Health Care Regulation Policy Committee

Tuesday, February 17, 2009
3:15 PM – 5:00 PM
116 Knott Building

Larry Cretul
Speaker pro tempore

Jimmy Patronis
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Care Regulation Policy Committee

Start Date and Time: Tuesday, February 17, 2009 03:15 pm

End Date and Time: Tuesday, February 17, 2009 05:00 pm

Location: 116 Knott Building

Duration: 1.75 hrs

Consideration of the following bill(s):

HB 53 Clinical Laboratories by Garcia
HB 231 Patient Lifting and Handling Practices by Grimsley
HB 387 Medical Faculty Certificates by Rivera

Presentation by Agency for Health Care Administration on Health Information Technology and Transparency.

NOTICE FINALIZED on 02/10/2009 15:44 by Manning.Karen

The Florida House of Representatives

Health Care Regulation Policy Committee

A G E N D A

February 17, 2009
3:15 PM - 5:00 PM
116 Knott Building

I. **Opening Remarks by Chair Patronis**

II. **Consideration of the following bill(s):**

HB 53 Clinical laboratories by Garcia

HB 231 Patient Lifting and handling Practices by Grimsley

HB 387 Medical Faculty Certificates by Rivera

III. **Presentation by Agency for Health Care Administration (AHCA) on Health Information Technology and Transparency**

IV. **Closing Remarks by Chair Patronis**

V. **Adjournment**

1301 The Capitol, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850) 487-2242

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 53 Clinical Laboratories
SPONSOR(S): Garcia
TIED BILLS: **IDEN./SIM. BILLS:** SB 408

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Policy Committee		Calamas	Calamas VCC
2) Health & Family Services Policy Council			
3) Policy Council			
4)			
5)			

SUMMARY ANALYSIS

The bill requires clinical laboratories to accept human specimens submitted for examination by Florida-licensed advanced registered nurse practitioners.

The bill appears to have no fiscal impact on state or local government.

The bill is effective July 1, 2009.

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.

The bill does not appear to implicate any of the House Principles.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Advanced Registered Nurse Practitioners

Part I of Chapter 464, F.S., the Nurse Practice Act, regulates the profession of nursing. The part provides definitions and requirements for licensed practical nurses, registered nurses, and advanced registered nurse practitioners (ARNPs). The part specifies violations and limits the use of specified titles and abbreviations to only duly licensed or certified nurses who have met certain requirements.

An ARNP is "any person licensed in this state to practice professional nursing and certified in advanced or specialized nursing practice."[1] An ARNP must have a master's degree and can be a certified nurse anesthetist, certified nurse midwife, or nurse practitioner.[2] In order to become certified as an ARNP, a nurse must submit an application to the Department of Health demonstrating that he or she has a current license to practice professional nursing and that he or she meets certain requirements set forth by the Board of Nursing. These requirements include:

- Satisfactory completion of a formal post-basic educational program of at least one academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice.
- Certification by an appropriate specialty board.
- Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills.[3]

Additionally, the Board of Nursing requires ARNPs to have a minimum of $100,000/$300,000 (per incident and aggregate, respectively) in medical malpractice insurance.[4]

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[1] Section 464.003(7), F.S.
[2] ARNP applicants graduating on or after October 1, 1998, must have a master's degree for certification. Registered nurse anesthetist applicants graduating on or after October 1, 2001, must have a master's degree. S. 464.012(1)(c), F.S.
[3] Section 464.012(1), F.S.
[4] Rule 64B9-4.002, F.A.C.

Under the Nurse Practice Act, an ARNP must perform his or her authorized functions under an established protocol filed with the Board of Nursing.[5] Practitioners licensed in medical practice, osteopathy, or dentistry must supervise the ARNP within the framework of the protocol.[6] The Board of Nursing and the Board of Medicine have promulgated identical administrative rules setting forth standards for the protocols, which establish obligations on medical physicians, osteopathic physicians, and dentists who enter into protocol relationships with ARNPs.[7] The Board of Osteopathic Medicine and the Board of Dentistry are not required to adopt administrative rules regarding the standards for ARNP protocols.

The authorized duties of an ARNP include:

- Monitoring and altering drug therapies;
- Initiating appropriate therapies for certain conditions;
- Ordering and evaluating diagnostic tests;
- Ordering physical and occupational therapy;
- Performing acts of nursing diagnosis and nursing treatment of alterations of the health status; and
- Performing acts of medical diagnosis and treatment, prescription, and operation.[8]

An ARNP may also perform certain duties within his or her specialty.[9] Although ARNPs may prescribe medications in accordance with the protocol and under the authority of the supervising physician, they cannot prescribe controlled substances.

