorbed, as they are part of the day-to-day responsibilities of the department.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state sales tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   Vote Requirement

   Section 24(c) of Article I of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created public record or public meeting exemption. The bill creates a public record exemption; thus, it requires a two-thirds vote for final passage.

   Public Necessity Statement

   Section 24(c) of Article I of the Florida Constitution requires a public necessity statement for a newly created or expanded public record or public meeting exemption. The bill creates a public record exemption; thus, it includes a public necessity statement.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to public records; providing an exemption from public records requirements for statements of reference submitted by certain persons for practitioners seeking controlled substance dispensing registration by the Board of Pharmacy within the Department of Health; providing an exception to the exemption; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Statements of reference held by the Board of Pharmacy within the Department of Health pursuant to s. 465.0276(3) are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution, unless utilized in an investigation which results in a finding of probable cause. This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15, Florida Statutes, and shall stand repealed on October 2, 2015, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that statements of reference held by the Board of Pharmacy within the Department of Health concerning a practitioner requesting controlled substance dispensing registration be made confidential and exempt from public records

requirements. Candid and honest responses by referring persons will help ensure that controlled substance dispensing registrants safely dispense prescription drugs which are highly susceptible to abuse. The Legislature finds that the failure to maintain the confidentiality of such statements of reference would prevent the exercise of important state interests to ensure high-quality, safe dispensing of controlled substances by health care practitioners in this state and would hinder the effective and efficient administration of a government program.

Section 3. This act shall take effect on the same date that House Bill 225 or similar legislation takes effect, if such legislation is adopted in the same legislative session, or an extension thereof, and becomes law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 355 Public Safety Telecommunicators
SPONSOR(S): Military & Local Affairs Policy Committee, Health Care Regulation Policy Committee, Roberson, K. and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 742

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee	14 Y, 0 N, As CS	Holt	Calamas
2)	Military & Local Affairs Policy Committee	13 Y, 0 N, As CS	Noriega	Hoagland
3)	Health Care Appropriations Committee		Clark	Massengale
4)	Health & Family Services Policy Council			
5)				

SUMMARY ANALYSIS

In 2008, the Legislature established a voluntary certification program for 911 emergency dispatchers. This bill makes the certification program mandatory and affects approximately 6,000 911 public safety telecommunicators responsible for answering, receiving, and transferring 911 calls, and for dispatching emergency services throughout the state.

The bill provides requirements for mandatory certification that include: education and training standards, continuing education, disciplinary provisions, and applicable fees. The grandfather clause created under the voluntary certification scheme allowed individuals with five years of full-time employment as a 911 public safety telecommunicator to qualify for certification. However, the bill provides that the grandfather clause expires on October 1, 2012, and all individuals seeking certification after this date must complete an approved 232-hour 911 public safety telecommunication training program and pass an examination.

Because this bill establishes the regulation of a new profession, the Sunrise Act criteria apply. Section 11.62, Florida Statutes, states that it is the intent of the Legislature that no profession or occupation be subject to regulation by the state unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage; and no profession or occupation be regulated by the state in a manner that unnecessarily restricts entry into the practice of the profession or occupation.

The bill provides a statement of public interest pursuant to Section 10 of Article VII of the Florida Constitution.

This bill authorizes the use of funds from the Emergency Communications Number E911 System Fund to cover dispatching functions and the initial certification and renewal fees for 911 public safety telecommunicators.

The Department of Health (DOH) has indicated that it will need one full-time equivalent employee, and that the collected certification fees will have a positive fiscal impact on the Emergency Medical Services Trust Fund within DOH. The Department of Management Services (DMS) has indicated that this bill will have a negative fiscal impact on the Emergency Communications Number E911 System Fund within DMS. The fiscal impact to other state agencies is indeterminate at this time.

The Revenue Estimating Conference has not met to address this bill in an impact conference. However, staff estimates that the provisions of this bill will have an indeterminate negative fiscal impact on local government revenues (see Fiscal Analysis section).

The bill has an effective date of July 1, 2010.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

In 2008, the Legislature established a voluntary certification program for 911 emergency dispatchers.[1] This bill makes the "911 public safety telecommunicator" (previously called "911 emergency dispatcher") certification program mandatory.

CURRENT SITUATION

Florida's Public Policy on 911 Services

Section 365.171, F.S., sets forth the provisions governing Florida's public policy on the emergency telephone number "911." The provision specifies that it is the intent of the Legislature to:[2]

> "establish and implement a cohesive statewide emergency telephone number "911" plan which will provide citizens with rapid direct access to public safety agencies by dialing the telephone number '911' with the objective of reducing response time to situations requiring law enforcement, fire, medical, rescue, and other emergency services."

Public Safety Agencies and Public Safety Answering Points

A public safety agency (PSA) is a functional division of a public agency[3] that provides firefighting, law enforcement, medical, or other emergency services.[4] A PSA operates public safety answering points (PSAPs) or 911 call centers. There are 208 primary PSAPs, 29 secondary PSAPs, and 42 backup PSAPs for a total of 279 PSAPs throughout the state.[5] Staff in these call centers include call takers, dispatchers, and dual call takers/dispatchers.[6] Call takers answer calls and record necessary information such as the caller's name and the nature of the emergency, and relay this information to the dispatchers who assess the information, determine the type of emergency response needed, and direct appropriate emergency series (e.g., police, fire, or ambulance) to respond to the call.[7]

---

[1] Chapter 2008-51, L.O.F.
[2] Section 365.171(2), F.S.
[3] A "public agency" is any city, county, city and county, municipal corporation, chartered organization, public district, or public authority located in whole or in part within this state which provides, or has authority to provide, firefighting, law enforcement, ambulance, medical, or other emergency services. *See s. 365.171(2)(c), F.S.*
[4] Section 365.171(2)(d), F.S.
[5] State of Florida E911 Board 2008 Annual Report, February 28, 2009 *available at:* http://dms.myflorida.com/suncom/public_safety_bureau/florida_e911/e911_board (last viewed on February 8, 2010).
[6] Office of Program Policy Analysis & Government Accountability, 911 Call Center Training in Florida Varies; Options Exist for Creating Minimum Standards. Report No. 10-12. *available at*: http://www.oppaga.state.fl.us/Summary.aspx?reportNum=10-12 (last viewed on February 9, 2010).
[7] Ibid.

Types of 911 Calls

In Fiscal Year 2007-2008, there were approximately 14 million 911 calls across the state and these calls were handled by approximately 4,800 911 call takers.[8] There are five methods of handling 911 calls.[9] County 911 systems use a combination of these methods depending on the type of 911 system and the nature of each particular call.

Direct Dispatch—An emergency call received at a 911 PSA, which has the responsibility for dispatching emergency vehicles for that particular emergency, is handled with the direct dispatch method. The person answering the call functions as a call taker and conveys the necessary information to a radio dispatcher. For small 911 PSAPs, the person answering the call may also handle the radio dispatching function. Calls handled by the direct dispatch method minimize the time required for a citizen to be connected to the call taker. Direct dispatch is the preferred method of handling 911 calls to minimize the response time to the greatest possible extent.

Call Transfer—An emergency call received at a 911 PSAP intended for a PSA remotely located from the PSAP is handled with the call transfer method. After the call taker has determined the proper remote agency, the caller is transferred to that agency's call taker. The PSAP call taker remains on the line until the agency answers and until the correctness of the transfer is ascertained. With enhanced systems, the transfer switching is often done at the service provider's central office, and the transfer line originates at that central office. This method is often used where the expected call volume is not large enough to warrant the cost of a dedicated transfer line.

Transfers of Voice and Data—Agencies receiving transfers of both voice and data are referred to as Secondary PSAPs. These facilities often act as a back-up if there is a failure in the Primary PSAP.

Call Relay—The call relay method, like the call transfer method, is used to convey information to a remotely located agency; however, the information is transferred to the remote agency rather than the caller. This method is suited for use with agencies that do not have a large call volume. The call relay method is sometimes the best approach if the caller is too emotionally distressed to be transferred. The overall response time of a voice-relayed call is longer than other call handling methods. Therefore, the use of this method should be minimized to the greatest possible extent.

Call Referral—Non-emergency and administrative calls received by a 911 PSAP may be handled by the call referral method. Call referral must never be used for an emergency call. In Florida, as well as nationally, experience has established that not all 911 calls are true emergencies. Many calls are administrative or of a non-emergency nature and can be handled by the call referral method to keep PSAP lines open. It is recognized that in some areas the treatment of administrative and emergency calls is essentially the same. This tends to be the case in the more rural areas of Florida.

