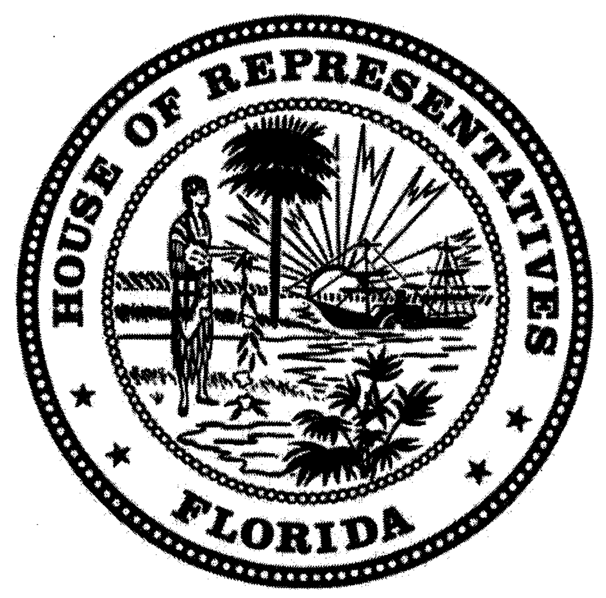

Health & Human Services Committee

Friday, March 22, 2013
8:30 AM – 10:00 AM
Morris Hall

Will Weatherford
Speaker

Richard Corcoran
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time:	Friday, March 22, 2013 08:30 am
End Date and Time:	Friday, March 22, 2013 10:00 am
Location:	Morris Hall (17 HOB)
Duration:	1.50 hrs

Consideration of the following bill(s):

CS/CS/HB 83 Infant Death by Health Care Appropriations Subcommittee, Health Quality Subcommittee, Santiago
CS/HB 93 Homelessness by Healthy Families Subcommittee, Reed
CS/HB 115 Professional Licensure of Military Veterans by Department of Health by Health Quality Subcommittee, Santiago
HB 195 Emergency Medical Services by Perry
CS/HB 349 Treatment Programs for Impaired Licensees and Applicants by Health Quality Subcommittee, Renuart
HB 463 Examination of Dentists by Rodríguez, J.
CS/HB 529 Public Records by Health Quality Subcommittee, Renuart
CS/HB 625 Physician Assistants by Health Quality Subcommittee, Renuart
HB 671 Pharmacy Technicians by Hutson

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Thursday, March 21, 2013.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Thursday, March 21, 2013.

NOTICE FINALIZED on 03/20/2013 16:13 by Iseminger.Bobbye

CS/CS/HB 83

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 83 Infant Death
SPONSOR(S): Health Care Appropriations Subcommittee; Health Quality Subcommittee; Santiago
TIED BILLS: **IDEN./SIM. BILLS:** SB 56

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	13 Y, 0 N, As CS	Holt	O'Callaghan
2) Health Care Appropriations Subcommittee	12 Y, 1 N, As CS	Rodriguez	Pridgeon
3) Health & Human Services Committee		Holt	Calamas

SUMMARY ANALYSIS

CS/CS/HB 83 amends s. 383.3362, F.S., relating to Sudden Infant Death Syndrome (SIDS) to update the activities of the Department of Health (DOH) and the medical examiners when reporting and classifying the cause of death of an infant under 1 year of age who suddenly dies, when in apparent good health. The bill brings the law into conformity with current federal Centers for Disease Control and Prevention (CDC) standards of practice by redefining and using a category for infant death that is broader than SIDS called "Sudden Unexpected Infant Death (SUID)," which includes infant death resulting from: SIDS, accidental suffocation, metabolic errors, injury or trauma and unclassified or accidental causes.

The bill amends the legislative intent, definitions, training requirements for first responders, autopsy requirements performed by medical examiners, and the protocol for medical and legal investigations to reflect the new SUID standard. The bill requires the DOH to consult with child protection teams established in the Division of Children's Medical Services when developing training curriculum that is part of the CDC SUID Initiative and all other DOH duties relating to SUID. The bill amends the timeframe that an autopsy must be performed from within 24 hours to 48 hours after death or as soon as feasible.

The bill requires that birth center clients and their families receive information on safe sleeping practices and the possible causes of SUID and requires hospitals that provide birthing services to provide similar information.

Additionally, the bill deletes references to SIDS, and the SIDS hotline. The bill makes technical changes by restructuring the language to improve readability and deleting unnecessary words and an obsolete date.

This bill has an insignificant fiscal impact on state and local governments.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Sudden Infant Death Syndrome verses Sudden Unexpected Infant Death

The federal Centers for Disease Control and Prevention (CDC) defines Sudden Infant Death Syndrome (SIDS) as the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including a completed autopsy, examination of the death scene, and review of the clinical history.[1] According to the CDC, SIDS is considered a diagnosis of exclusion and of unknown etiology. SIDS is a diagnosis that should be given only after all other possible causes of sudden, unexplained death have been ruled out through a careful case investigation, which includes a thorough examination of the death scene, a complete autopsy, and a review of the infant's medical history.[2]

SIDS is the leading cause of death among infants aged 1–12 months, and is the third leading cause overall of infant mortality in the United States.[3] SIDS most commonly occurs in infants from two to four months of age and rarely after eight months of age. SIDS also occurs more frequently in African Americans, American Indians, and Alaska Natives than in Caucasians.[4] Modifiable risk factors for SIDS include: overheating; stomach and side sleeping positions; soft sleeping surfaces; loose bedding; inappropriate sleep surface; sharing the same sleep surface; and maternal and secondhand smoking.[5] SIDS is not caused by suffocation, aspiration, abuse, or neglect. According to the National Institute of Child Health and Human Development, recent research suggests that certain infants may be highly susceptible to SIDS, due to an abnormality in a specific nerve cell in the brain.[6]

SIDS is a subset of SUID. In contrast to SIDS, SUID is defined as deaths in infants less than one year of age that occur suddenly and unexpectedly, and whose cause of death is not immediately obvious prior to investigation. The most common causes of SUID are: SIDS, accidental suffocation, metabolic errors, injury or trauma and unclassified causes (e.g., if the death scene investigation and/or autopsy were incomplete or not done and the death certifier has insufficient evidence to record a more specific cause of death).

Federal Initiative for Sudden Unexpected Infant Death

Since the early 1990s, SIDS rates have declined by 50 percent, in large part due to the national campaign to place infants on their backs to sleep (Back-to-Sleep Campaign). Two reports[7] conducted

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[1] Centers for Disease Control and Prevention, Sudden Unexpected Infant Death and Sudden Infant Death Syndrome. Available at: http://www.cdc.gov/SIDS/index.htm (last viewed Feb. 5, 2013).

[2] Centers for Disease Control, Guidelines for the Scene Investigator. Available at: www.cdc.gov/sids/PDF/SUIDManual/Chapter1_tag508.pdf (last viewed Feb. 5, 2013).

[3] *Id.*

[4] *See* Supra note 2.

[5] *Id.*

[6] Eunice Kennedy Shriver, National Institute of Child Health & Human Development, "SIDS Linked to Low Levels of Serotonin". Available at: http://www.nichd.nih.gov/news/releases/Pages/020310-SIDS-linked-serotonin.aspx (last viewed Feb. 5, 2013).