Clinical Laboratories

Clinical laboratories are regulated by Part I, Chapter 483, F.S., administered by the Agency for Health Care Administration. A clinical laboratory is the physical location where statutorily defined services "are performed to provide information or materials for use in the diagnosis, prevention, or treatment of a disease or the identification or assessment of a medical or physical condition."[10] Health care facilities (including physician offices) performing any clinical laboratory testing are required to obtain a state clinical laboratory license and a federal Clinical Laboratory Improvement Amendment (CLIA) certificate.[11]

Current Florida law permits clinical laboratories to examine human specimens only at the request of a "licensed practitioner or other person authorized by law[12] to use the findings of clinical laboratory examinations."[13] A "licensed practitioner" is a Florida-licensed medical physician, physician assistant, osteopathic physician, chiropractic physician, podiatric physician, dentist, naturopathic physician, or advanced registered nurse practitioner.[14] The statute also recognizes practitioners from another state licensed under similar statutes, with certain qualifiers, as a licensed practitioner for purposes of chapter 483, F.S. Florida law requires clinical laboratories to accept human specimens from these licensed practitioners, if the specimen and test are the type performed by the clinical laboratory. Clinical laboratories may refuse to accept specimen from one of these practitioners only if there is a history of nonpayment for services by the practitioner. Additionally, a clinical laboratory may not charge a different price for tests based on what kind of licensed practitioner is submitting the test.[15]

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[5] Section 464.012(3), F.S.
[6] *Id.*
[7] Rules 64B9-4.010 and 64B8-35.002, F.A.C.
[8] Sections 464.012(3) and 464.003(d), F.S.
[9] Section 464.012(4), F.S.
[10] Section 483.041(2), F.S.
[11] Section 483.101, F.S.; Agency for Health Care Administration, "Clinical Laboratories," http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/clinical.shtml (last visited February 13, 2009).
[12] "Other persons authorized by law" include individuals submitting a sample of his or her own blood, if the sample was taken using a home HIV test kit approved by the U.S. Food and Drug Administration. Section 483.181(1), F.S.
[13] Section 483.181(1), F.S.
[14] Section 483.041(7), F.S.
[15] Section 483.181(5), F.S.

Florida law permits a clinical laboratory to examine human specimens at the request of an ARNP, but it does not require the laboratory to do so. According to the Department of Health, ARNPs commonly submit specimens under the name of another practitioner, from whom clinical laboratories are required to accept specimens. Florida law requires clinical laboratories to report test results directly to the person who requested it.[16]

Effect of Proposed Changes

The bill amends s. 483.181, F.S., to require clinical laboratories to accept specimens submitted for examination by Florida-licensed ARNPs. The bill allows clinical laboratories to refuse specimens submitted by ARNP with histories of nonpayment. The bill prohibits clinical laboratories from charging prices to an ARNP that are different from the prices the laboratory charges other licensed practitioners.

According to the Department of Health, the bill could have a positive impact to public health. The ARNP practice of submitting specimens under the name of another practitioner may contribute to delays in the initiation of treatment for infections when the results are returned not to the practitioner who collected the specimen and who manages the patient, but rather, to the professional colleague who submitted the specimen. Requiring clinical laboratories to accept specimens from ARNPs will allow them to return the results directly to the ARNP.

The bill is effective July 1, 2009.

B. SECTION DIRECTORY:

Section 1. Amends s. 483.181, F.S., regarding the acceptance, collection, identification, and examination of specimens.

Section 2. Provides an effective date of July 1, 2009.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

[16] Section 483.181(2), F.S.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The department appears to have sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to clinical laboratories; amending s. 483.181, F.S.; requiring clinical laboratories to accept human specimens submitted by advanced registered nurse practitioners; providing an effective date.

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

Section 1. Section 483.181, Florida Statutes, is amended to read:

483.181 Acceptance, collection, identification, and examination of specimens.--

(1) A clinical laboratory may examine human specimens at the request only of a licensed practitioner or other person authorized by law to use the findings of clinical laboratory examinations. An individual forwarding a sample of the individual's own blood to a clinical laboratory, when such blood sample has been taken pursuant to a home access HIV test kit approved by the United States Food and Drug Administration, shall be considered a person authorized to request and use a clinical laboratory test for human immunodeficiency virus, for the purposes of this part.

(2) The results of a test must be reported directly to the licensed practitioner or other authorized person who requested it. The report must include the name and address of the clinical laboratory in which the test was actually performed, unless the test was performed in a hospital laboratory and the report becomes an integral part of the hospital record.

(3) The results of clinical laboratory tests performed by a clinical laboratory complying with this part and performed before a patient's admission to a facility licensed under chapter 395 must be accepted in lieu of clinical laboratory tests required upon a patient's admission to the facility and in lieu of tests that may be ordered for patients of the facility, except that the facility may not be required to accept transfusion compatibility test results. The agency shall establish, by rule, standards for accepting laboratory test results to specify acceptable timeframes for such laboratory tests to assure that the timeframes do not adversely affect the accuracy of the test.

(4) All specimens accepted by a clinical laboratory must be tested on the premises, except that specimens for infrequently performed tests may be forwarded for examination to another clinical laboratory approved under this part. This subsection does not prohibit referring specimens to a clinical laboratory excepted under s. 483.031. However, the clinical laboratory director of the referring clinical laboratory must assume complete responsibility.

(5) A clinical laboratory licensed under this part must accept a human specimen submitted for examination by a practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, s. 464.012, or chapter 466, if the specimen and test are the type performed by the clinical laboratory. A clinical laboratory may only refuse a specimen based upon a history of nonpayment for services by the practitioner. A clinical laboratory shall not charge different

prices for tests based upon the chapter under which a practitioner submitting a specimen for testing is licensed.

Section 2. This act shall take effect July 1, 2009.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 231 Patient Lifting and Handling Practices
SPONSOR(S): Grimsley and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 626

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee		Calamas	Calamas
2)	Civil Justice & Courts Policy Committee			
3)	Health & Family Services Policy Council			
4)				
5)				

SUMMARY ANALYSIS

House Bill 231 requires hospitals to adopt and implement evidence-based policies for hospital employees that minimize the risk of injury to patients and employees associated with lifting and handling patients.