911 Emergency Dispatchers

According to the United States Department of Labor, emergency dispatchers monitor the location of emergency services personnel from one or all of the jurisdiction's emergency services departments. These workers dispatch the appropriate type and number of units in response to calls for assistance. Dispatchers are often the first point of contact for the public when emergency assistance is required. If trained for emergency medical services, the dispatcher may provide medical instruction to those persons on the scene of the emergency until the medical staff arrives.[10]

When handling calls, dispatchers question each caller to determine the type, seriousness, and location of the emergency. The information obtained is generally posted electronically by computer. The dispatcher then decides the priority of the incident, the kind and number of units needed, and the

[8] State of Florida E911 Board 2008 Annual Report, February 28, 2009 *available at:* http://dms.myflorida.com/suncom/public_safety_bureau/florida_e911/e911_board (last viewed on February 8, 2010).
[9] Ibid.
[10] United States Department of Labor, Bureau of Labor Statistics, "Occupational Outlook Handbook - Dispatchers," http://www.bls.gov/oco/ocos138.htm (last visited on February 10, 2010).

location of the closest and most suitable units available. When appropriate, dispatchers stay in contact with other service providers. In a medical emergency, dispatchers keep in touch not only with the dispatched units, but also with the caller. Dispatchers may give extensive first-aid instructions before the emergency personnel arrive. Dispatchers also continuously give updates on the patient's condition to the ambulance personnel and often serve as a link between the medical staff in a hospital and the emergency medical technicians in the ambulance.[11]

Department of Education Curriculum Framework and Standards

The Division of Workforce Education at the Department of Education (DOE) publishes curriculum frameworks and standards aligned to the 16 Career Clusters delineated by the United States Department of Education. Each program's course standards are composed of two parts: a curriculum framework and the student performance standards. The curriculum framework includes four major sections: major concepts/content, laboratory activities, special notes, and intended outcomes. Student performance standards are listed for each intended outcome.[12] According to DOE, the curriculum is reviewed every three years.

The public safety telecommunication program is designed to prepare students for employment as a police, fire, ambulance, or emergency medical dispatcher. The program is divided into two levels. The first level, "Occupational Completion Point A," is a 208-hour curriculum designed for police, fire, and ambulance dispatchers. The second level, "Occupational Completion Point B," is to be completed after the first level through a minimum of an additional 24-hour curriculum designed for emergency medical dispatchers.[13] The course content includes, but is not limited to:

- Ethics and the role of the telecommunicator;
- Standard telecommunication operating procedures;
- Relationship to field personnel;
- Understanding of command levels;
- Typical layouts of message centers;
- Use of performance aids;
- Overview of emergency agencies;
- Communications equipment, functions and terminology;
- Types of telecommunication equipment;
- Proper and correct telephone and dispatching procedures and techniques;
- Cooperation and reciprocal agreements with other agencies;
- Federal, state, and local communication rules;
- Emergency situations and operating procedures;
- Emergency medical dispatch procedures; and
- Health and safety issues to include Cardiopulmonary Resuscitation (CPR).

Voluntary Emergency Dispatcher Certification Program

In 2008, the Legislature established a voluntary certification program for 911 emergency dispatchers that was implemented by the Florida Department of Health (DOH).[14] As of January 2010, DOH reported that 1,112 individuals had applied for and received certification.[15] Current law defines a "911 emergency dispatcher" as a person who is employed by a state agency or local government as a public safety dispatcher or 911 operator whose duties and responsibilities include:[16]

- Answering 911 calls;

[11] Ibid.
[12] Florida Department of Education, "Curriculum Framework, Public Safety Telecommunication," July 2010.
[13] Ibid.
[14] Chapter 2008-51, L.O.F.
[15] According to OPPAGA Report No. 10-12, as of December 2009, two local government agencies and one Florida college offered training programs approved by the Department of Health. However, the Sunrise Questionnaire states that three Florida colleges currently offer training programs.
[16] Section 401.465(1), F.S.

- Dispatching law enforcement officers, fire rescue services, emergency medical services, and other public safety services to the scene of an emergency;
- Providing real-time information from federal, state, and local crime databases; or
- Supervising or serving as the command officer to a person or persons having such duties and responsibilities.

The definition of 911 dispatcher does not include administrative support personnel, including, but not limited to, those persons whose primary duties and responsibilities are in accounting, purchasing, legal, and personnel.

Applicants for certification must submit specified forms, pay a certification fee,[17] and meet the educational and training requirements for certification and recertification as a 911 emergency dispatcher.[18] DOH determines whether the applicant meets the requirements for certification and issues a certificate to any person who meets the following requirements:[19]

- Five years of documented full-time supervised experience as a 911 emergency dispatcher since January 1, 2002 ("grandfather clause"); *or*

- Completion of an appropriate 911 emergency dispatcher training program that is equivalent to the most recently approved DOE emergency dispatcher course and that consists of not less than 208 hours;
- Completion and documentation of at least 2 years of supervised full-time employment as a 911 emergency dispatcher since January 1, 2002;
- Certification under oath that the applicant is not addicted to alcohol or any controlled substance;
- Certification under oath that the applicant is free from any physical or mental defect or disease that might impair the applicant's ability to perform his or her duties;
- Submission of the application fee prescribed in subsection (3); *and*
- Submission of a completed application to DOH indicating compliance with the requirements for certification.[20]

Of the 1,112 certified 911 dispatchers identified by DOH, all but three qualified for certification under the grandfather clause.[21] The remaining three individuals qualified for certification by having two years of supervised full-time employment and by completing an approved training program.[22] As of December 2009, there were two local government agencies and one Florida college that offered a DOH-approved training program.[23]

Each 911 emergency dispatcher certificate expires automatically if not renewed at the end of the two-year period. A certificate that is not renewed at the end of the two-year period automatically reverts to an inactive status for a period that may not exceed 180 days and may be reactivated and renewed within the 180-day period if the certificate-holder meets the qualifications for renewal and pays a $50 late fee.[24] DOH may suspend or revoke a certificate at any time if it determines that the certificate-holder does not meet the applicable qualifications.[25]

Section 401.411, Florida Statutes, specifies disciplinary action, such that DOH may deny, suspend, or revoke a license, certificate, or permit or may reprimand or fine a 911 emergency dispatcher certificate-holder on any of the following grounds:

- Addiction to alcohol or any controlled substance;

---

[17] The fee for initial certification is $75 and biannual renewal is $100.
[18] Section 401.465(2)(a), F.S.
[19] Section 401.465(2)(b), F.S.
[20] Application is done through DH Form 5066. (64J-3.001, F.A.C.).
[21] Office of Program Policy Analysis & Government Accountability, 911 Call Center Training in Florida Varies; Options Exist for Creating Minimum Standards. Report No. 10-12. *available at*: http://www.oppaga.state.fl.us/Summary.aspx?reportNum=10-12 (last viewed on February 9, 2010).
[22] Ibid.
[23] Office of Program Policy Analysis & Government Accountability, 911 Call Center Training in Florida Varies; Options Exist for Creating Minimum Standards. Report No. 10-12. *available at*: http://www.oppaga.state.fl.us/Summary.aspx?reportNum=10-12 (last viewed on February 9, 2010).
[24] Section 401.465(2)(d), F.S.
[25] Section 401.465(2)(e), F.S.

- Engaging in or attempting to engage in the possession, except in legitimate duties under the supervision of a licensed physician, or the sale or distribution of any controlled substance as set forth in chapter 893;
- A conviction in any court in any state or in any federal court of a felony, unless the person's civil rights have been restored;
- Knowingly making false or fraudulent claims; procuring, attempting to procure, or renewing a certificate, license, or permit by fakery, fraudulent action, or misrepresentation;
- Sexual misconduct with a patient, including inducing or attempting to induce the patient to engage, or engaging or attempting to engage the patient, in sexual activity;
- Failure to give DOH true information upon request regarding an alleged or confirmed violation;
- Practicing as an emergency medical technician, paramedic, or other health care professional operating under this part without reasonable skill and safety to patients by reason of illness, drunkenness, or the use of drugs, narcotics, or chemicals or any other substance or as a result of any mental or physical condition;
- Fraudulent or misleading advertising or advertising in an unauthorized category; and
- Failure to report to DOH any person known to be in violation these disciplinary provisions.

Unprofessional conduct, such as failing to conform to the prevailing standards of acceptable practice, is not a basis for disciplinary action.[26]

911 System Funding

E911 fee revenues are collected pursuant to section 365.172(8), Florida Statutes, and are processed and disbursed through the Emergency Communications Number E911 System Fund (or "E911 Trust Fund").[27] Expenditures for the E911 system are limited to call taking and call transfers and do not include costs associated with the dispatching or training of dispatch personnel.[28] The E911 Board has determined that training and certification costs for 911 call takers are allowable expenditures. Thus, funding for call taker training is paid primarily through E911 funds and dispatcher training is paid primarily through local funding sources.[29] While call taking and call taking training have been determined to be allowable expenditures by the E911 Board, the E911 Trust Fund currently does not receive enough revenue to support all allowable expenditures.[30] In its 2008 Annual Report, the E911 Board reported to the Legislature that the fee revenue only covered 66 percent of the allowable expenditures. According to section 365.173, Florida Statutes, the Legislature recognized that the E911 fee may not necessarily provide the total funding required for establishing or providing the E911 service.