[7] Shaprio-Mendoza CK, Tomashek KM, Anderson RN, and Wingo J, "Recent national trends in sudden, unexpected infant deaths: more evidence supporting a change in classification or reporting" *American Journal of Epidemiology* (2006 Apr 15; 163(8): 762-9),

in 2005 and 2006, provide evidence that cause-of-death reporting and classifying of SUID may be unreliable. The studies found that the decline in the SIDS rate since 1999 was offset by an increase in mortality rates for accidental suffocation and strangulation in bed and for unknown/unspecified causes. Some deaths that were previously reported as SIDS are now reported as deaths due to accidental suffocation or unknown cause. This finding suggests that changes in reporting of cause of death might account for part of the recent decrease in the rate of SIDS.[8]

To address these changes, the CDC began the SUID Initiative in order to improve investigation and reporting practices for SIDS and SUID. The SUID Initiative's goals include:

- Standardization and improvement of data collection at the death scene;
- Promotion of the consistent classification and reporting of the cause of death;
- Improving the national reporting of SUID; and
- Reducing SUID by using improved data to identify those at risk.

As a result, the CDC revised reporting forms, developed standardized training materials and implemented a state-based SUID case registry. In 2012, the CDC dispersed grants to 10 states to participate in the state-based SUID case registry.[9]

Florida Infant Death Statistics

The DOH reports annually on infant deaths throughout the state in the Florida Vital Statistics Annual Report.[10] This report provides the number of fetal deaths per 1,000 live births, the number of deaths by race and compares that data to national figures. Additionally, specific information on infant mortality rates, including data on SIDS and SUID deaths by county may be queried in the FloridaCHARTS.com database.[11]

From 2011 to 2009, there were 610 SUID and 181 SIDS recorded infant deaths in Florida.[12]

Recorded Florida Infant Deaths		
Year	SUID	SIDS
2011	195	47
2010	207	62
2009	208	72

Source: FloridaCHARTS.com

Florida Sudden Infant Death Syndrome

Florida law currently defines SIDS as the "sudden unexpected death of an infant under 1 year of age which remains unexplained after a complete autopsy, death-scene investigation, and review of case history. The term includes only those deaths for which, currently, there is no known cause or cure."[13]

Since 1993, the DOH has been statutorily tasked with oversight of the SIDS program in Florida.[14] The DOH is required to develop and adopt by rule a training curriculum in collaboration with the EMS

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and Malloy MH, and MacDorman M., "Changes in the classification of sudden unexpected infant deaths: United States, 1992-2001," *Pediatrics* (2005 May; 115(5): 1247-53).

[8] *See* Supra note 2.

[9] The 10 state grantees are: Arizona, Colorado, Connecticut, Louisiana, Michigan, Minnesota, New Jersey, New Mexico, New Hampshire, and Wisconsin.

[10] *See* Florida Vital Statistics Annual Report 2011, http://www.flpublichealth.com/VSBOOK/VSBOOK.aspx, (last visited Feb. 5, 2013).

[11] *See* Florida Department of Health, Division of Public Health Statistics & Performance Management, Infant Deaths Query. Available at: http://www.floridacharts.com/FLQUERY/InfantMortality/InfantMortalityRpt.aspx (last visited Feb. 5, 2013).

[12] *Id.*

[13] S. 383.3362(2), F.S.

[14] Ch. 93-182, L.O.F.

Advisory Council; Firefighters Employment, Standards, and Training Council; and the Criminal Justice Standards and Training Commission. The training targets first responders (or "emergency responders"[15]) and is directed to focus on the nature of SIDS, standard procedures to be followed by law enforcement investigating infant death cases that may implicate SIDS, and training on how to appropriately respond to families or caretakers at the time of the infant's death.[16]

The current rule requires that the SIDS Recognition and Response training program include, at a minimum, the following learning objectives:[17]

- Define SIDS.
- Describe the epidemiology of SIDS.
- Describe the physical features of an infant who has died of SIDS.
- Describe the circumstances associated with a SIDS death.
- Identify the activities the emergency responder initiates.
- Describe the varied responses of SIDS families to sudden infant death.
- Respond to SIDS families in a sensitive manner.
- Describe the varied emotional reactions of emergency responders to sudden infant death.
- Identify ways emergency responders may cope with their own critical incident stress.
- Identify the community resources available to SIDS families.

According to Florida Department of Law Enforcement, the training on the proper response in infant death cases is included in the Criminal Justice Standards and Training Commission approved curricula for basic and advanced training of law enforcement officers. Both the basic and advanced training curricula have been updated and now use the term SUID.[18]

Furthermore, the DOH is required to:[19]

- Collaborate with other agencies in the development and presentation of the SIDS training program for first responders, including emergency medical technicians and paramedics, firefighters, and law enforcement officers.
- Maintain a database of statistics on reported SIDS deaths, and analyze the data as funds allow.
- Serve as liaison and closely coordinate activities with the Florida SIDS Alliance[20], including the services related to the SIDS hotline.
- Maintain a library reference list and materials about SIDS for public dissemination.
- Provide professional support to field staff.
- Coordinate the activities of, and promote a link between, the fetal and infant mortality review committees of the local healthy start coalitions, the local SIDS alliance, and other related support groups.

Florida Medical Examiners Commission

Chapter 406, part I, F.S., creates the Medical Examiners Act and the Medical Examiners Commission. Florida law, under s. 383.3362, F.S., requires that an autopsy must be performed in all suspected SIDS

[15] An emergency responder is defined in rule to mean the law enforcement officers, paramedics, firefighters, emergency medical technicians, or other medical personnel who respond to the initial report of an unresponsive infant. *See* Rule 64F-5.001, F.A.C.

[16] S. 383.3362(3), F.S.

[17] Rule 64F-5.002, F.A.C.

[18] Florida Department of Law Enforcement, Agency Analysis for HB 83, dated January 18, 2013, on file with the Health Quality Subcommittee.

[19] S. 383.3362(5), F.S.

[20] The Florida SIDS Alliance formed in 1985 and its mission is to provide a reliable and continuous source of assistance to parents who have lost a child suddenly and unexpectedly, provide information and referral networking, sponsor educational campaigns, and promote and support research into the cause and possible prevention of SIDS through fundraising and public education. The Florida SIDS Alliance operates a hotline (1-800-SIDS-FLA) and a website. *See* http://flasids.com/blog/florida-sids-alliance/ (last visited Feb. 5, 2013).

cases by a medical examiner within 24 hours, or as soon as feasible.[21] Section 383.3362(4)(d), F.S., cross-references s. 406.11, F.S., which provides the medical examiner authority, when deaths occur under certain circumstances, to examine, investigate, and perform autopsies as he or she deems necessary.

If the medical examiner's findings are consistent with SIDS, this condition must be listed as the cause of death on the death certificate. The Legislature granted medical examiners an exemption from civil action for any act or omission that may occur from complying with the law by conducting the required autopsy on the infant.[22]

Moreover, the Medical Examiners Commission within the Florida Department of Law Enforcement is required to develop a protocol for handling suspected SIDS autopsies.[23] The protocol was last updated on July 28, 2010.[24] All medical examiners are required to follow the protocol requiring familiarity with the circumstance and location of the body; review of the infant's clinical history to include determination of prenatal, delivery and postnatal medical information, which includes history of familial disease, mental illness and social setting pertinent to the exclusion of illnesses or child abuse; and a comprehensive autopsy. The comprehensive autopsy should include: x-rays; histology slides to exclude diagnosable disease processes; bacterial and viral cultures to exclude suspected infectious agents; and a toxicology study when indicated.[25]

Effect of Proposed Changes

The bill amends the law relating to SIDS to update the activities of the DOH and the medical examiners when reporting and classifying the cause of death of an infant under 1 year of age who suddenly dies, when in apparent good health. The bill brings the law into conformity with current CDC standards of practice by redefining and using a category for infant death that is broader than SIDS called, "Sudden Unexpected Infant Death," which includes infant death resulting from: SIDS, accidental suffocation, metabolic errors, injury or trauma and unclassified or accidental causes.