The bill requires that the policy be developed by either a newly created or existing committee of management and non-management hospital employees, including registered nurses engaged in direct patient care.

The bill requires committees to use data to evaluate the risk of injury and to determine the appropriateness of alternative lifting and handling strategies based on the population of patients served at the hospital and identified hospital-specific risk factors. The bill lists specific issues a committee must consider, and requires an ongoing evaluation process to determine the effectiveness of the policy.

The bill has no fiscal impact to state or local government.

The effective date of the bill is October 1, 2009.

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:

Background

Patient handling and lifting tasks can be both physically demanding and unpredictable in nature, due to the variation in size, physical disability, cognitive function, level of cooperation, and fluctuation of condition in patients.[1] Patient lifts are often accomplished in awkward positions such as bending or reaching over beds or chairs while a nurse's back is flexed.[2] One study has estimated that the cumulative weight lifted by a nurse in a typical 8-hour shift is equivalent to 1.8 tons.[3]

Nursing, psychiatric, and home health aides are especially susceptible to lifting injuries.[4] In 2006, 9,200 registered nurses suffered a median 6 days away from work due to musculoskeletal disorders, while 27,590 nursing aides, orderlies and attendants suffered a median 5 days away from work.[5]

Present Situation

The Agency for Health Care Administration (AHCA) is responsible for the licensure and regulation of health care facilities as authorized in Chapter 395, F.S., Hospitals Licensing and Regulation. Florida law imposes requirements for nursing services and functional safety on hospitals licensed under Chapter 395. AHCA's administrative rules governing hospitals require that:

- Each hospital develop written standards of nursing practice and related policies and procedures to define and describe the scope and conduct of patient care provided by the nursing staff.[6]

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[1] *Evidence-based practices for Safe Patient Handling and Movement*, Online Journal of Issues in Nursing, Vol. 9, No. 3 (Sept. 2004). Available online at http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume92004/No3Sept04/EvidenceBasedPractices.aspx; viewed February 13, 2009.

[2] *Id.* (*citing* Blue, C.L., *Preventing back injury among nurses, Orthopaedic Nursing*, 15, 9-22 (1996); Videman, T., *et al.*, *Low back pain in nurses and some loading factors of work, Spine*, 9(4), 400-404 (1984)).

[3] *See* Tuohy-Main, K., *Why manual handling should be eliminated for resident and career safety, Geriaction*, 15, 10-14(1997).

[4] Hoskins, Anne B., *Occupational Injuries, Illnesses, and Fatalities among Nursing, Psychiatric, and Home Health Aides, 1995-2004*, June 30, 2006. Available online at http://www.bls.gov/opub/cwc/content/sh20060628ar01p1.stm; viewed February 13, 2009.

[5] Bureau of Labor Statistics, *Nonfatal Occupational Injuries and Illnesses Requiring Days Away From Work, 2006*, (released Nov. 8, 2007). Available online at http://www.bls.gov/news.release/pdf/osh2.pdf; viewed February 13, 2009.

[6] Rule 59A-3.2085(5)(d), F.A.C.

- Each hospital have a hospital safety committee to adopt, implement and monitor a comprehensive, hospital-wide safety program. The safety program is required to adopt written policies and procedures to enhance the safety of the hospital, its personnel and patients.[7]

There is no requirement for a specific committee to oversee safe patient handling and lifting in hospitals. According to AHCA, a large majority of hospitals may have already adopted safe lifting policies and programs through their safety committees. Hospitals are responsible for paying worker's compensation claims and paying for temporary help when staff is unavailable because of injury.[8] AHCA further advises that many hospitals in Florida already have patient lifting equipment.

Remodeling plans for the purpose of incorporating patient handling and moving equipment would have to be submitted to the Office of Plans and Construction for approval. No construction work, including demolition, of a hospital may be started until written approval has been given by AHCA's Office of Plans and Construction.[9] This includes all construction of new facilities and any and all additions, modifications or renovations to existing facilities.

Several states have recently passed legislation concerning safe patient lifting, including Texas in 2005, and Washington in 2006.[10] Washington provides a tax credit of up to $1,000 for each acute care available inpatient bed towards the cost of purchasing mechanical lifting devices and other equipment that is primarily used to minimize patient handling by health care providers.[11]

Effect of Proposed Legislation

HB 231 creates s. 381.029, F.S., and requires that hospitals establish and implement an "evidence-based policy" regarding the safe lifting and associated handling of patients by hospital employees so as to minimize the risk of injuries to patients and employees. The bill does not define the term "evidence-based policy." The bill applies to facilities that are licensed under chapter 395, which includes hospitals, ambulatory surgical centers, and mobile surgical facilities.

The bill requires that hospitals' safe lifting policies be developed by a committee composed of an "approximate mix" of management and non-management employees, at least half of whom are clinical employees, including registered nurses, engaged in direct patient care. The committee may be a newly created committee or a hospital committee already in existence. The bill does not define what constitutes an "approximate mix."