In the Enhance 911 Services Act,[31] Congress found that, "any funds that are collected from fees imposed on consumer bills for the purposes of funding 911 services or E911 should be expended for the purposes for which the funds are collected."[32]

Professional Regulation and the Florida Sunrise Act

There are three different types or levels of regulation:[33]

> Licensure is the most restrictive form of state regulation. Under licensure laws, it is illegal for a person to practice a profession without first meeting all of the standards imposed by the state;

---

[26] Unprofessional conduct is, however, a basis for discipline of emergency medical technicians and paramedics. S. 401.411(1)(g), F.S.
[27] Section 365.173, F.S.
[28] Section 365.172(9), F.S.
[29] Office of Program Policy Analysis & Government Accountability, 911 Call Center Training in Florida Varies; Options Exist for Creating Minimum Standards. Report No. 10-12. *available at*: http://www.oppaga.state.fl.us/Summary.aspx?reportNum=10-12 (last viewed on February 9, 2010).
[30] Department of Management Services, 2010 Legislative Bill Analysis of House Bill 355 (February 9, 2010).
[31] Public Law 108-494,108th Congress SEC. 102.(3).
[32] State of Florida E911 Board 2008 Annual Report, February 28, 2009 *available at:* http://dms.myflorida.com/suncom/public_safety_bureau/florida_e911/e911_board (last viewed on February 8, 2010).
[33] Schmitt, K. & Shimberg, B. (1996). Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask. *Council on Licensure, Enforcement, and Regulation.*

Certification grants title protection to those who meet training and other standards. Those who do not meet certification standards cannot use the title, but can still perform the services; and

Registration is the least restrictive form of regulation and usually only requires individuals to file their name, address, and qualifications with a government agency before practicing the occupation.

This bill requires that all individuals employed as a 911 public safety telecommunicator by a PSAP must be *certified* by DOH by October 1, 2012.

Section 456.003, Florida Statutes, specifies that health care professions be regulated only for the preservation of the health, safety, and welfare of the public under the police powers of the state. Such professions shall be regulated when:

- Their unregulated practice can harm or endanger the health, safety, and welfare of the public, and when the potential for such harm is recognizable and clearly outweighs any anticompetitive impact which may result from regulation;
- The public is not effectively protected by other means, including, but not limited to, other state statutes, local ordinances, or federal legislation; and
- Less restrictive means of regulation are not available.

Section 11.62, Florida Statutes, the Sunrise Act, provides legislative intent regarding the regulation of new professions and occupations:[34]

- No profession or occupation is subject to regulation by the state unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage and that the police power of the state be exercised only to the extent necessary for that purpose; and
- No profession or occupation is regulated by the state in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the professional or occupational services to the public.

In determining whether to regulate a profession or occupation, section 11.62(3), Florida Statutes, requires the Legislature to consider the following:

- Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote;
- Whether the practice of the profession or occupation requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability;
- Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment;
- Whether the public is or can be effectively protected by other means; and
- Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable.

The Sunrise Act requires proponents of regulation to submit information documenting the need for the proposed regulation. A sunrise questionnaire was submitted by the Florida Association of Public Safety Communications Officials (FAPCO). FAPCO represents 675 active members who, according to FAPCO, support requiring the certification of public safety telecommunicators.

[34] Section 11.62(2), F.S.

Sunrise Act Criteria

Substantial Harm or Endangerment

> Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote.[35]

Errors in 911 call taking or dispatching have led to adverse outcomes.[36] Currently, each PSA conducts individual quality assurance and compliance reviews, and complaints against 911 call center staff are not published, so the exact impact is unknown.

Specialized Skill or Training, and Measurability

> Whether the practice of the profession or occupation requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability.[37]

Currently, the training of 911 call center staff is not consistent across the state and there are no universal training requirements. The majority of the staff receives on-the-job training that is tailored to each PSA's needs. The DOE curriculum framework proposed in the bill would provide consistent measureable and quantifiable examination and training requirements statewide. There does not appear to be a national examination or certification process currently available for 911 dispatchers/call takers. A state-administered examination would need to be created to accomplish the purpose of this bill.

According to proponents, 22 states currently have training standards. It appears that the training standards vary greatly. The Association of Public Safety Communication Officials (APCO) has published minimum training standards for public safety telecommunicators requiring 14 hours of additional training that should be conducted within the first 12 months of employment.

Unreasonable Effect on Job Creation or Job Retention

> Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment.[38]

Currently, there is high turnover of 911 call center staff. Regulation will have an effect on jobs by requiring individuals to have a minimum competency level, which is currently not required. Under this bill, starting in October 2012, individuals who cannot pass the examination and cannot successfully complete the 232-hour training program will not be able to practice as public safety telecommunicators.

Can the Public be Effectively Protected by Other Means?

> Whether the public is or can be effectively protected by other means.[39]

Currently, there is a voluntary certification process. Counties, cities, and state agencies can require individuals to become certified and not hire individuals unless they are certified.

---

[35] Section 11.62(3), F.S.
[36] According to the OPPAGA Report No. 10-12, in 2008, Denise Amber Lee was abducted from her home and murdered after calling 911 to report her own abduction. According to the Sunrise Questionnaire, a dispatcher was fired in Orlando for misprioritizing a 911 call related to a March 2009 murder-suicide.
[37] Section 11.62(3), F.S.
[38] Ibid.
[39] Ibid.

Favorable Cost-effectiveness and Economic Impact

> Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable.[40]

The actual cost to state, city, and county entities is indeterminate at this time. However, mandatory regulation will affectt approximately 6,000 call center staff. The average full-time dispatcher salary is $16.06 per hour. Usually, once a profession becomes regulated, it demands a higher salary commensurate with the education level. This bill proposes utilizing E911 funds to support certification fees. Currently, E911 funds only support 66 percent of current expenditures. Consumer phone bills may be increased if E911 fees need to be raised to support expenditures associated with the regulation of 911 public safety telecommunicators.

EFFECT OF THE PROPOSED CHANGES

This bill specifies that, effective October 1, 2012, any person serving at a PSAP as a 911 public safety telecommunicator must be certified by DOH. The bill also provides requirements for mandatory certification that include: education and training standards, continuing education, disciplinary provisions, and applicable fees.

The bill provides an exception for uncertified trainees. A PSA may employ a 911 public safety telecommunicator trainee for a period not to exceed 12 months, as long as the trainee is under the direct supervision of a certified dispatcher and enrolled in a public safety telecommunication training program.

The grandfather clause in current law is unaffected by the bill, but will expire on October 1, 2012. Individuals with five years of documented, supervised full-time employment as 911 public safety telecommunicators may qualify for certification without completing an approved training program and passing an examination. However, because the bill specifies that the grandfather clause expires on October 1, 2012, all individuals seeking certification after this date must complete an approved 232-hour 911 public safety telecommunication training program and pass an examination.

The bill defines "public safety telecommunication training program" as any program consisting of at least 232 hours that DOH determines to be equivalent to the most recent public safety telecommunication training program curriculum framework developed by DOE. The bill requires 20 hours of continuing education training at the time of certificate renewal. The bill provides DOH the authority to promulgate rules for the continuing education procedures and the approval process for the 911 public safety telecommunication training programs.

The bill changes the term "911 emergency dispatcher" to "911 public safety telecommunicator." The bill amends the definition of 911 public safety telecommunicator to include receiving, transferring, and dispatching functions relating to 911 calls. The bill also amends the disciplinary provisions in section 401.411, Florida Statutes, to ensure that 911 public safety telecommunicators are subject to the same disciplinary actions as EMTs and paramedics.

The bill provides a State of Emergency waiver for the 911 public safety telecommunicator certification requirements when the Governor declares a state of emergency as defined in section 252.36, Florida Statutes.

The bill also provides a statement of public interest pursuant to Section 18 of Article VII of the Florida Constitution.

The bill authorizes the use of funds from the Emergency Communications Number E911 System Fund to cover dispatching functions and the initial certification and renewal fees for 911 public safety telecommunicators.

---

[40] Ibid.

The bill also authorizes DOH to charge a fee not exceed $50 for the approval of a public safety telecommunication training program, a $50 fee for initial application, a $50 fee for certification renewal, and a $75 fee for the examination. Current law provides that these fees must be deposited into the Emergency Medical Services Trust Fund within DOH, and may only be used to support salaries and expenses incurred in administering this program.

The bill takes effect on July 1, 2010.

B. SECTION DIRECTORY:

Section 1. Amends s. 365.172, F.S., relating to emergency communications number.

Section 2. Amends s. 401.411, F.S., relating to disciplinary actions and penalties.

Section 3. Amends s. 401.465, F.S., relating to 911 public safety telecommunicator certification.

Section 4. Provides an effective date of July 1, 2010.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

Summary

The fiscal impact mainly addresses the following four areas:

- Cost incurred by DOH to regulate 911 public safety telecommunicators.
- Cost incurred by DOE for the review and approval of 911 public safety telecommunicator training programs.
- Cost incurred by state, city, and local governments:
  - Cost to provide in-house training or send employees to an outside entity that offers a 232-hour, DOH-approved training program;
  - Initial application and renewal fees associated with certification as public safety telecommunicators; and
  - Fee to have the 232-hour training program reviewed for approval by DOH.
- E911 Trust Fund authorized expenditures and sustainability of E911 funds.