The bill amends the legislative intent, definitions, training requirements for first responders, autopsy requirements performed by medical examiners, and the protocol for medical and legal investigations to reflect the new SUID standard. The bill requires that the child protection teams within DOH's Division of Children's Medical Services be consulted on the development of the training curriculum that is part of the CDC SUID Initiative and all other DOH duties relating to SUID. The bill amends the timeframe that an autopsy must be performed from within 24 hours to 48 hours after death or as soon as feasible.

Additionally, the bill deletes references to SIDS, and the SIDS hotline. The bill makes technical changes by restructuring the language to improve readability and deleting unnecessary words and an obsolete date.

B. SECTION DIRECTORY:

Section 1. Amends s. 383.3362, F.S., relating to sudden infant death syndrome.
Section 2. Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

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[21] S. 383.3362(4), F.S.
[22] S. 383.3362(4)(c), F.S.
[23] S. 383.3364(4)(b), F.S. The Administrative Rule governing the SIDS Autopsy Protocol was repealed May 21, 2012. *See* ch. 11G-2.0031, F.A.C.
[24] Florida Department of Law Enforcement, Medical Examiners Commission, Practice Guidelines: Infant Deaths. Available at: http://www.fdle.state.fl.us/Content/getdoc/916d04c4-f522-4d8a-b16b-15fe90a9b28e/Practice-Guidelines-2009-Adopted.aspx (last viewed Feb. 5, 2013).
[25] *Id.*

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   An insignificant increase in state expenditures is possible. This increase may be absorbed within agency existing resources associated with rule development and promulgation.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   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 shared with counties or municipalities.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

An insignificant economic impact on the private sector is possible related to the requirement that hospitals that provide birthing services incorporate information on safe sleep practices and the possible causes of SUID.

D. FISCAL COMMENTS:

None.

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 Identified.

B. RULE-MAKING AUTHORITY:

The Department of Health has sufficient authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 7, 2013, the Health Quality Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment:

- Requires the DOH to consult with the child protection teams under DOH's Children's Medical Services when developing training curricula for emergency medical service personnel.
- Requires the DOH to consult with the child protection teams when performing other SUID duties.
- Reinstates that the DOH is to coordinate with the Florida SIDS Alliance.

On March 12, 2013, the Health Care Appropriations Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment:

- Requires that birth center clients receive information on safe sleeping practices and the possible causes of SUID.
- Corrects references to the Children's Medical Services program to the Division of Children's Medical Services.
- Requires that basic training program curriculum required for specific public safety personnel certification is consistent with the CDC SUID Initiative.
- Requires that if an autopsy is performed, it must be performed within 48 hours after death or as soon as feasible.
- Requires that a hospital that provides birthing services shall incorporate information on safe sleeping practices and the possible causes of SUID into postpartum instruction on the care of newborns.

This analysis is drafted to the committee substitute.

1 A bill to be entitled
2 An act relating to infant death; amending ss. 383.311
3 and 383.318, F.S.; revising the education,
4 orientation, and postpartum care requirements for
5 birth center clients to include certain instruction on
6 safe sleep practices and causes of Sudden Unexpected
7 Infant Death; amending s. 383.3362, F.S.; revising
8 legislative findings and intent with respect to the
9 sudden unexpected death of an infant under a specified
10 age; defining the term "Sudden Unexpected Infant
11 Death"; revising provisions relating to training
12 requirements for first responders; revising
13 requirements relating to autopsies performed by
14 medical examiners; requiring the Medical Examiners
15 Commission to provide for the development and
16 implementation of a protocol for the medicolegal
17 investigation of Sudden Unexpected Infant Death;
18 creating s. 395.1053, F.S.; requiring a hospital that
19 provides birthing services to incorporate certain
20 information into the hospital's postpartum instruction
21 on the care of newborns; providing an effective date.
22
23 Be It Enacted by the Legislature of the State of Florida:
24
25 Section 1. Paragraph (f) of subsection (2) of section
26 383.311, Florida Statutes, is amended to read:
27 383.311 Education and orientation for birth center clients
28 and their families.—

29 (2) The clients shall be prepared for childbirth and
30 childbearing by education in:
31 (f) The care of the newborn, including safe sleep
32 practices and the possible causes of Sudden Unexpected Infant
33 Death.
34 Section 2. Paragraph (e) of subsection (3) of section
35 383.318, Florida Statutes, is amended to read:
36 383.318 Postpartum care for birth center clients and
37 infants.—
38 (3) Postpartum evaluation and followup care shall be
39 provided, which shall include:
40 (e) Instruction in child care, including immunization, ~~and~~
41 breastfeeding, safe sleep practices, and the possible causes of
42 Sudden Unexpected Infant Death.
43 Section 3. Section 383.3362, Florida Statutes, is amended
44 to read:
45 383.3362 Sudden Unexpected Infant Death ~~Syndrome~~.—
46 (1) FINDINGS AND INTENT.—The Legislature recognizes that
47 more than 4,500 infants in the United States die suddenly and
48 unexpectedly of no immediate or obvious cause. According to
49 statistics from the Department of Health, more than 200 infants
50 in this state experienced Sudden Unexpected Infant Death in 2010
51 ~~Sudden Infant Death Syndrome, or SIDS, is a leading cause of~~
52 ~~death among children under the age of 1 year, both nationally~~
53 ~~and in this state~~. The Legislature further recognizes that first
54 responders to emergency calls relating to such a death need
55 access to special training to better enable them to recognize
56 that such deaths may result from natural and accidental causes

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

57 or may be caused ~~distinguish SIDS from death caused~~ by criminal
58 acts and to appropriately interact with the deceased infant's
59 parents or caretakers. At the same time, the Legislature,
60 recognizing that the primary focus of first responders is to
61 carry out their assigned duties, intends to increase ~~the~~
62 awareness of the possible causes of Sudden Unexpected Infant
63 Death ~~SIDS by first responders~~, but in no way expand or take
64 away from their duties. Further, the Legislature recognizes the
65 importance of a multidisciplinary investigation and standardized
66 investigative protocols in cases of Sudden Unexpected Infant
67 Death ~~standard protocol for review of SIDS deaths by medical~~
68 ~~examiners and the importance of appropriate followup in cases of~~
69 ~~certified or suspected SIDS deaths~~. Finally, the Legislature
70 finds that it is desirable to analyze existing data~~,~~ and ~~to~~
71 conduct further research on~~,~~ the possible causes of Sudden
72 Unexpected Infant Death ~~SIDS~~ and on how to reduce its incidence
73 ~~lower the number of sudden infant deaths~~.