In developing the policy, the committee is required to use data to evaluate the risk of injury to patients and employees. The committee must also determine whether alternative strategies for lifting and handling patients are appropriate based upon the population of patients at that hospital and any other identified hospital-specific risks. In making that determination, the committee must consider, at a minimum:

- Using mechanical lifting devices or other engineering controls that minimize the need for employees to manually lift and handle patients;
- Using teams of personnel to lift and handle patients;
- Providing training in safe lifting and handling practices for direct-care employees;
- Incorporating physical space and construction design for mechanical lifting devices in architectural plans for construction or renovation of the hospital;
- Developing an ongoing evaluation process to determine the effectiveness of the policy.

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[7] Rule 59A-3.277, F.A.C.

[8] Pursuant to s. 440.09(5), F.S, a 25 percent reduction in workers' compensation benefits is allowed if an employee knowingly refuses to use a safety appliance and the employee knew he/she was required to use the safety appliance; an employee knowingly refuses to follow a safety rule if the safety rule is in statute or in an administrative rule of the Department of Financial Services and the employee knew about the safety rule; or an employee knowingly refuses to use a safety appliance provided by the employer.

[9] Rule 59A-3.080, F.A.C.

[10] Tex. Code Ann. §256.002; Wash. Rev. Code Ann. §70.41.390.

[11] Washington State Nurses Association *Questions and Answers on Safe Patient Handling Legislation*. Available online at http://www.wsna.org/legal/patienthandling/faq.asp; viewed February 13, 2009.

The bill creates a new section of law in Chapter 381, F.S. However, chapter 395 delegates to AHCA the authority to license and regulate hospitals pursuant to Part II of chapter 408, F.S. and part I of chapter 395. The bill does not provide for regulation or oversight by AHCA should a hospital fail to comply, and establishes no penalty for non-compliance.

The effective date of the bill is October 1, 2009.

B. SECTION DIRECTORY:

Section 1. Creates s. 381.029, F.S.; provides definitions; requires hospitals to adopt a policy related to patient lifting and handling.

Section 2. Provides effective date of October 1, 2009.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

For hospitals currently without safe patient handling policies, the bill may result in a decrease in the number of injuries suffered by nurses, when engaged in lifting or handling patients, and by patients, who will gain additional protections against avoidable injuries. Nurses will miss fewer days of work, resulting in an increase in productivity and continuity of patient care.

Hospitals may need to acquire patient handling and moving equipment if the requirement for such is included in the policy developed by their respective committees and the hospitals do not already have the necessary equipment on site. Acquisition of new equipment, as necessary, by hospitals may also result in the need for architectural plans for and the renovation of the hospital, which requires approval from AHCA's Office of Plans and Construction. Hospitals may also incur additional expenses associated with training employees regarding their respective patient lifting policies.

D. FISCAL COMMENTS:

The bill is unlikely to result in increased complaints to AHCA's Division of Health Quality Assurance. Patients, families, and staff can currently file a hospital complaint related to safe lifting practices, or any other quality issue. The bill does not require AHCA to enforce compliance. Hospitals may decide to remodel in order to incorporate lifting equipment. If so, the plans and the remodeling may require reviews and surveys by the Agency.

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:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill creates in chapter 381 new requirements for hospitals licensed under chapter 395. The bill does not provide for regulation or oversight by AHCA should a hospital fail to comply, and establishes no penalty for non-compliance.

The bill at lines 16-17 defines "hospital" as a "health care facility licensed under chapter 395." Facilities that are licensed under chapter 395 include hospitals, ambulatory surgical centers, and mobile surgical facilities.

The bill at lines 18-21 directs hospitals to establish an "evidence-based" policy regarding patient lifting and handling; however, the term "evidence-based" is not defined. At lines 21-26, the bill requires committees established by hospitals to be an "appropriate mix" of management and non-management employees, but does not clarify what would be considered an "appropriate mix."

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to patient lifting and handling practices; creating s. 381.029, F.S.; providing a definition; requiring hospitals to establish a policy concerning the lifting and handling of patients by hospital employees; requiring a committee to develop the policy; providing for membership and duties of the committee; requiring continuing evaluation of the policy; providing an effective date.

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

Section 1. Section 381.029, Florida Statutes, is created to read:

381.029 Patient lifting and handling practices.--

(1) As used in this section, the term "hospital" means a health care facility licensed under chapter 395.

(2) A hospital shall establish an evidence-based policy regarding the safe lifting and associated handling of patients by hospital employees that minimizes the risk of injuries to patients and employees. The policy shall be developed by a committee composed of an appropriate mix of management and nonmanagement employees, including registered nurses engaged in direct patient care. The hospital may assign the task of developing the policy to a newly created committee or to an existing committee.

(3) The committee shall:

(a) Use data to evaluate the risk of injury to patients and employees.

(b) Determine the appropriateness of alternative strategies for lifting and handling patients based on the population of patients at the hospital and identified hospital-specific risk factors. At a minimum, the committee shall consider:

1. Using mechanical lifting devices or other engineering controls that minimize the need to lift and handle the patient manually.

2. Using teams to lift and handle patients.

3. Providing training in safe lifting and handling practices for employees engaged in caring for patients.

4. Incorporating physical space and construction design for mechanical lifting devices in architectural plans for construction or renovation of the hospital.

(c) Develop an ongoing evaluation process to determine the effectiveness of the policy established under this section.