Section 216.0236, Florida Statutes, states that it is the intent of the Legislature that all costs of providing a regulatory service or regulating a profession or business be borne solely by those who receive the service or who are subject to regulation. It is also the intent of the Legislature that the fees charged for providing a regulatory service or regulating a profession or business are reasonable and take into account the differences between the types of professions or businesses being regulated.

1. Revenues:

DOH, Division of Emergency Medical Operations, estimates that there is currently one emergency dispatcher for every 3,229 Florida residents. By applying the annual growth rate of 2.3 percent to the profession, the estimated increase in 911 public safety telecommunicators will be 6,171 in 2010, 6,312 in 2011, and 6,457 in 2012. By current projections, the remaining certification pool after the 2009 certification cycle ends will include 4,933 potential applicants in 2010. It is estimated that half of the remaining licensees will apply in 2010 (2,465 applicants), and that the residual applicants will apply in 2011 (2,521 applicants, adjusted for the annual growth rate). This two-year period (2010 and 2011) represents the initial surge of applicants.[41]

The bill states that the initial and renewal application fee for the 911 public safety telecommunicator is $50 and that the examination fee may not exceed $75. Since the majority of individuals who are

[41] This information was based on the grandfather clause ending on October 1, 2011. The CS/CS/HB 355 extends this period to October 1, 2012, and may affect the flow of applicants over the three-year period and the figures listed on Table 1.

certified under the voluntary certification program qualified via the grandfather clause, the majority of individuals would likely seek certification via this avenue in fiscal years 2010 and 2011. Because the grandfather clause will expire on October 1, 2012, however, it is projected that about half of the initial registrants would take the examination in 2012.

Based on information gathered from each county's State of Florida Emergency Telephone Number 911 Plan from the Department of Management Services, there are at least 251 PSAPs that could be certified as public safety telecommunication training programs. Currently, there is no fee to determine equivalency to the DOE curriculum framework. However, if this bill takes effect on July 1, 2010, it is estimated that 44 programs will apply prior to July 1, 2010, at no fee, and that the remaining 44 programs will apply after July 1, 2010, at the $50 fee. The methodology used to determine the number of training programs that may apply to DOH is based on a projection that two-thirds of the current PSAP centers will apply to become a training program. In addition to the two-thirds PSAP training programs, it is estimated that at least one community or technical college from each of the seven Regional Domestic Security Task Force Regions will apply to be a 911 public safety telecommunication training program. Using this methodology, it is projected that there will be 176 public safety telecommunication training programs in the state by 2012.

Table 1

	1st Year-2010	2nd Year-2011	3rd Year-2012	4th Year-2013 (Annualized/Recurring)
Applicants Initial Certification Fee @ $50	2,465 Applicants $123,250	2,512 Applicants $125,600	145 Applicants $7,250	148 Applicants $7,400
Applicants Certification Renewal Fee @ $50	-0-	1,100 Renewals $55,000	2,465 Renewals $123,250	2,512 Renewals $125,600
Programs Initial Training Evaluation Fee @ $50	44 Programs $2,200	88 Programs $4,400	6 Programs $300	10 Programs $500
Examination Fee @ $75	-0-	1,256 Exams $94,200	145 Exams $10,875	148 Exams $11,100
Total Revenue to EMS Trust Fund	**$125,450**	**$279,200**	**$141,675**	**$144,600**

2. Expenditures:

Department of Health (DOH), Division of Emergency Medical Operations

This bill does not specify which division within DOH must implement the act, although the bill provides for funding through the Emergency Medical Services Trust Fund. According to DOH, the Division of Emergency Medical Operations (DEMO) does not have available resources or the subject matter expertise to create an examination of this magnitude. The development and maintenance of this examination would currently be managed via a service licensure agreement between two divisions within DOH: the Division of Medical Quality Assurance (MQA) and DEMO. The estimate below is based on the utilization of current MQA resources, such as a psychometrician, contract manager, etc. Hourly costs are based on the average salaries in the MQA testing services unit. Many third party vendors administer similar examinations through testing centers. Normally, these testing centers charge each candidate a direct testing/examination fee. DEMO projects that it will cost $52,840 to create the first examination, and that there will be recurring annual costs of $12,032 for maintenance purposes.

Based on information gathered from each county's State of Florida Emergency Telephone Number 911 Plan from DMS, it is estimated that there are at least 251 PSAPs that could be certified as public safety telecommunication training programs. These 251 PSAPs employ approximately 6,033 of the 911 telecommunication professionals located throughout the state. According to MQA, it can process initial applications, issue licenses, and generally maintain a licensee pool at a rate of 5,751 per full-time equivalent (FTE) employee. According to DEMO, one FTE employee is required to

process initial applications, renewal applications, training center applications, and training program applications.

Table 2

	1st Year	2nd Year	3rd Year	4th Year (Annualized/Recurring)
Salaries				
1.0 – Regulatory Specialist. II, Pay Grade 17 (Salary Rate)	28,034	28,034	28,034	28,034
Fringe Benefits	$13,834	$13,834	$13,834	$13,834
Expenses				
Recurring Expenses, Limited Travel – 1.0 FTE	$16,853	$12,076	$12,076	$12,076
Human Resources (SC 107040)	$399	$399	$399	$399
Telecommunicator Examination Development Cost	$52,840	-0-	-0-	-0-
Examination Maintenance Cost	-0-	$12,032	$12,032	$12,032
Promulgate Rules, includes FAW notices, mailings and travel for 2 staff members for 2 meetings, and court reporting w/transcript cost. This cost will be covered by the EMS Trust Fund.	$3,200	-0-	-0-	-0-
Total Estimated Expenditures EMS Trust Fund	**$115,160**	**$66,375**	**$66,375**	**$66,375**

Department of Education (DOE)

DOE has indicated that this bill would increase its workload for the review and approval of training programs to ensure that these meet educational standards, and to provide regulatory functions for 911 dispatchers. Depending on the clarification of some implementation responsibilities, the increased workload could require an additional staff position to perform these duties. Also, DOE has stated that limited travel would be needed to perform periodic site visits of training programs.

Moreover, DOE has stated that the bill's proposed training requirement for current and future 911 dispatchers may result in additional FTEs and, consequently, in a greater need for additional state revenues to support facility, equipment, and operational expenditures in technical centers and colleges authorized to offer the emergency dispatch programs and related activities and services.

Department of Management Services (DMS)

DMS has indicated that it will not experience a fiscal impact, whether positive or negative, as a result of this bill.

Other State Agencies

The Florida Department of Law Enforcement (FDLE) estimates that eight FTE employees with Capitol Police that perform dispatch functions will be affected by the provisions of the bill.[42] An agency fiscal impact statement was not available to include in this bill analysis.

The Florida Department of Highway Safety and Motor Vehicles (FDHSMV), estimates that 281 FTE employees that perform dispatch functions will be affected by the provisions of the bill.[43] The FDHSMV currently offers a Basic Duty Officer training course to employees, but this course does not meet the 232-hour requirement. An agency fiscal impact statement was not available to include in this bill analysis.

[42] Per telephone conversation with FDLE staff on February 12, 2010.
[43] Per telephone conversation with FDHSMV staff on February 12, 2010.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

This bill authorizes the use of funds from the Emergency Communications Number E911 System Fund to support the costs incurred by local governments for the certification and recertification fees.

2. Expenditures:

The Revenue Estimating Conference (REC) has not met to address this bill in an Impact Conference. However, staff estimates that the provisions of this bill will have an indeterminate negative fiscal impact on local government revenues.

DMS has indicated that it has not determined the estimated fiscal impact on local governments, and that this impact would depend on a number of factors. Among these factors would be whether existing public safety training programs will be approved by DOH in some counties. Also, because the dispatching equipment has always been part of the costs for the emergency response agencies, including local municipality response agencies, the exact amount of equipment and maintenance costs is unknown. In addition, the fiscal impact on county governments for purposes of offsetting equipment and maintenance costs with E911 fee revenues is unknown. Overall, these costs will depend on the amount of dispatching equipment in section 365.172(9)(b), Florida Statutes,[44] that is determined to be fundable.

According to DMS, the E911 Board Prepaid Task Force Legislative Committee requested information from counties that have completed an estimate on the training cost associated with 911 public safety telecommunicators certification. Among the counties that provided information were the following:[45]

- *Polk County* estimated $600,315 in hourly wages and certification fees alone. Additionally, at the average turnover rate of 30 percent, $271,000 would have to be budgeted per year for DOH alone. These figures do not include the actual cost of training and certification, which will be significant as Emergency Medical Dispatcher alone costs $365 per student plus a $2,000 instructor's fee;

- *Pinellas County* indicated that if the legislation were to be passed as-is, and if none of their Communications Center training programs were certified, Pinellas County training costs could be as much as $2.7 million. This amount would roughly consist of $794,000 to use the E911 fees and $1,983,000 to General Revenue; and

- *Pasco County* estimated that it will cost $2,475 per hour to train the entire telecommunicator workforce. By multiplying this hourly cost with 232 for the course, Pasco County estimates that personnel costs will be $574,200.