74 (2) DEFINITION.—As used in this section, the term "Sudden
75 Unexpected Infant Death ~~Syndrome~~," or "SUID," ~~"SIDS,"~~ means the
76 sudden unexpected death of an infant under 1 year of age while
77 in apparent good health whose death may have been a result of
78 natural or unnatural causes ~~which remains unexplained after a~~
79 ~~complete autopsy, death-scene investigation, and review of the~~
80 ~~case history~~. ~~The term includes only those deaths for which,~~
81 ~~currently, there is no known cause or cure.~~

82 (3) TRAINING.—

83 (a) The Legislature finds that an emergency medical
84 technician, a paramedic, a firefighter, or a law enforcement

85 officer is likely to be the first responder to a request for
86 assistance which is made immediately after the sudden unexpected
87 death of an infant. The Legislature further finds that these
88 first responders should be trained in appropriate responses to
89 sudden infant death.
90 (b) ~~After January 1, 1995,~~ The basic training programs
91 required for certification as an emergency medical technician, a
92 paramedic, a firefighter, or a law enforcement officer as
93 defined in s. 943.10, other than a correctional officer or a
94 correctional probation officer, must include curriculum that
95 contains instruction on SUID ~~Sudden Infant Death Syndrome~~.
96 (c) The Department of Health, in consultation with the
97 Emergency Medical Services Advisory Council, the Firefighters
98 Employment, Standards, and Training Council, the child
99 protection teams established in the Division of Children's
100 Medical Services, and the Criminal Justice Standards and
101 Training Commission, shall develop and adopt, by rule,
102 curriculum that is part of the Centers for Disease Control SUID
103 Initiative, which must ~~at a minimum, includes training in the~~
104 ~~nature of SIDS, standard procedures to~~ be followed by law
105 enforcement agencies in investigating cases involving sudden
106 deaths of infants, and training in responding appropriately to
107 the parents or caretakers who have requested assistance.
108 (4) AUTOPSIES.—
109 (a) The death of any infant younger than 1 year of age who
110 dies suddenly and unexpectedly while in apparent good health
111 falls under the jurisdiction of the medical examiner as provided
112 in s. 406.11 ~~The medical examiner must perform an autopsy upon~~

113 ~~any infant under the age of 1 year who is suspected to have died~~
114 ~~of Sudden Infant Death Syndrome~~. If an autopsy is performed, it
115 ~~The autopsy~~ must be performed within 48 ~~24~~ hours after the
116 death, or as soon thereafter as is feasible. ~~When the medical~~
117 ~~examiner's findings are consistent with the definition of sudden~~
118 ~~infant death syndrome in subsection (2), the medical examiner~~
119 ~~must state on the death certificate that sudden infant death~~
120 ~~syndrome was the cause of death.~~
121 (b) The Medical Examiners Commission shall provide for the
122 development and implementation of ~~develop and implement~~ a
123 protocol for the medicolegal investigation of SUID ~~dealing with~~
124 ~~suspected sudden infant death syndrome~~. ~~The protocol must be~~
125 ~~followed by all medical examiners when conducting the autopsies~~
126 ~~required under this subsection.~~ The protocol may include
127 requirements and standards for scene investigations,
128 requirements for specific data, criteria for any specific tissue
129 sampling, and any other requirements that are deemed
130 ~~ascertaining cause of death based on the autopsy, criteria for~~
131 ~~any specific tissue sampling, and any other requirements that~~
132 ~~the commission considers~~ necessary.
133 (c) A medical examiner is not liable for damages in a
134 civil action for any act or omission done in compliance with
135 this subsection.
136 ~~(d) An autopsy must be performed under the authority of a~~
137 ~~medical examiner under s. 406.11.~~
138 (5) DEPARTMENT DUTIES RELATING TO SUDDEN UNEXPECTED INFANT
139 DEATH (SUID) ~~SYNDROME (SIDS)~~.—The Department of Health, in
140 consultation with the child protection teams established in the

141 Division of Children's Medical Services, shall:
142 (a) Collaborate with other agencies in the development and
143 presentation of the SUID ~~Sudden Infant Death Syndrome (SIDS)~~
144 training programs for first responders, including those for
145 emergency medical technicians and paramedics, firefighters, and
146 law enforcement officers.
147 (b) Maintain a database of statistics on reported SUID
148 ~~SIDS~~ deaths~~,~~ and analyze the data as funds allow.
149 (c) Serve as liaison and closely coordinate activities
150 with the Florida SIDS Alliance~~, including the services related~~
151 ~~to the SIDS hotline~~.
152 (d) Maintain a library reference list and materials about
153 SUID ~~SIDS~~ for public dissemination.
154 (e) Provide professional support to field staff.
155 (f) Coordinate the activities of and promote a link
156 between the fetal and infant mortality review committees of the
157 local healthy start coalitions, the Florida ~~local~~ SIDS Alliance,
158 and other related support groups.
159 Section 4. Section 395.1053, Florida Statutes, is created
160 to read:
161 395.1053 Postpartum education.—A hospital that provides
162 birthing services shall incorporate information on safe sleep
163 practices and the possible causes of Sudden Unexpected Infant
164 Death into the hospital's postpartum instruction on the care of
165 newborns.
166 Section 5. This act shall take effect July 1, 2013.

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Santiago offered the following:
4
5 **Amendment**
6 Remove line 101 and insert:
7 Training Commission, ~~shall develop and adopt, by rule~~, shall
8 adopt and modify when necessary, by rule,
9

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/CS/HB 83 (2013)

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Santiago offered the following:
4
5 **Amendment**
6 Remove line 115 and insert:
7 ~~The autopsy~~ must be performed within 72 ~~24~~ hours after the
8

CS/HB 93

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 93 Homelessness
SPONSOR(S): Healthy Families Subcommittee; Reed and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 402

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthy Families Subcommittee	12 Y, 0 N, As CS	Entress	Schoolfield
2) Transportation & Economic Development Appropriations Subcommittee	12 Y, 0 N	Rayman	Davis
3) Health & Human Services Committee		Entress	Calamas

SUMMARY ANALYSIS

CS/HB 93 creates and revises multiple sections of Florida Statutes relating to homelessness. Specifically the bill makes the following changes:

- Authorizes the collection of voluntary contributions in the amount of $1.00 to be added to motor vehicle registration and driver's license fees, both initial and renewal fees, to aid the homeless.
- Waives the $10,000 application fee for the voluntary contribution to aid the homeless for vehicle registration and renewal forms as well as driver license application forms.
- Replaces s. 414.16, F.S., as it relates to Emergency Financial Assistance Program for Families with s. 414.161, F.S., establishing a homeless prevention grant program to be administered by local homeless continuums of care to provide emergency financial assistance to families facing the loss of their current home due to financial or other crises.
- Limits the amount a lead agency may spend on administrative costs under a Challenge Grant.

The Department of Children and Families estimates a revenue increase of $20,000 per year to benefit the homeless from the collection of voluntary contributions. The Department of Highway Safety and Motor Vehicles estimates a one-time $65,600 programming cost to develop the new application forms.

The bill provides an effective date of July 1, 2013, unless otherwise specified.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

The Council on Homelessness

The Council on Homelessness (council) and the State Office on Homelessness (office) were created in 2001 within the Department of Children and Family Services (DCF)[1]. The office coordinates state agency responses to homelessness, serves as a single point of contact on homeless issues in the state, and administers state-funded grant programs that support the activities of the 28 local homeless coalitions[2]. The 17-member council is comprised of representatives of state agencies, counties, homeless advocacy organizations, and volunteers[3]. The council's duties include developing policy and advising the office.