Section 2. This act shall take effect October 1, 2009.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 387 Medical Faculty Certificates
SPONSOR(S): Rivera
TIED BILLS: **IDEN./SIM. BILLS:** SB 1136

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee		Holt	Calamas
2)	State Universities & Private Colleges Policy Committee			
3)	Health & Family Services Policy Council			
4)				
5)				

SUMMARY ANALYSIS

A medical faculty certificate allows medical school faculty physicians to practice medicine in Florida without sitting for and successfully passing a licensure examination. A physician who receives a medical faculty certificate has all rights and responsibilities as other licensed physicians, except they may only practice in conjunction with a full-time faculty position at an accredited medical school and its affiliated clinical facilities or teaching hospitals. The initial medical faculty certificate is valid for 2 years, and may be renewed (or extended) biannually thereafter. The number of physicians holding renewed medical faculty certificates is statutorily limited by medical school.

The bill increases the number of allowed renewed medical faculty certificates for the following medical schools from 15 to 30:

- The University of Florida
- The University of Miami
- The University of South Florida
- The Florida State University
- The Florida International University
- The University of Central Florida

The H. Lee Moffitt Cancer Center and Research Institute is also permitted to increase the number of allowed medical faculty certificates from 15 to 30. Additionally, the number of renewed medical faculty certificates for The Mayo Medical School at the Mayo Clinic in Jacksonville, Florida, is increased from 5 to 10.

The bill has an insignificant fiscal impact on the Medical Quality Assurance Trust Fund within the Department of Health.

The bill takes effect July 1, 2009.

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

The Department of Health, Board of Medicine, may issue medical faculty certificates to physicians allowing them to practice medicine in Florida without sitting for and successfully passing a national examination.[1] These physicians have the same rights and responsibilities as other licensed physicians, except they may only practice in conjunction with a full-time faculty position at an accredited medical school and its affiliated clinical facilities or teaching hospitals.

To be eligible to receive a medical faculty certificate a physician must:[2]

- Be a graduate of an accredited medical school or its equivalent, or is a graduate of a foreign medical school listed with the World Health Organization;
- Hold a valid, current license to practice medicine in another jurisdiction;
- Complete the application form and remitted a nonrefundable application fee not to exceed $500;
- Complete an approved residency or fellowship of at least one year or its equivalent;
- Be at least 21 years of age;
- Be of good moral character;
- Not have committed any act in Florida or any other jurisdiction which would constitute the basis for disciplining a physician; and
- Have accepted a full-time faculty appointment to teach in a program of medicine at any of the following:
    - The University of Florida
    - The University of Miami
    - The University of South Florida
    - The Florida State University
    - The Florida International University
    - The University of Central Florida
    - The Mayo Medical School at the Mayo Clinic in Jacksonville, Florida

[1] There are 5 different types of national examinations: a State Board Examination, National Board of Medical Examiners, United States Medical Licensing Examination, Federation Licensing Examination (FLEX), and Special Purpose Examination (SPEX).

[2] Section 458.3145(1)(i), F.S.

Currently, a medical faculty certificate holder is required to pay an application fee of $500 and $424 for the issuance of the initial certificate. The initial certificate is valid for 2 years, or until the applicant terminates their relationship with the medical school or teaching institution. To renew (or extend) a certificate an applicant must submit an approved form, remit a renewal fee of $360, and submit a letter from the dean of the medical school stating that the applicant is a distinguished medical scholar and an outstanding practicing physician.[3]

There is no limitation on the number of initial certificates a medical school or teaching institution may receive. However, the number of medical faculty certificates that may be renewed by each medical school or teaching institution is statutorily limited.[4] All medical schools, except the Mayo Medical School at the Mayo Clinic in Jacksonville, Florida, are limited to 15 renewed medical faculty certificates. Mayo is limited to 5 renewed medical faculty certificates. The H. Lee Moffitt Cancer Center and Research Institute is also permitted to have up to 15 renewed faculty certificates.[5]

An annual review of each medical faculty certificate recipient is made by the dean of the accredited 4-year medical schools and reported to the Board of Medicine within the Department of Health on an annual basis. According to the Department of Health as of February 2009, the Board of Medicine oversees 34 active medical faculty certificates.

Medical School or Teaching Institution	Initial Medical Faculty Certificates	Renewed Medical Faculty Certificates	Total Medical Faculty Certificates
University of Florida	3	6	9
University of Miami	6	15	21
University of South Florida and H. Lee Moffitt Cancer Center and Research Institute[6]	0	3	3
Florida State University	0	0	0
Florida International University	0	0	0
University of Central Florida	0	0	0
Mayo Medical School (Jacksonville)	0	1	1
Total	9	25	34

Effect of Proposed Changes

The bill increases the number of renewed (or extended) medical faculty certificates for the following medical schools from 15 to 30:

- The University of Florida
- The University of Miami
- The University of South Florida
- The Florida State University
- The Florida International University
- The University of Central Florida

The H. Lee Moffitt Cancer Center and Research Institute is also permitted to increase the number of allowed medical faculty certificates from 15 to 30. Additionally, the number of renewed medical faculty certificates for The Mayo Medical School at the Mayo Clinic in Jacksonville, Florida, is increased from 5 to 10.

[3] Section 458.3145(2), F.S.
[4] Section 458.3145(4), F.S.
[5] Section 458.3145 (4), F.S.
6 The Department of Health does not distinguish between the certificates issued to the University of South Florida and H. Lee Moffitt Cancer Center and Research Institute.

B. SECTION DIRECTORY:

Section 1. Amends 458.3145, F.S., relating to medical faculty certificates.