In addition, the West Palm Beach Police Department estimated that 21 employees will need to take the training to meet the certification requirements. Because of minimum staffing levels, the training must either be done on overtime, or overtime would be necessary to fill the position to allow for training. As a result, West Palm Beach County estimates that the provisions of this bill will cost them $147,289 in overtime salaries and $1,575 in certification costs.[46]

It is unclear what assumptions were used by these entities to estimate their fiscal impacts. In particular, it is unclear whether these amounts are offset by current county training expenditures or whether these amounts are all new expenditures. Similarly, it is unclear whether these counties' current training programs meet the 232 hours and the DOE curriculum framework required by the bill. Therefore, staff is not able to ascertain a possible net effect or offset for current training costs.

[44] Section 365.172(9)(b), F.S., addresses the "authorized expenditures of E911 fee."
[45] Department of Management Services, 2010 Legislative Bill Analysis of House Bill 355 (February 9, 2010).
[46] E-mail correspondence on file with the Health Care Regulation Policy staff dated February 11, 2010.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There may be an increase in enrollment at private education facilities that offer a 911 public safety telecommunicator training program.

DOH has indicated that the bill will affect private emergency medical services providers if they choose to pay the required costs for their 911 public safety telecommunicators to become certified and to become a training program. However, the estimated costs cannot be determined as this would be an internal business decision.

DMS has indicated that the provisions of this bill may affect some private sector telecommunicators, such as the one for the Reedy Creek Improvement District.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The mandates provision in Section 18 of Article VII of the Florida Constitution appears to apply because this bill may require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. However, if the Legislature determines that the bill fulfills an important state interest, an exception to the mandates provision exists because the bill applies to all persons similarly situated, including the state. The bill includes a statement of public interest.

2. Other:

This bill authorizes DOH to promulgate rules for the approval of public safety telecommunication training programs. Because the bill does not provide DOH minimal standards or guidelines on the approval process, the bill may implicate the non-delegation doctrine contained in Section 3 of Article II of the Florida Constitution.

B. RULE-MAKING AUTHORITY:

The bill appears to provide sufficient rulemaking authority to DOH.

C. DRAFTING ISSUES OR OTHER COMMENTS:

DOH has provided the following comments:

The bill provides DOH rule authority to determine the definition of "direct supervision" as it relates to a training period. However, the bill has no provisions for instructor qualifications as it relates to a training period. This may be problematic for DOH as seen with other professions. Other public safety professions provide some type of regulatory control over the instructors of their respective curriculum.

DOE has provided the following comments:

- It is unclear who will be responsible for developing the 20-hour training for biennial renewal certification;
- The bill would require DOH to establish, by rule, a procedure to approve public safety telecommunications training programs; however, DOE already approves the curriculum framework for the program. It is unclear whether the procedure is expected to duplicate DOE's approval process. If the process is expected to monitor colleges in the implementation of the approved public safety telecommunications curriculum framework, then the bill language should be revised; and

- The bill does not specify which educational delivery system or combination of educational delivery systems must be certified to offer the emergency dispatch training program. Because of the multiple combinations and varied financial impacts resulting from different combinations of public and private educational entities offering the required training, specific information concerning potential revenues and expenditures for these educational entities cannot be determined at this time.

DMS has provided the following comments:

Because the bill addresses certification costs for dispatching, DMS suggests amending section 365.172(9)(a), Florida Statutes, which addresses the "authorized expenditures of E911 fee." Statutory changes related to dispatcher certification can affect training costs and expenditures, as well as significant additional personnel costs not contemplated by the original intent of the E911 fee program.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

On February 16, 2010, the Health Care Regulation Policy Committee adopted the following seven amendments and reported the bill favorably as a committee substitute. The amendments:

- Added costs for dispatching functions as an authorized expenditure of E911 funds;
- Provided a statement of public interest pursuant to Section 18 of Article VII of the Florida Constitution;
- Reduced the fee for placing and renewing a license that is on inactive status from $75 to $50;
- Reduced the initial application fee from $75 to $50;
- Reduced the certification biannual renewal and application for training program approval fees from $75 to $50;
- Deleted the phrase "most recent," which is unnecessary language that references the DOE curriculum framework; and
- Changed terms from "is" to "works" to specify that a trainee works under direct supervision.

This analysis is drafted to the committee substitute adopted by the Health Care Regulation Policy Committee.

On March 25, 2010, the Military & Local Affairs Policy Committee adopted one amendment and reported the bill favorably as a committee substitute. This amendment postpones the effective date of the mandatory certification provisions until October 1, 2012.

This analysis reflects the amendment adopted by the Military & Local Affairs Policy Committee.

A bill to be entitled

An act relating to public safety telecommunicators; amending s. 365.172, F.S.; including dispatching as a function of E911 service; including fees for certification and recertification collected by the Department of Health in authorized expenditures for E911 services; amending s. 401.411, F.S.; revising applicability of certain disciplinary actions and penalties; amending s. 401.465, F.S.; redefining the term "emergency dispatcher" as "public safety telecommunicator"; defining the term "public safety telecommunication training program"; providing requirements for training and certification of a public safety telecommunicator, including fees; requiring the department to establish a procedure for the approval of public safety telecommunication training programs; providing for temporary waiver of certification requirements in an area of the state for which the Governor has declared a state of emergency; providing a declaration of important state interest; providing an effective date.

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

Section 1. Paragraphs (a) and (b) of subsection (9) of section 365.172, Florida Statutes, are amended to read:

365.172 Emergency communications number "E911."—

(9) AUTHORIZED EXPENDITURES OF E911 FEE.—

(a) For purposes of this section, E911 service includes

the functions of database management, call taking, dispatching, location verification, and call transfer.

(b) All costs directly attributable to the establishment or provision of E911 service and contracting for E911 services are eligible for expenditure of moneys derived from imposition of the fee authorized by this section. These costs include the acquisition, implementation, and maintenance of Public Safety Answering Point (PSAP) equipment and E911 service features, as defined in the Public Service Commission's lawfully approved 911 and E911 and related tariffs or the acquisition, installation, and maintenance of other E911 equipment, including call answering equipment, call transfer equipment, ANI controllers, ALI controllers, ANI displays, ALI displays, station instruments, E911 telecommunications systems, visual call information and storage devices, recording equipment, telephone devices and other equipment for the hearing impaired used in the E911 system, PSAP backup power systems, consoles, automatic call distributors, and interfaces, including hardware and software, for computer-aided dispatch (CAD) systems, integrated CAD systems for that portion of the systems used for E911 call taking, network clocks, salary and associated expenses for E911 call takers for that portion of their time spent taking and transferring E911 calls, salary and associated expenses for a county to employ a full-time equivalent E911 coordinator position and a full-time equivalent mapping or geographical data position and a staff assistant position per county for the portion of their time spent administrating the E911 system, training costs for PSAP call takers, supervisors, and managers

in the proper methods and techniques used in taking and transferring E911 calls, costs to train and educate PSAP employees regarding E911 service or E911 equipment, including Department of Health fees for the certification and recertification of 911 public safety telecommunicators as required under s. 401.465, and expenses required to develop and maintain all information, including ALI and ANI databases and other information source repositories, necessary to properly inform call takers as to location address, type of emergency, and other information directly relevant to the E911 call-taking and transferring function. Moneys derived from the fee may also be used for next-generation E911 network services, next-generation E911 database services, next-generation E911 equipment, and wireless E911 routing systems.

Section 2. Paragraphs (g) and (k) of subsection (1) of section 401.411, Florida Statutes, are amended to read:

401.411 Disciplinary action; penalties.—

(1) The department may deny, suspend, or revoke a license, certificate, or permit or may reprimand or fine any licensee, certificateholder, or other person operating under this part for any of the following grounds:

(g) Unprofessional conduct, including, but not limited to, any departure from or failure to conform to the minimal prevailing standards of acceptable practice under this part ~~as an emergency medical technician or paramedic~~, including undertaking activities that the emergency medical technician, ~~or~~ paramedic, health care professional, or other professional is not qualified by training or experience to perform.

(k) Practicing as an emergency medical technician, paramedic, ~~or other~~ health care professional, or other professional operating under this part without reasonable skill and without regard for the safety of the public ~~to patients~~ by reason of illness, drunkenness, or the use of drugs, narcotics, or chemicals or any other substance or as a result of any mental or physical condition.

Section 3. Section 401.465, Florida Statutes, is amended to read:

401.465 911 public safety telecommunicator ~~emergency dispatcher~~ certification.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "911 public safety telecommunicator ~~emergency dispatcher~~" means ~~a person employed by a state agency or local government as~~ a public safety dispatcher or 911 operator whose duties and responsibilities include the answering, receiving, transferring, and dispatching functions related to 911 calls; dispatching law enforcement officers, fire rescue services, emergency medical services, and other public safety services to the scene of an emergency; providing real-time information from federal, state, and local crime databases; or supervising or serving as the command officer to a person or persons having such duties and responsibilities. However, the term does not include administrative support personnel, including, but not limited to, those whose primary duties and responsibilities are in accounting, purchasing, legal, and personnel.