The office administers all homelessness prevention grants through lead agencies. The lead agency has the responsibility for continuum of care plans that help communities or regions envision, plan and implement comprehensive and long term solutions to the problem of homelessness in the community. Lead agencies are also authorized applicants for the Challenge Grant and the Homeless Housing Assistance Grant.

Emergency Assistance Program

This is a state grant program to provide support to families, with at least one minor child, who are currently without shelter or face the loss of shelter because of the following:[4]

- Nonpayment of rent or mortgage resulting in eviction or notice of eviction;
- Household disaster, which renders the home uninhabitable;
- Other emergency situations defined in rule.[5]

Families may receive up to $400 during one period of 30 consecutive days in any 12 consecutive months.[6] DCF serves approximately 2,000 families a year under this program and utilizes Other Personal Services (OPS) staff to assess eligibility and process payments.[7]

Homeless Housing Assistance Grants

This grant program provides homeless housing assistance grants up to $750,000 annually to lead agencies to acquire, construct, or rehabilitate transitional or permanent housing units for homeless persons.[8] Administrative costs are capped at 5% of the funds awarded.[9]

[1] Ch. 2001-98, L.O.F
[2] s.420.622(3), F.S.
[3] s.420.622(2), F.S.
[4] s. 414.16, F.S.
[5] s. 414.16(1), F.S.
[6] 65A-33.011, F.A.C.
[7] DCF Staff Analysis HB 93 (2013). On file with committee staff.
[8] s. 420.622(5), F.S.
[9] s. 420.622(5)(f), F.S.

Challenge Grant

The challenge grant is a state program which includes grants of up to $500,000 to lead agencies who have developed and implemented a local homeless assistance continuum of care plan to provide services including outreach, emergency shelter, support services, and permanent shelter in the area.[10] This grant program was not funded in the General Appropriations Act for FY 2012-13.

Voluntary Checkoffs

Voluntary checkoffs provide the opportunity for citizens to make a voluntary donation by checking a box on a form when registering a vehicle or applying for a driver's license. Current statute provides that an organization must seek authorization from the Department of Highway Safety and Motor Vehicles (DHSMV) prior to establishing a voluntary contribution checkoff. Organizations must submit the request to DHSMV, pay an application fee not to exceed $10,000 and submit a marketing strategy prior to seeking Legislative authorization for the creation of a new voluntary contribution fee on motor vehicle registration or driver license applications.[11]

DHSMV must discontinue the checkoff if less than $25,000 has been contributed by the end of the fifth year, or if less than $25,000 is contributed during any subsequent 5-year period.[12]

Currently there are 24 voluntary contribution checkoff opportunities for motor vehicle registration applicants and 17 contribution checkoff opportunities for driver license applicants.[13] DHSMV informs that due to the increased number of voluntary contribution checkoffs, the renewal notices are overcrowded with information, making them difficult to read.[14] The 2010 Legislature passed a moratorium on new voluntary checkoffs from July 1, 2010 to July 1, 2013. An exception could be made to the moratorium if certain conditions were met or a bill was filed during the 2010 Legislative session to establish a voluntary contribution and satisfy the requirements of s. 320.023 or s. 322.081, F.S.[15] A bill was filed during the 2010 Legislative Session, HB 923, which attempted to establish the same voluntary contribution for the homeless (as in the HB 93) and addressed the requirements in law.[16]

Effect of Proposed Changes

The bill authorizes the collection of voluntary contributions in the amount of $1.00 to be added to the motor vehicle and driver's license fees - initial and renewal fees - to aid the homeless, as of October 1, 2013. This is accomplished by adding a homelessness voluntary contribution checkoff to the forms when paying for a driver license or vehicle registration. The bill does not require the voluntary contributions be subject to the checkoff procedures and requirements of s. 320.023, F.S., and s. 322.081, F.S. Funds collected will be placed in a grants and donations trust fund for use by the Office on Homelessness to supplement Challenge Grants and Homeless Housing Assistance Grants and to provide information on homelessness to the public. The effect of this change is estimated to generate an additional $20,000 a year.

The bill repeals s. 414.16, F.S., relating to the Emergency Assistance Program and replaces it with a Homelessness Prevention Grant Program under s. 414.161, F.S. The new program will be administered by the Office on Homelessness at DCF, with the concurrence of the Council on Homelessness. The office may provide prevention grants through contracts with local lead agencies for

[10] s. 420.622(4), F.S.
[11] s. 320.023, F.S. , 322.081,F.S.
[12] ss. 320.023(4)(a) and 322.081(4)(a), F.S.
[13] s.320.02(8), (14),(15),F.S. and 322.08(7), F.S.
[14] Department of Highway Safety and Motor Vehicles Agency Bill Analysis, 1/25/13, on file with the committee.
[15] Section 26, chapter 2010-223, LOF.
[16] HB923 2010 Legislative Session.

homeless assistance continuums of care. The bill specifies the grant application process and certain preferences for applicants who can leverage additional funds and demonstrate effective programs. Eligibility for the grant program is limited to lead agencies who have implemented a local homeless assistance plan for their area. The grants are capped at $300,000 and may be used to assist families facing the loss of their current home to pay past due rent and mortgage payments, past due utility bills, and case management. Program administrative costs are capped at 3 percent of the grant award.

The bill also limits lead agency spending at a maximum of 8 percent of funding for administrative costs expended on Challenge Grants which are authorized in s. 420.622, F.S.

B. SECTION DIRECTORY:

Section 1: Amends s. 320.02, F.S., relating to registration required; application for registration; forms.

Section 2: Amends s. 322.08, F.S., relating to application for license; requirements for license and identification card forms.

Section 3: Amends s. 322.18, F.S., relating to original applications, licenses, renewals; expiration of licenses; delinquent licenses.

Section 4: Creates s. 414.161, F.S., relating to Homelessness prevention grants.

Section 5: Amends s. 420.622, F.S., relating to the State Office on Homelessness; Council on Homelessness.

Section 6: Amends s. 420.625, F.S., relating to Grant-in-aid program.

Section 7: Repeals s. 414.16, F.S., relating to emergency assistance program.

Section 8: Provides an effective date of July 1, 2013, unless otherwise specified.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   According to DCF, the voluntary contributions from motor vehicle registrations and renewals, and original or renewal driver's licenses could provide an estimated $20,000 annually.

   The bill waives the application fees for these voluntary contributions normally required by ss. 320.023 and 322.081, F.S. The two application fees total $20,000.

2. Expenditures:

   DHSMV estimates a one-time programming cost of $65,600 to the Highway Safety Operating Trust Fund to redesign the application forms associated with vehicle registration/renewal transaction and issuance of an original, replacement, or renewal of a driver license/identification card.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None

D. FISCAL COMMENTS:

A fiscal impact of $65,600 in programming costs is estimated by DHSMV in order to redesign application forms. The department states it can accommodate the programming costs within existing resources.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable.

2. Other:

   None

B. RULE-MAKING AUTHORITY:

None

C. DRAFTING ISSUES OR OTHER COMMENTS:

Line 152 has a technical deficiency and the word "paragraph" should be changed to "subsection."