Section 2. Provides an effective date of July 1, 2009.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

See Fiscal Comments.

2. Expenditures:

See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

Not applicable.

2. Expenditures:

Not applicable.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There may be an increase in workload for the medical school, which would have to review each medical faculty recipient.

D. FISCAL COMMENTS:

The Division of Medical Quality Assurance within the Department of Health may see an increase in workload from processing additional medical faculty certificate renewals. However, the fee of $360 per renewal should support the increase.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax sharing with counties or municipalities.

2. Other:

Not applicable.

B. RULE-MAKING AUTHORITY:

The department appears to have sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to medical faculty certificates; amending s. 458.3145, F.S.; increasing the maximum number of medical faculty certificates issued to faculty at certain institutions; providing an effective date.

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

Section 1. Subsection (4) of section 458.3145, Florida Statutes, is amended to read:

458.3145 Medical faculty certificate.--

(4) In any year, the maximum number of extended medical faculty certificateholders as provided in subsection (2) may not exceed 30 ~~15~~ persons at each institution named in subparagraphs (1)(i)1.-6. and at the facility named in s. 1004.43 and may not exceed 10 ~~5~~ persons at the institution named in subparagraph (1)(i)7.

Section 2. This act shall take effect July 1, 2009.

AHCA Presentation

Agency Initiatives Relating to Health Information Exchange and Transparency

Florida House of Representatives, Health Care Regulation Policy Committee
February 17, 2009

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for All Floridians

Health Information Exchange and Health Transparency

- Agency's Health Information Exchange (HIE) Initiatives
- Health Care Transparency Initiatives

Health Information Exchange Requires Electronic Care Coordination

- Sending patient records from one physician to another
- Accessing medication and prescription history
- E-prescribing
- Transmitting radiology images and lab results among treating providers

Health Information Exchange Requires

- Electronic patient record systems
- Secure & interoperable networks to transmit health care information
- Broadband networks to transfer clear images
- Adoption of national standards
- Participation of all payers and providers
- Consumer engagement

Health Information Exchange Benefits

- Reduces duplication of services
- Reduces medical and medication errors
- Decreases administrative burden
- Decreases fraud and abuse
- Improves coordination and quality of services
- Provides access to electronic health records in an emergency or disaster

Florida Public-Private Partnership: Legislative Direction to Agency on HIE

2004 Legislation

- Develop a strategy for the adoption of electronic health records
- Funding to create a policy unit for HIE

2006 Legislation

- Develop a strategy for a health information network
- Provide data to health care practitioners through the network
- Administer grants for development of health information network
- Provide technical assistance to health information network

Florida Public-Private Partnership: Legislative Direction to Agency on HIE

2007 Legislation

- Produce website to promote e-Prescribing
- Accelerate adoption through public-private partnership
- Track e-Prescribing metrics
- Health Information Exchange Coordinating Council created

2008 Legislation

- Creates Point of Care Model Electronic Health Records Grant Program

Accomplishments of Agency's Health Information Technology Initiatives - 2008

- Point of Care Grants Program
- Request for Information (RFI) to determine current capabilities for Florida Medicaid multi-payer health information exchange (HIE).
- Personal Health Record Toolkit
- Electronic Prescribing (e-Prescribing) Initiatives
- Federal Communications Commission (FCC) Sustainability Plan for Rural Health Broadband Pilot Program
- Health Information Security and Privacy Collaboration (HISPC)
- Federal-State Law Crosswalk Toolkit

Proposed Legislation - 2009

"The Electronic Health Records Exchange Act"

- Provides standards for authorizing health information exchange
- Expands the exchange of clinical hospital and laboratory data to treating physicians
- Provides disclosure standards for authorized health care personnel in an emergency
- Provides for adoption of a Universal Patient Authorization form
- Provides liability protection for providers using Universal form for consent
- Provides standards for patient consent

American Recovery and Reinvestment Act of 2009 – Provides Funding for HIT

- Funding to Deploy Broadband Access
- Incentives to Providers for Adoption of Electronic Health Records
- Funding to Medicaid Physicians and Acute Care/Children hospitals for HIT
- Grants to States for Health Information Exchange

Grants to States to Promote Health Information Exchange

- States Must Prepare Qualified Plan
- Broad Range in Use of Funds
- Plan Must Include National Standards
  - HIE Legislation Based on recommendations from Florida's participation in federal Health Information Security and Privacy Collaboration
- Must consult with stakeholders – Agency's Health Information Exchange Coordinating Committee

Health Care Transparency Definition

The essential sharing of health care information:

- With consumers so they can make decisions about their health care
- With professionals & health care stakeholders to provide an understanding of how the health care system is performing – as a whole and as individual sectors
- Holding individual sectors accountable for performance and quality