(b) "Department" means the Department of Health.

(c) "Public safety telecommunication training program" means a 911 emergency public safety telecommunications training program that the department determines to be equivalent to the public safety telecommunication training program curriculum framework developed by the Department of Education and consists of not less than 232 hours.

(2) PERSONNEL; STANDARDS AND CERTIFICATION.—

(a) Effective October 1, 2012, any person employed as a 911 public safety telecommunicator at a public safety answering point, as defined s. 365.172(3)(a), must be certified by the department.

(b) A public safety agency, as defined s. 365.171(3)(d), may employ a 911 public safety telecommunicator trainee for a period not to exceed 12 months, provided the trainee works under the direct supervision of a certified 911 public safety telecommunicator, as determined by rule of the department, and is enrolled in a public safety telecommunication training program.

(c) ~~(a)~~ An applicant for certification or recertification ~~Any person who desires to be certified or recertified~~ as a 911 public safety telecommunicator must ~~emergency dispatcher may~~ apply to the department under oath on forms provided by the department. The department shall establish by rule educational and training criteria for the certification and recertification of 911 public safety telecommunicators ~~emergency dispatchers~~.

(d) ~~(b)~~ The department shall determine whether the applicant meets the requirements specified in this section and in rules of the department and shall issue a certificate to any

person who meets such requirements. Such requirements must include~~, but need not be limited to,~~ the following:

1. Completion of an appropriate 911 public safety telecommunication ~~emergency dispatcher~~ training program ~~that is equivalent to the most recently approved emergency dispatcher course of the Department of Education and consists of not less than 208 hours~~;

~~2. Completion and documentation of at least 2 years of supervised full-time employment as a 911 emergency dispatcher since January 1, 2002;~~

2.~~3.~~ Certification under oath that the applicant is not addicted to alcohol or any controlled substance;

3.~~4.~~ Certification under oath that the applicant is free from any physical or mental defect or disease that might impair the applicant's ability to perform his or her duties;

4.~~5.~~ Submission of the application fee prescribed in subsection (3); ~~and~~

5.~~6.~~ Submission of a completed application to the department which indicates compliance with subparagraphs 1., 2., and 3.~~;~~ and ~~4.~~

6. Effective October 1, 2012, passage of an examination administered by the department that measures the applicant's competency and proficiency in the subject material of the public safety telecommunication training program.

(e)~~(c)~~ The department shall establish by rule a procedure that requires 20 hours of training for the biennial renewal certification of 911 public safety telecommunicators ~~emergency dispatchers~~.

(f) ~~(d)~~ A ~~Each~~ 911 public safety telecommunicator ~~emergency dispatcher~~ certificate expires automatically if not renewed at the end of the 2-year period and may be renewed if the holder meets the qualifications for renewal as established by the department. A certificate that is not renewed at the end of the 2-year period automatically reverts to an inactive status for a period that may not exceed 180 days. Such certificate may be reactivated and renewed within the 180-day period if the certificateholder meets all other qualifications for renewal and pays a $50 late fee. Reactivation shall be in a manner and on forms prescribed by department rule.

(g) ~~(e)~~ The department may suspend or revoke a certificate at any time if it determines that the certificateholder does not meet the applicable qualifications.

(h) ~~(f)~~ A certificateholder may request that his or her 911 public safety telecommunicator ~~emergency dispatcher~~ certificate be placed on inactive status by applying to the department before his or her current certification expires and paying a fee set by the department, which may not exceed $50 ~~$100~~.

1. A certificateholder whose certificate has been on inactive status for 1 year or less may renew his or her certificate pursuant to the rules adopted by the department and upon payment of a renewal fee set by the department, which may not exceed $50 ~~$100~~.

2. A certificateholder whose certificate has been on inactive status for more than 1 year may renew his or her certificate pursuant to rules adopted by the department.

3. A certificate that has been inactive for more than 6 years automatically expires and may not be renewed.

(i) ~~(g)~~ The department shall establish by rule a procedure for the initial certification of 911 public safety telecommunicators ~~emergency dispatchers~~ as defined in this section who have documentation of at least 5 years of supervised full-time employment as a 911 public safety telecommunicator or an emergency dispatcher since January 1, 2002. This paragraph expires October 1, 2012.

(j) The department shall establish by rule a procedure for the approval of public safety telecommunication training programs required by this section.

(3) FEES.—

(a) The initial application fee for ~~application for~~ the 911 public safety telecommunicator ~~emergency dispatcher~~ original certificate is $50 ~~$75~~.

(b) The examination fee for the 911 public safety telecommunicator set by the department, which may not exceed $75.

(c) ~~(b)~~ The application fee for the 911 public safety telecommunicator ~~emergency dispatcher~~ biennial renewal certificate set by the department, which may not exceed $50 ~~is $100~~.

(d) The application fee for department approval of a public safety telecommunication training program set by the department, which may not exceed $50.

(e) ~~(c)~~ Fees collected under this section shall be deposited into the Emergency Medical Services Trust Fund and

used solely for salaries and expenses of the department incurred in administering this section.

(f) ~~(d)~~ If a certificate issued under this section is lost or destroyed, the person to whom the certificate was issued may, upon payment of a fee set by the department, which may not exceed $25, obtain a duplicate or substitute certificate.

(g) ~~(e)~~ Upon surrender of the original 911 public safety telecommunicator or emergency dispatcher certificate and receipt of a replacement fee set by the department, which may not exceed $25, the department shall issue a replacement certificate to make a change in name.

(4) STATE-OF-EMERGENCY WAIVER.—The provisions of this section may be temporarily waived by the department in a geographic area of the state where a state of emergency has been declared by the Governor pursuant to s. 252.36.

Section 4. The Legislature finds that this act fulfills an important state interest.

Section 5. This act shall take effect July 1, 2010.

Amendment No. 1

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

Council/Committee hearing bill: Health Care Appropriations Committee

Representative Roberson, K. offered the following:

Amendment (with title amendment)

Between lines 239 and 240, insert:

Section 5. For the 2010-2011 fiscal year, one full-time equivalent position with associated salary rate of 28,034 is authorized and the sums of $66,375 in recurring funds and $48,785 in nonrecurring funds is appropriated from the Emergency Medical Services Trust Fund to the Department of Health for the purposes of approving public safety telecommunication training programs, administering examinations and certifying 911 public safety telecommunicators as required under s. 401.465, Florida Statutes.

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

Remove line 20 and insert:

appropriation; providing an effective date.

Amendment No. 2

COUNCIL/COMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health Care Appropriations Committee

Representative(s) Roberson, K. offered the following:

Amendment (with title amendment)

Between lines 203 and 204, insert:

(j) If a person was employed as a 911 public safety telecommunicator before April 1, 2012, he or she must pass the examination administered by the department which measures the competency and proficiency in the subject material of the public safety telecommunication program, as defined in paragraph (1)(c). Upon passage of the examination, the completion of the public safety telecommunication training program shall be waived.

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

Remove line 13 and insert:

public safety telecommunicator, including fees; requiring certain 911 public safety telecommunicators to pass an examination administered by the department; requiring

Amendment No. 3

COUNCIL/COMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health Care Appropriations Committee

Representative Nehr offered the following:

Amendment (with title amendment)

Between lines 233 and 234, insert:

(4) Exemption.-The provisions of this section do not apply to sworn, certified law enforcement officers.

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

Between lines 15 and 16, insert:

providing an exemption from certification for all sworn certified law enforcement officers;

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 945 Automated External Defibrillators in Assisted Living Facilities
SPONSOR(S): Elder & Family Services Policy Committee; Anderson
TIED BILLS: **IDEN./SIM. BILLS:** SB 2008

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Elder & Family Services Policy Committee	14 Y, 0 N, As CS	Shaw	Shaw
2)	Health Care Appropriations Committee		Edwards ELE	Pridgeon
3)	Health & Family Services Policy Council			
4)				
5)				

SUMMARY ANALYSIS

An assisted living facility (ALF) is a residential establishment for adults that provides housing, meals, and one or more personal services relating to the activities of daily living. Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.

Automated external defibrillators (AED) are computerized devices that are used by healthcare providers and by lay rescuers to revive victims who are thought to be in cardiac arrest.

The bill amends s. 429.255, F.S., to provide that an ALF with 17 or more beds must have on the premises at all times a functioning AED. The bill encourages the location of the AED to be registered with the medical director of the local emergency medical service.

The bill directs that facility staff may withdraw or withhold the use of an AED if presented with an order not to resuscitate in the same manner as they can now withdraw or withhold cardiopulmonary resuscitation. The civil immunity provisions of the Cardiac Arrest Survival Act and the Good Samaritan Act will apply to both the ALF and the facility staff.

The bill provides that the Department of Elder Affairs may adopt rules relating to the use of an automated external defibrillator in an ALF.

The bill appears to have a significant fiscal impact on state government (See Fiscal Comments).