Recommend changing the effective date for sections 1, 2, and 3 related to the voluntary checkoffs for homelessness contributions to provide sufficient time for DHSMV to implement form changes.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 7, 2013, the Healthy Families Subcommittee approved two amendments and reported favorably as a committee substitute. The amendments:

- Corrects a technical error in drafting changing "paragraph" to "subsection".
- Changes the effective date of the voluntary contribution sections of the bill to October 1, 2013.

1 A bill to be entitled
2 An act relating to homelessness; amending ss. 320.02,
3 322.08, and 322.18, F.S.; requiring the motor vehicle
4 registration form and registration renewal form, the
5 driver license application form, and the driver
6 license application form for renewal issuance or
7 renewal extension to include an option to make a
8 voluntary contribution to aid the homeless; providing
9 for such contributions to be deposited into the Grants
10 and Donations Trust Fund of the Department of Children
11 and Families and used by the State Office on
12 Homelessness for certain purposes; providing exemption
13 from certain application fee requirements; providing
14 that voluntary contributions for the homeless are not
15 income of a revenue nature for the purpose of applying
16 certain service charges; creating s. 414.161, F.S.;
17 establishing a homelessness prevention grant program;
18 requiring grant applicants to be ranked competitively;
19 providing preference for certain grant applicants;
20 providing eligibility requirements; providing grant
21 limitations and restrictions; requiring lead agencies
22 for local homeless assistance continuums of care to
23 track, monitor, and report on assisted families for a
24 specified period; amending s. 420.622, F.S.; limiting
25 the percentage of funding that lead agencies may spend
26 on administrative costs; amending s. 420.625, F.S.;
27 deleting a cross-reference to conform; repealing s.
28 414.16, F.S., relating to the emergency assistance

29 program for families with children that have lost
30 shelter or face loss of shelter due to an emergency;
31 transferring emergency assistance program funds to the
32 homelessness prevention grant program; providing
33 effective dates.
34
35 Be It Enacted by the Legislature of the State of Florida:
36
37 Section 1. Effective October 1, 2013, paragraph (s) is
38 added to subsection (15) of section 320.02, Florida Statutes, to
39 read:
40 320.02 Registration required; application for
41 registration; forms.—
42 (15)
43 (s) Notwithstanding s. 320.023, the application form for
44 motor vehicle registration and renewal of registration must
45 include language permitting a voluntary contribution of $1 per
46 applicant to aid the homeless. Contributions made pursuant to
47 this paragraph shall be deposited into the Grants and Donations
48 Trust Fund of the Department of Children and Families and used
49 by the State Office on Homelessness to supplement grants made
50 under s. 420.622(4) and (5), provide information to the public
51 about homelessness in the state, and provide literature for
52 homeless persons seeking assistance. The application fee
53 required under s. 320.023 for an organization that seeks
54 authorization to establish a voluntary contribution does not
55 apply to this paragraph.
56

57 For the purpose of applying the service charge provided in s.
58 215.20, contributions received under this subsection are not
59 income of a revenue nature.
60 Section 2. Effective October 1, 2013, subsection (7) of
61 section 322.08, Florida Statutes, is amended to read:
62 322.08 Application for license; requirements for license
63 and identification card forms.—
64 (7) The application form for an original, renewal, or
65 replacement driver license or identification card shall include
66 language permitting the following:
67 (a) A voluntary contribution of $1 per applicant, which
68 contribution shall be deposited into the Health Care Trust Fund
69 for organ and tissue donor education and for maintaining the
70 organ and tissue donor registry.
71 (b) A voluntary contribution of $1 per applicant, which
72 contribution shall be distributed to the Florida Council of the
73 Blind.
74 (c) A voluntary contribution of $2 per applicant, which
75 shall be distributed to the Hearing Research Institute,
76 Incorporated.
77 (d) A voluntary contribution of $1 per applicant, which
78 shall be distributed to the Juvenile Diabetes Foundation
79 International.
80 (e) A voluntary contribution of $1 per applicant, which
81 shall be distributed to the Children's Hearing Help Fund.
82 (f) A voluntary contribution of $1 per applicant, which
83 shall be distributed to Family First, a nonprofit organization.
84 (g) A voluntary contribution of $1 per applicant to Stop

85 Heart Disease, which shall be distributed to the Florida Heart
86 Research Institute, a nonprofit organization.
87 (h) A voluntary contribution of $1 per applicant to Senior
88 Vision Services, which shall be distributed to the Florida
89 Association of Agencies Serving the Blind, Inc., a not-for-
90 profit organization.
91 (i) A voluntary contribution of $1 per applicant for
92 services for persons with developmental disabilities, which
93 shall be distributed to The Arc of Florida.
94 (j) A voluntary contribution of $1 to the Ronald McDonald
95 House, which shall be distributed each month to Ronald McDonald
96 House Charities of Tampa Bay, Inc.
97 (k) Notwithstanding s. 322.081, a voluntary contribution
98 of $1 per applicant, which shall be distributed to the League
99 Against Cancer/La Liga Contra el Cancer, a not-for-profit
100 organization.
101 (l) A voluntary contribution of $1 per applicant to
102 Prevent Child Sexual Abuse, which shall be distributed to
103 Lauren's Kids, Inc., a nonprofit organization.
104 (m) A voluntary contribution of $1 per applicant, which
105 shall be distributed to Prevent Blindness Florida, a not-for-
106 profit organization, to prevent blindness and preserve the sight
107 of the residents of this state.
108 (n) Notwithstanding s. 322.081, a voluntary contribution
109 of $1 per applicant to the state homes for veterans, to be
110 distributed on a quarterly basis by the department to the State
111 Homes for Veterans Trust Fund, which is administered by the
112 Department of Veterans' Affairs.

113 (o) A voluntary contribution of $1 per applicant to the
114 Disabled American Veterans, Department of Florida, which shall
115 be distributed quarterly to Disabled American Veterans,
116 Department of Florida, a nonprofit organization.
117 (p) A voluntary contribution of $1 per applicant for
118 Autism Services and Supports, which shall be distributed to
119 Achievement and Rehabilitation Centers, Inc., Autism Services
120 Fund.
121 (q) A voluntary contribution of $1 per applicant to
122 Support Our Troops, which shall be distributed to Support Our
123 Troops, Inc., a Florida not-for-profit organization.
124 (r) Notwithstanding s. 322.081, a voluntary contribution
125 of $1 per applicant to aid the homeless. Contributions made
126 pursuant to this paragraph shall be deposited into the Grants
127 and Donations Trust Fund of the Department of Children and
128 Families and used by the State Office on Homelessness to
129 supplement grants made under s. 420.622(4) and (5), provide
130 information to the public about homelessness in the state, and
131 provide literature for homeless persons seeking assistance.
132
133 A statement providing an explanation of the purpose of the trust
134 funds shall also be included. For the purpose of applying the
135 service charge provided in s. 215.20, contributions received
136 under paragraphs (b)-(r) ~~(b)-(q)~~ are not income of a revenue
137 nature.
138 Section 3. Effective October 1, 2013, subsection (9) is
139 added to section 322.18, Florida Statutes, to read:
140 322.18 Original applications, licenses, and renewals;