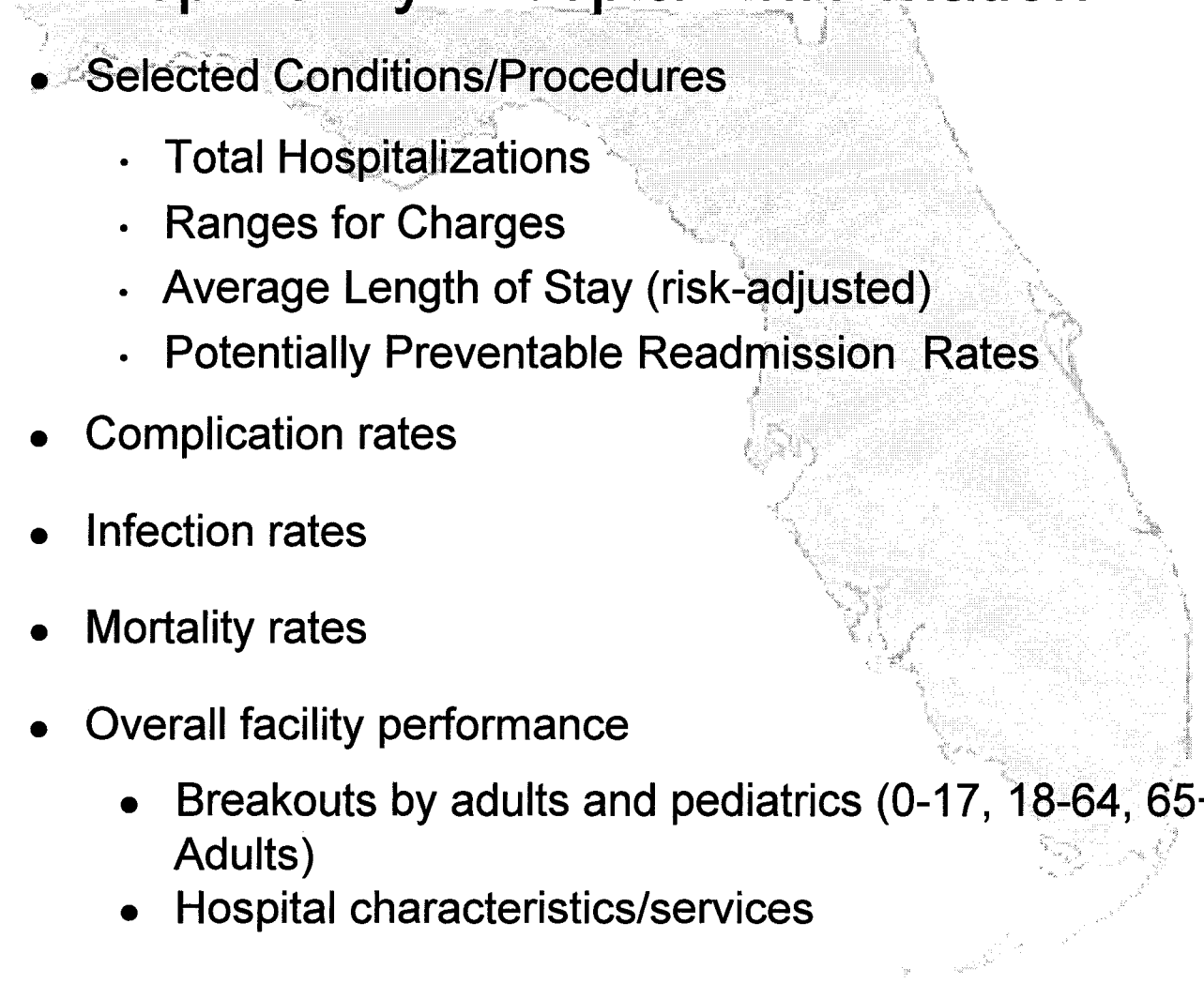
Health Care Transparency Benefits

- Improve quality of care – comparison across providers
- Increase accountability – public access
- Decrease costs – comparison across providers
- Increase consumers' active participation in managing their own health care