The bill is effective upon July 1, 2010.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

PRESENT SITUATION

Assisted Living Facilities

An assisted living facility (ALF) is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[2] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks. Florida currently has 2,851 licensed assisted living facilities with 909 of them having 17 or more licensed beds.[3] A typical resident is age 83 or older, is female, and is either widowed or single. [4]

ALFs are licensed by the Agency for Health Care Administration (AHCA) pursuant to part I of ch.429, F.S., relating to assisted care communities and part II of ch.408, F.S., relating to the general licensing provisions for health care facilities. ALFs are also subject to regulation under Rule Chapter 58A-5, F.A.C. These rules are adopted by the Department of Elder Affairs in consultation with the AHCA, the Department of Children and Family Services, and the Department of Health. An ALF must also comply with the Uniform Fire Safety Standards for ALFs contained in Rule Chapter 69A-40, F.A.C., and standards enforced by the DOH concerning food hygiene, physical plant sanitation, biomedical waste, and well, pool, or septic systems. Rules adopted to regulate ALFs are required to make distinct standards for facilities based upon the size of the facility; the types of care provided; the physical and mental capabilities and needs of the residents; the type, frequency, and amount of services and care offered; and the staffing characteristics of the facility.

In general, an ALF does not provide medical services to its residents. An ALF may obtain a limited nursing license which enables the facility to provide, directly or through contract, a select number of nursing services in addition to the personal services that are authorized under the standard license.

---

[1] s. 429.02(5), F.S.
[2] s. 429.02(16), F.S.
[3] *Agency for Health Care Administration, 2010 Bill Analysis & Economic Impact Statement for HB 945*, on file with the Elder & Family Services Policy Committee
[4] Florida Assisted Living Association, http://www.falausa.com/what_is_an_alf.php (last visited on March 8, 2010).

The nursing services authorized to be provided with this license are limited to acts specified in administrative rules.[5]

The Department of Elder Affairs provides by rule[6] the core training requirements and a competency test for ALF facility staff. The training consists of a minimum of 26 hour and includes areas such as assistance with medications, HIV/AIDS, infection control, including universal precautions, and facility sanitation procedures prior to providing personal care to residents. Additionally, staff must have training in facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.[7]

A staff member who has completed courses in First Aid and CPR and holds a currently valid card documenting completion of such courses must be in the facility at all times.[8] In an emergency situation, persons licensed under the nurse practice act may carry out their professional duties until emergency medical personnel assume responsibility for care.[9]

An order not to resuscitate (DNRO) is a document executed by a resident and the resident's physician indicating that the resident does not want resuscitation during an emergency situation.[10] If a resident of an ALF has an order not to resuscitate, facility staff may withhold or withdraw cardiopulmonary resuscitation.[11] If a resident has a DNRO, then the ALF and facility staff shall not be subject to criminal or civil liability, or be considered to have acted negligently or unprofessionally, for withholding or withdrawing cardiopulmonary resuscitation.[12]

Automated External Defibrillators

The American Heart Association provides the following description of cardiac arrest:

> "Cardiac arrest is the sudden, abrupt loss of heart function. The victim may or may not have diagnosed heart disease. . . .Sudden death (also called sudden cardiac death) occurs within minutes after symptoms appear."[13]

Time is of the essence in responding to cardiac arrest because brain death begins in just 4 to 6 minutes. Cardiac arrest can be reversed if it is treated within a few minutes with an electric shock to the heart to restore a normal heartbeat – a procedure known as *defibrillation*. According to the American Heart Association, a victim's chances of survival are reduced by 7 to 10 percent with every minute that passes without defibrillation, and few attempts at resuscitation succeed after 10 minutes have elapsed.[14]

---

[5] Rule 58A-5.031, F.A.C. The additional nursing services that might be performed pursuant to the LNS license include: conducting passive range of motion exercises; applying ice caps or collars; applying heat, including dry heat, hot water bottle, heating pad, aquathermia, moist heat, hot compresses, sitz bath and hot soaks; cutting the toenails of diabetic residents or residents with a documented circulatory problem if the written approval of the resident's health care provider has been obtained; performing ear and eye irrigations; conducting a urine dipstick test; replacing an established self-maintained indwelling urinary catheter, or performing an intermittent urinary catheterization; performing digital stool removal therapies; applying and changing routine dressings that do not require packing or irrigation, but are for abrasions, skin tears and closed surgical wounds; caring for stage 2 pressure sores, (care for stage 3 or 4 pressure sores are not permitted); caring for casts, braces and splints, (care for head braces, such as a halo, is not permitted); assisting, applying, caring for, and monitoring the application of anti-embolism stockings or hosiery; administering and regulating portable oxygen; applying, caring for, and monitoring a transcutaneous electric nerve stimulator (TENS); performing catheter, colostomy, and ileostomy care and maintenance; conducting nursing assessments; and, for hospice patients, providing any nursing service permitted within the scope of the nurse's license, including 24-hour nursing supervision.
[6] s. 429.52, F.S and Rule 58A-5.0191, F. A. C.
[7] Id.
[8] Id.
[9] s. 429.255(1)(c), F.S.
[10] s. 401.45, F.S.
[11] s. 429.255(3), F.S., directs the Department of Elder Affairs to adopt rules providing for the implementation of DNROs in assisted living facilites. The Department is in the process of adopting such rules. See Proposed Rule 58A-0183, F.A.C.
[12] s. 429.255(3), F.S.
[13] The American Heart Association, http://www.americanheart.org/presenter.jhtml?identifier=4481 (last visited on March 6, 2010).
[14] *Id.*

Automated external defibrillators (AED)[15] are computerized devices that are used by healthcare providers and lay rescuers on victims who are thought to be in cardiac arrest. Modern AEDs are now about the size of a laptop computer and they provide voice and visual prompts to lead rescuers through the steps of operation. AEDs analyze the victim's heart rhythm, determine if a defibrillation shock is needed, then prompt the rescuer to "clear" the victim and deliver a shock. According to the American Heart Association, with early defibrillation of a person in cardiac arrest, the person's possibility of survival jumps to more than 50 percent.[16]

Prior to July 1, 2008, s. 401.2915, F.S., required all persons who use an AED to have certain training and required all persons in possession of an AED to notify the local emergency medical services director of the location of the AED. Section 401.2915, F.S., was amended and now provides that all persons who use an automated external defibrillator are encouraged to obtain appropriate training, which includes completion of a course in cardiopulmonary resuscitation or successful completion of a basic first aid course that includes cardiopulmonary resuscitation training, and demonstrated proficiency in the use of an automated external defibrillator.[17] Additionally, the notification of the medical director of the local emergency medical services of the location of the automated external defibrillator is now only encouraged.

Cardiac Arrest Survival Act

The Cardiac Arrest Survival Act[18] provides civil immunity for any person[19] who uses or attempts to use an AED on the victim of a perceived medical emergency. However, this civil immunity will not apply if:

- The harm involved was caused by that person's willful or criminal misconduct, gross negligence, reckless disregard or misconduct, or a conscious, flagrant indifference to the rights or safety of the victim who was harmed;
- The person is a licensed or certified health professional who used the automated external defibrillator device while acting within the scope of the license or certification of the professional and within the scope of the employment or agency of the professional;
- The person is a hospital, clinic, or other entity whose primary purpose is providing health care directly to patients, and the harm was caused by an employee or agent of the entity who used the device while acting within the scope of the employment or agency of the employee or agent;
- The person is an acquirer of the device who leased the device to a health care entity, or who otherwise provided the device to such entity for compensation without selling the device to the entity, and the harm was caused by an employee or agent of the entity who used the device while acting within the scope of the employment or agency of the employee or agent; or
- The person is the manufacturer of the device.

The act also provides civil immunity to any person who acquired the AED and makes it available for use. However, immunity will not apply if the person:

- Fails to properly maintain and test the device; or
- Fails to provide appropriate training in the use of the device to an employee or agent of the acquirer when the employee or agent was the person who used the device on the victim, except that such requirement of training does not apply if:
    - The device is equipped with audible, visual, or written instructions on its use, including any such visual or written instructions posted on or adjacent to the device;
    - The employee or agent was not an employee or agent who would have been reasonably expected to use the device; or

[15] s. 786.1325 (2)(b), F.S., provides: "Automated external defibrillator device" means a lifesaving defibrillator device that: Is commercially distributed in accordance with the Federal Food, Drug, and Cosmetic Act; is capable of recognizing the presence or absence of ventricular fibrillation, and is capable of determining without intervention by the user of the device whether defibrillation should be performed; and upon determining that defibrillation should be performed, is able to deliver an electrical shock to an individual.
[16] The American Heart Association, http://www.americanheart.org/presenter.jhtml?identifier=4483 (last visited on March 6, 2010).
[17] s. 1, ch. 2008-101, L.O.F.
[18] s. 768.1325, F.S.
[19] s. 1.01(3), F.S., provides the word "person" includes individuals, children, firms, associations, joint adventures, partnerships, estates, trusts, business trusts, syndicates, fiduciaries, corporations, and all other groups or combinations.

- The period of time elapsing between the engagement of the person as an employee or agent and the occurrence of the harm, or between the acquisition of the device and the occurrence of the harm in any case in which the device was acquired after engagement of the employee or agent, was not a reasonably sufficient period in which to provide the training.