141 expiration of licenses; delinquent licenses.—
142 (9) The application form for a renewal issuance or renewal
143 extension shall include language permitting a voluntary
144 contribution of $1 per applicant to aid the homeless.
145 Contributions made pursuant to this subsection shall be
146 deposited into the Grants and Donations Trust Fund of the
147 Department of Children and Families and used by the State Office
148 on Homelessness to supplement grants made under s. 420.622(4)
149 and (5), provide information to the public about homelessness in
150 the state, and provide literature for homeless persons seeking
151 assistance. For the purpose of applying the service charge
152 provided in s. 215.20, contributions received under this
153 subsection are not income of a revenue nature.
154 Section 4. Section 414.161, Florida Statutes, is created
155 to read:
156 414.161 Homelessness prevention grants.—
157 (1) ESTABLISHMENT OF PROGRAM.—There is created a grant
158 program to provide emergency financial assistance to families
159 facing the loss of their current home due to a financial or
160 other crisis. The State Office on Homelessness, with the
161 concurrence of the Council on Homelessness, may accept and
162 administer moneys appropriated to the Department of Children and
163 Families to provide homelessness prevention grants annually to
164 lead agencies for local homeless assistance continuums of care,
165 as recognized by the State Office on Homelessness. These moneys
166 shall consist of any sums that the state may appropriate, as
167 well as money received from donations, gifts, bequests, or
168 otherwise from any public or private source that is intended to

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

169 assist families to prevent them from becoming homeless.
170 (2) GRANT APPLICATIONS.—Grant applicants shall be ranked
171 competitively. Preference shall be given to applicants who
172 leverage additional private funds and public funds, who
173 demonstrate the effectiveness of their homelessness prevention
174 programs in keeping families housed, and who demonstrate the
175 commitment of other assistance and services to address family
176 health, employment, and education needs.
177 (3) ELIGIBILITY.—In order to qualify for a grant, a lead
178 agency must develop and implement a local homeless assistance
179 continuum of care plan for its designated catchment area. The
180 homelessness prevention program must be included in the
181 continuum of care plan.
182 (4) GRANT LIMITS.—The maximum grant amount per lead agency
183 may not exceed $300,000. The grant assistance may be used to pay
184 past due rent or mortgage payments, past due utility costs,
185 provision of case management services, and program
186 administration costs not to exceed 3 percent of the grant award.
187 The homelessness prevention program must develop a case plan for
188 each family to be assisted, setting forth what costs will be
189 covered and the maximum level of assistance to be offered.
190 (5) PERFORMANCE.—The lead agency must track, monitor, and
191 report on each family assisted for at least 12 months after the
192 last assistance provided to the family. The goal for the
193 homelessness prevention program is to enable at least 85 percent
194 of the families assisted to remain in their homes and avoid
195 becoming homeless during the ensuing year.

196 Section 5. Paragraph (d) is added to subsection (4) of
197 section 420.622, Florida Statutes, to read:
198 420.622 State Office on Homelessness; Council on
199 Homelessness.—
200 (4) Not less than 120 days after the effective date of
201 this act, the State Office on Homelessness, with the concurrence
202 of the Council on Homelessness, may accept and administer moneys
203 appropriated to it to provide "Challenge Grants" annually to
204 lead agencies for homeless assistance continuums of care
205 designated by the State Office on Homelessness. A lead agency
206 may be a local homeless coalition, municipal or county
207 government, or other public agency or private, not-for-profit
208 corporation. Such grants may be up to $500,000 per lead agency.
209 (d) A lead agency may spend a maximum of 8 percent of its
210 funding on administrative costs.
211 Section 6. Paragraph (d) of subsection (3) of section
212 420.625, Florida Statutes, is amended to read:
213 420.625 Grant-in-aid program.—
214 (3) ESTABLISHMENT.—There is hereby established a grant-in-
215 aid program to help local communities in serving the needs of
216 the homeless through a variety of supportive services, which may
217 include, but are not limited to:
218 (d) Emergency financial assistance for persons who are
219 totally without shelter or facing loss of shelter~~, but who are~~
220 ~~not eligible for such assistance under s. 414.16~~.
221 Section 7. Section 414.16, Florida Statutes, is repealed,
222 and any balances remaining in the emergency assistance program
223 terminated by this act shall, on the date of termination, be

224 transferred to the homelessness prevention grant program created
225 under s. 414.161, Florida Statutes.
226 Section 8. Except as otherwise expressly provided in this
227 act and except for this section, which shall take effect upon
228 this act becoming a law, this act shall take effect July 1,
229 2013.

CS/HB 115

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 115 Professional Licensure of Military Veterans by Department of Health
SPONSOR(S): Health Quality Subcommittee; Santiago
TIED BILLS: **IDEN./SIM. BILLS:** SB 160

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	13 Y, 0 N, As CS	O'Callaghan	O'Callaghan
2) Veteran & Military Affairs Subcommittee	12 Y, 0 N	Thompson	De La Paz
3) Health Care Appropriations Subcommittee	13 Y, 0 N	Rodriguez	Pridgeon
4) Health & Human Services Committee		O'Callaghan	Calamas

SUMMARY ANALYSIS

CS/HB 115 requires the Department of Health (DOH) to waive initial licensure and certificate fees for military veterans who apply for a fee waiver using a DOH form and who provide supporting documentation required by DOH. A military veteran is only eligible for the fee waiver if the veteran has been honorably discharged from any branch of the United States Armed Forces within 24 months from the application. Current law does not allow the DOH or its regulatory boards to distinguish applicants for initial licensure based on military service.

The bill has an insignificant, negative fiscal impact on state government and no fiscal impact on local government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Military and Veteran Presence in Florida

The United States currently has 1.4 million people serving in the United States Armed Forces,[1] over 23 million veterans living in the United States, and over 200 military installations in 46 states, the District of Columbia, and Puerto Rico.[2]

Florida, with its 20 major military installations, is home to a large population of active duty and reserve military members, as well as veterans. Currently, there are over 61,000 active duty military members[3] and 12,000 National Guard members[4] in Florida. The number of veterans living in Florida is over 1.6 million, the third highest in the nation behind California and Texas.[5]

While the majority of programs and benefits for military personnel and veterans are administered by the Federal Government, states and state legislatures are playing an increasingly larger role in military issues.

Professional Licensure Benefits for Military Members, Veterans, and Spouses

In recent years, the Florida Legislature has enacted laws to assist current military personnel, their spouses, and veterans in obtaining and renewing professional licensure in Florida.

In 2011, the Legislature created the Florida Defense Support Task Force (FDSTF) under s. 288.987, F.S.,[6] with a defined mission to:

- Make recommendations to preserve and protect military installations.
- Support the state's position in research and development related to or arising out of military missions and contracting.
- Improve the state's military-friendly environment for service members, military dependents, military retirees and businesses that bring military and base-related jobs to the state.