Agency's Strategic Initiatives for Transparency

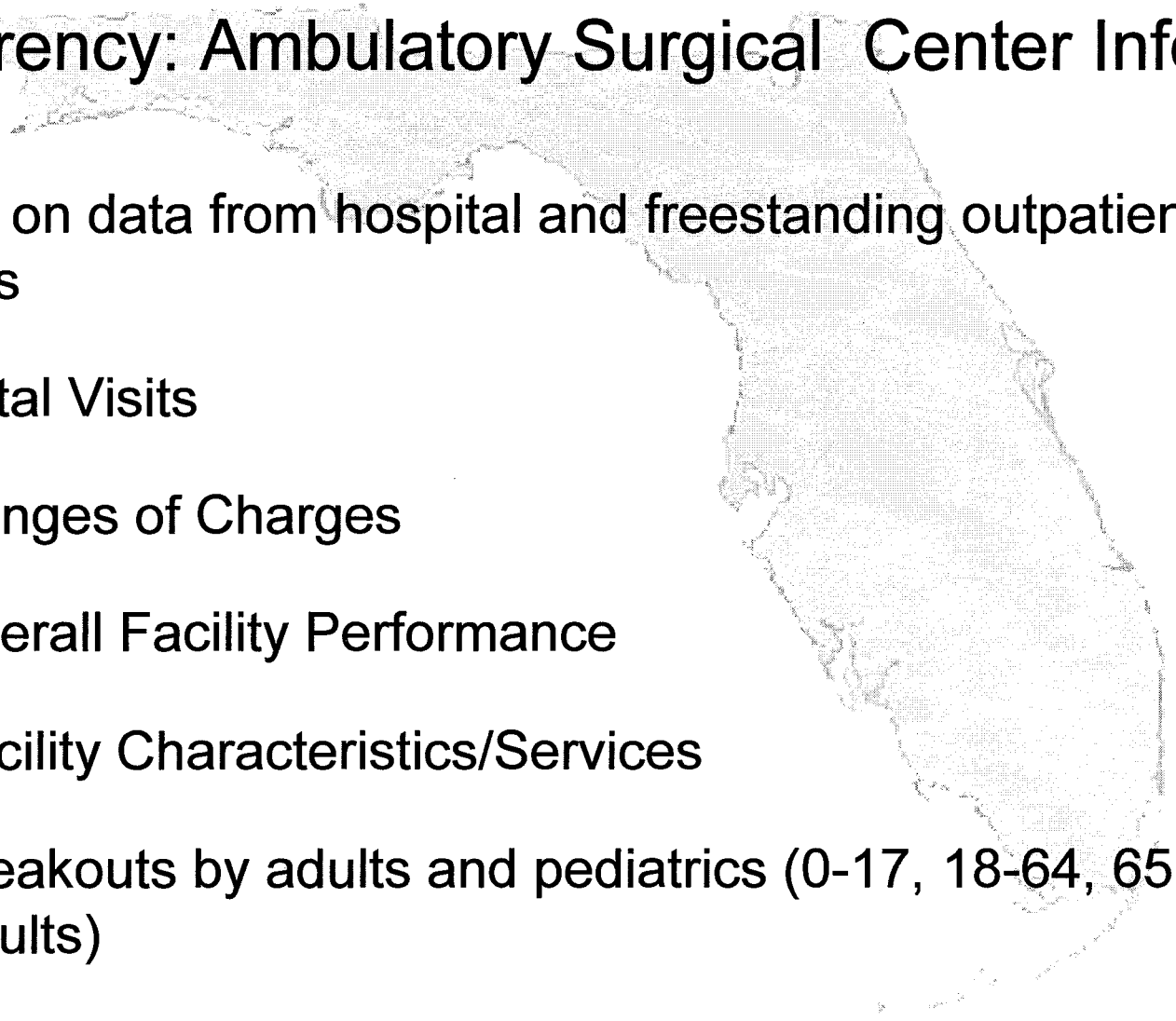
- Report retail prices for prescription drugs
  - www.MyFloridaRx.com
- Health data and information provided using facility data collected
  - www.FloridaHealthFinder.gov
  - Emergency Department Care – 5.7 million patient visits
  - Health Plans – HEDIS and CAHPS survey results
  - Hospitals – 2.5 million patient discharges
  - Ambulatory Surgery Centers – 3 million visits
  - Nursing Homes – 670 facilities
- In collaboration with the State Consumer Health Information and Policy Advisory Council

Transparency: Hospital Information



- Selected Conditions/Procedures
  - Total Hospitalizations
  - Ranges for Charges
  - Average Length of Stay (risk-adjusted)
  - Potentially Preventable Readmission Rates
- Complication rates
- Infection rates
- Mortality rates
- Overall facility performance
  - Breakouts by adults and pediatrics (0-17, 18-64, 65+, All Adults)
  - Hospital characteristics/services

Transparency: Ambulatory Surgical Center Information



Based on data from hospital and freestanding outpatient surgery centers

- Total Visits
- Ranges of Charges
- Overall Facility Performance
- Facility Characteristics/Services
- Breakouts by adults and pediatrics (0-17, 18-64, 65+, All Adults)

Transparency: Emergency Department Information

- Annual report on trends in Emergency Department utilization with information on patient acuity, payer, and reason for emergency department visit
- New interactive query tool offered on FloridaHealthFinder.gov for Emergency Department data
  - Searchable by:

Patient's reason for visit	Principal diagnosis
Principal procedure	Key word or code
Demographic criteria	Facility criteria

Transparency: Health Plan Quality Information

Health Plan Quality of Care (HEDIS) Measures

- Asthma Medications for Long-Term Control
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Controlling High Blood Pressure
- Diabetes Care: Lipid Profile Performed
- Diabetes Care: Lipids Controlled
- Diabetes Care: Dilated Eye Exam Performed
- Diabetes Care: Kidney Disease Screening
- Timeliness of Prenatal Care

Transparency: Health Plan Quality Information

Health Plan Member Satisfaction Indicators (CAHPS Measures)

- Overall Plan Satisfaction
- Ease in Getting Needed Care
- Ease in Getting Care Quickly
- How Well Doctors Communicate
- How Well Plan Processes Claims
- Getting Help from Customer Service
- Rate the Number of Doctors to Choose From
- Recommend Health Plan to Family or Friends
- Would You Select Your Current Plan Again

Stakeholder Uses of Data:

- Facilities:
  - Compare their performance (patient safety measures and mortality) with peers
  - Use data for planning and market share (by zip code)
  - Analyze present on admission data to better understand preventable complications
  - Analyze readmissions and take measures to prevent readmissions

Stakeholder Uses of Data:

- Health Plans
  - Compare their performance on health plan report card (on website)
  - Analyze facility data regarding costs, quality and market share for contracting with facilities
- Employers
  - Compare facility quality and costs
  - Analysis of data can be used by self-insured employers in contracting with facilities

Stakeholder Uses of Data:

- Department of Health
  - Coordinate data with vital statistics, birth defects registry and cancer registry
  - Data used in analysis and research related to injuries, asthma, diabetes and other disease tracking
- National Initiatives
  - Florida is a key data source for national databases supporting research, quality reports, disparity reports, children's health research

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FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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