Good Samaritan Act

The Good Samaritan Act[20] also provides immunity to any person that gratuitously renders medical care or treatment in direct response to an emergency. More specifically, the Good Samaritan Act provides immunity from civil liability to:

- Any persons, including those licensed to practice medicine, who gratuitously and in good faith render emergency care or treatment either in direct response to emergency situations related to and arising out of a public health emergency declared pursuant to s. 381.00315, F.S., or a state of emergency which has been declared pursuant to s. 252.36, F.S., or at the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment. The immunity applies if the person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.

- Any health care provider, including a licensed hospital providing emergency services pursuant to federal or state law. The immunity applies to damages as a result of any act or omission of providing medical care or treatment, including diagnosis, which occurs prior to the time that the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency, in which case the immunity applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following surgery, or which is related to the original medical emergency. The act does not extend immunity from liability to acts of medical care or treatment under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of another.

- Any health care practitioner who is in a hospital attending to a patient of his or her practice or for business or personal reasons unrelated to direct patient care, and who voluntarily responds to provide care or treatment to a patient with whom at that time the practitioner does not have a then existing health care patient practitioner relationship, and when such care or treatment is necessitated by a sudden or unexpected situation or by an occurrence that demands immediate medical attention, unless that care or treatment is proven to amount to conduct that is willful and wanton and would likely result in injury so as to affect the life or health of another. The immunity extended to health care practitioners does not apply to any act or omission of providing medical care or treatment unrelated to the original situation that demanded immediate medical attention.

Effect of Proposed Changes

The bill amends s. 429.255, F.S., to provide that an ALF with 17 or more beds must have on the premises at all times a functioning AED. The bill encourages the location of the AED to be registered with the medical director of the local emergency medical service.

The bill directs that facility staff may withdraw or withhold the use of an AED if presented with an order not to resuscitate in the same manner as they now can withdraw or withhold cardiopulmonary resuscitation.

The civil immunity provisions of the Cardiac Arrest Survival Act and the Good Samaritan Act will apply to both the ALF and the facility staff.

[20] s. 678.13, F.S.

The bill provides that the Department of Elder Affairs may adopt rules relating to the use of an automated external defibrillator in an ALF.

B. SECTION DIRECTORY:

Section 1: Amends s. 429.0255, F.S.

Section 2: Provides an effective date of July 1, 2010.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

	Amount Year 1 FY 10-11	Amount Year 2 FY 11-12
ESTIMATED NON-RECURRING EXPENDITURES		
Salaries	$0	$0
OPS	$0	$0
Expense	$6,200	$0
Operating Capital Outlay	$5,000	$0
TOTAL Non-Recurring Expenditures	$11,200	

		Amount Year 1 FY 09-10	Amount Year 2 FY 10-11
ESTIMATED RECURRING EXPENDITURES			
Salaries (2.0 FTE's)	**Rate**		
Health Facility Evaluator II	34,634	$44,280	$44,280
Health Facility Evaluator II	35,595	$45,508	$45,508
Total Salary and Benefits	**70,229**	**$89,788**	**$89,788**
OPS		$0	$0
Expense		$22,440	$22,440
Human Resources Services		$802	$802
TOTAL RECURRING EXPENDITURES	**70,229**	**$113,030**	**$113,030**

Non-Recurring Expenditures	$11,200	$0
Recurring Expenditures	$113,030	$113,030
TOTAL EXPENDITURES	**$124,230**	**$113,030**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

ALFs will be required to purchase AEDs. Most AEDs cost between $1,500 and $2,000.[21] Additionally, the ALFs may have costs for training employees in the use of AEDs.

D. FISCAL COMMENTS:

The Agency for Health Care Administration will have to complete on-site inspections to verify that the ALFs have a functioning AED on their premises. The agency believes the bill will increase the number of complaints or inquires related to the use of AEDs in assisted living facilities.

Miami-Dade and Pinellas Counties currently have 1200 assisted living facilities, totaling 42% of the states assisted living facilities. The agency bill analysis states that it does not believe it can fulfill the requirements of the bill within its existing resources. The agency estimated that it would need two FTEs (two Health Facility Evaluator II's, one each for the Miami-Dade and Pinellas Counties) at a cost of $124,230 in FY 2010-2011 with a recurring cost of $113,030. These estimates include the competitive area differential amount for one Health Facility Evaluator II for the surveyor in Miami and two tablet notebooks with docking stations.

[21] American Heart Association, http://www.americanheart.org/presenter.jhtml?identifier=3011859, (last viewed March 6, 2010)

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides the Department of Elder Affairs may adopt rules relating to the use of automated external defibrillators.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

On March 9, 2010, the Elder & Family Services Policy Committee adopted a strike-all amendment to the bill. The amendment removed from the original bill the requirements that:

- All facility staff must be trained in the use of an AED.
- Only facility staff who are trained may use the AED.
- The owner or administrator of the ALF must establish requirements for the use of the AED.
- The location of the AED must be registered with the medical director of the local emergency medical service.

The original bill provided that the Department of Health shall adopt rules relating to the use of automated external defibrillators. The amendment transferred the rulemaking authority to the Department of Elder Affairs, and makes such rulemaking discretionary.

The original bill provided an effective date of upon becoming a law. The amendment provides an effective date of July 1, 2010.

The bill was reported favorably as a Committee Substitute. This analysis reflects the committee substitute.

A bill to be entitled

An act relating to automated external defibrillators in assisted living facilities; amending s. 429.255, F.S.; requiring certain assisted living facilities to possess a functioning automated external defibrillator; encouraging an assisted living facility to register the location of the automated external defibrillator with a local emergency medical services medical director; providing immunity from liability under the Good Samaritan Act and the Cardiac Arrest Survival Act; authorizing the Department of Elderly Affairs to adopt rules relating to the use of automated external defibrillators; providing an effective date.

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

Section 1. Present subsection (3) of section 429.255, Florida Statutes, is renumbered as subsection (4) and amended, and new subsections (3) and (5) are added to that section, to read:

429.255 Use of personnel; emergency care.—

(3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b).

(b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director.

(c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility.

(4) ~~(3)~~ Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45. The department shall adopt rules providing for the implementation of such orders. Facility staff and facilities shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator pursuant to such an order and rules adopted by the department. The absence of an order to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise permitted by law.

(5) The Department of Elderly Affairs may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator.

Section 2. This act shall take effect July 1, 2010.

Amendment No. 1

COUNCIL/COMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health Care Appropriations Committee

Representative(s) Anderson offered the following:

Amendment (with title amendment)

Between lines 48 and 49, insert:

Section 2. The sum of $22,447 in recurring funds and $11,200 in nonrecurring funds from the General Revenue Fund and two full-time equivalent positions with associated salary rate of 70,229 is appropriated to the Agency for Health Care Administration for Fiscal Year 2010-2011 to implement the provisions of this act. An additional $113,030 in recurring funds is appropriated to the Agency for Health Care Administration for Fiscal Year 2011-2012 from the General Revenue Fund for the same purpose.

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

Amendment No. 1

Remove line 12 and insert:

the use of automated external defibrillators; providing appropriations; providing an

Amendment No. 2

COUNCIL/COMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health Care Appropriations Committee

Representative(s) Anderson offered the following:

Amendment

Remove line 49 and insert:

Section 3. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2011.

Amendment No. 3

COUNCIL/COMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Health Care Appropriations Committee

Representative(s) Chestnut offered the following:

Amendment (with title amendment)

Remove lines 31-45 and insert:

(4)(a) Any employee or contractor of the facility who uses or attempts to use an automated external defibrillator on a victim of a perceived medical emergency, without objection of the victim of the perceived medical emergency, is immune from civil liability for any harm resulting from the use of such device, unless the harm results from that person's willful or criminal misconduct, gross negligence, reckless disregard or misconduct, or a conscious, flagrant indifference to the rights or safety of the victim who was harmed.

(b) Any facility that acquires the device and makes it available for use is immune from civil liability if the harm was not due to the failure of such facility to:

1. Properly maintain and test the device; or

2. Provide appropriate training in the use of the device to an employee or contractor of the facility when the employee or contractor was the person who used the device on the victim.

(c) The owner or administrator of a facility may establish policies and procedures for the use of an automated external defibrillator. Residents must comply with policies and procedures adopted by the facility that allow for the identification of residents with an order not to resuscitate.

(5) ~~(4)~~ Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45. The department shall adopt rules providing for the implementation of such orders. Facility staff and facilities shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator pursuant to such an order and rules adopted by the department. The absence of an order to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise permitted by law. Any employee or person under contract with the facility and the facility shall be immune from civil liability arising from the use of an automated external defibrillator on a person with such an order where the person using the automated external defibrillator does not personally

have actual knowledge of the existence and validity of this order.

(6) The provisions of this section shall control over any conflicting provisions contained in s. 768.1325.

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

Remove line 10 and insert:
the Cardiac Arrest Survival Act; providing immunity from liability for persons employed by or under contract with assisted living facilities; authorizing the