One of the FDSTF's long-range goals is to strengthen state support for military families and veterans with a focus on education, health care, employment and family programs.[7]

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[1] Section 250.01, F.S., concerning Military Affairs in Florida, defines "Armed Forces" to mean the United States Army, Navy, Air Force, Marine Corps, and Coast Guard.
[2] National Conference of State Legislatures, *Military and Veterans Affairs*, available at: http://www.ncsl.org/issues-research/env-res/military-and-veterans-affairs.aspx (last visited on Feb. 5, 2013).
[3] University of West Florida: *Florida Defense Industry, Economic Impact Analysis*, pg. 14, 2013 Draft Report, on file with the Health Quality Subcommittee.
[4] Florida Department of Military Affairs, *Department of Military Affairs Mission*, available at: http://dma.myflorida.com/?page_id=2 (last visited on Feb. 5, 2013).
[5] California has approximately 2 million veterans and Texas has approximately 1.6 million veterans. United States Census Bureau, *A Snapshot of Our Nation's Veterans*, available at: http://www.census.gov/how/pdf/census_veterans.pdf (last visited on Feb. 5, 2013). *See also*, Department of Veterans Affairs, *Texas and the U.S. Department of Veteran Affairs*, and *Florida and the U.S. Department of Veteran Affairs*, November 2010, on file with the Health Quality Subcommittee.
[6] The Florida Defense Support Task Force replaced the Florida Council on Military Base and Mission Support, which was dismantled when s. 288.984, F.S., was repealed in 2011. *See* s. 38, ch. 2011-76, L.O.F.
[7] The Florida Defense Support Task Force, *2011 Annual Report and 2012 Work Plan*, available at: http://www.eflorida.com/fdstf/about.html (last visited on Feb. 5, 2013).

Current law[8] exempts military personnel from license renewal requirements for the duration of active duty while absent from the state of Florida, and for a period of six months after discharge or return to the state. This benefit applies to military members who hold certain professional licenses regulated by the Department of Business and Professional Regulation (DBPR) or the DOH, who are not practicing their profession in the private sector.[9] This benefit is also available to the spouses of active duty military members.[10]

To address the obstacles military families face due to frequent moves, the Legislature enacted CS/CS/CS/HB 713 in 2010[11] and CS/CS/CS/HB 1319[12] in 2011 to allow the DBPR and the DOH, respectively, to issue a temporary professional license to the spouse of an active duty military member. To obtain a temporary license, the spouse must submit proof of marriage to the military member, proof that he or she holds an active license in another state or jurisdiction, and proof that the military member is assigned to a duty station in Florida.[13] In addition, the spouse must submit a complete set of his or her fingerprints to the Department of Law Enforcement for a statewide criminal history check.

Most recently, in 2012, the Legislature enacted CS/CS/HB 887,[14] which waives the initial licensing fee, the initial application fee, and the initial unlicensed activity fee for a military veteran who applies to the DBPR for a license within 24 months of being honorably discharged. These licensure fee waivers apply only to professions regulated by the DBPR and does not apply to health professions under the DOH.

Department of Health Regulated Professions

Section 20.43, F.S., creates several divisions under the DOH, including the Division of Medical Quality Assurance (division), which is responsible for the following boards established within the division:

- The Board of Acupuncture, created under chapter 457.
- The Board of Medicine, created under chapter 458.
- The Board of Osteopathic Medicine, created under chapter 459.
- The Board of Chiropractic Medicine, created under chapter 460.
- The Board of Podiatric Medicine, created under chapter 461.
- The Board of Optometry, created under chapter 463.
- The Board of Nursing, created under part I of chapter 464.
- The Board of Pharmacy, created under chapter 465.
- The Board of Dentistry, created under chapter 466.
- The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.
- The Board of Nursing Home Administrators, created under part II of chapter 468.
- The Board of Occupational Therapy, created under part III of chapter 468.
- The Board of Athletic Training, created under part XIII of chapter 468.
- The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.
- The Board of Massage Therapy, created under chapter 480.
- The Board of Clinical Laboratory Personnel, created under part III of chapter 483.
- The Board of Opticianry, created under part I of chapter 484.
- The Board of Hearing Aid Specialists, created under part II of chapter 484.
- The Board of Physical Therapy Practice, created under chapter 486.
- The Board of Psychology, created under chapter 490.

[8] Sections 455.02(1) and 456.024(1), F.S.

[9] *See also*, s. 401.271, F.S., relating to certification of emergency medical technicians and paramedics who are on active duty with the United States Armed Forces.

[10] Sections 455.02(2) and 456.024(2), F.S.

[11] Section 5, ch. 2010-106, L.O.F.

[12] Section 1, ch. 2011-95, L.O.F.

[13] Sections 455.02(3) and 456.024(3), F.S.

[14] Section 3, ch. 2012-72, L.O.F.

- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

In addition to the professions regulated by the various aforementioned boards, the DOH also regulates the following professions:

- Naturopathy, as provided under chapter 462.
- Nursing assistants, as provided under part II of chapter 464.
- Midwifery, as provided under chapter 467.
- Respiratory therapy, as provided under part V of chapter 468.
- Dietetics and nutrition practice, as provided under part X of chapter 468.
- Electrolysis, as provided under chapter 478.
- Medical physicists, as provided under part IV of chapter 483.
- School psychologists, as provided under chapter 490.
- Emergency medical technicians and paramedics, as provided under chapter 490.
- Radiological personnel, as provided under part IV of chapter 468.

Typical fees associated with obtaining an initial license include an initial licensing fee,[15] an initial application fee,[16] and an initial unlicensed activity fee.[17] Each board within the jurisdiction of the DOH, or the DOH when there is no board, determines by rule the amount of license fees for the profession it regulates.[18]

Effect of Proposed Changes

CS/HB 115 requires the DOH to waive the initial licensing fee, initial application fee, and initial unlicensed activity fee for a military veteran who applies to the DOH for a license within 24 months after being honorably discharged from any branch of the United States Armed Forces. Additionally, the DOH must waive the initial application fee for a military veteran who applies for certification in the radiological profession[19] within 24 months after honorable discharge. However, the applicant for certification is still required to pay the fee for purchasing the examination from a national organization required for certification as a radiological professional.

The bill requires the application for both fee waivers to be submitted on a form prepared and furnished by the DOH and to include supporting documentation required by the DOH. The supporting documentation may be used to verify that the military veteran was honorably discharged.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.013, F.S., relating to the DOH's general licensing provisions.
Section 2: Amends s. 468.304, F.S., relating to certification.
Section 3: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

[15] Pursuant to s. 456.013(2), F.S., before the issuance of any license, the DOH shall charge an initial license fee as determined by the applicable board or, if there is no board, by rule of the DOH.
[16] Each DOH board, or the DOH when there is no board, determines by rule the amount of initial application fees for the profession it regulates pursuant to each practice act. *See e.g.*, ss. 458.311(1)(a), 459.0055(1)(a), and 460.406, F.S.
[17] Pursuant to s. 456.065, F.S, the DOH imposes upon initial licensure and each licensure renewal, a special fee of $5 per license to fund efforts to combat unlicensed activity.
[18] Section 456.025(3), F.S.
[19] Certified radiological professionals include basic X-ray machine operators, basic X-ray machine operators in podiatric medicine, general radiographers, nuclear medicine technologists, radiologist assistants, and specialty technologists. Section 468.304, F.S.

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The number of military veterans that will apply for licensure or certification, who have been honorably discharged from the United States Armed Forces within 24 months of applying for licensure or certification is unknown. Therefore, the actual fiscal impact cannot be determined at this time. However, it is anticipated that the bill will have an insignificant negative impact on the Medical Quality Assurance Trust Fund revenues related to the potential reduction in licensing fees.[20]

Similarly, the bill grants a waiver to applicable military veterans that may seek a radiological personnel certification. The fee for radiological certification may not exceed $100 and the proceeds are deposited into the Radiation Protection Trust Fund. This provision will have an insignificant negative impact on the revenues deposited into the Radiation Protection Trust Fund.[20]

A similar law enacted last year affected professions licensed by the DPBR. From July 1, 2012, to January 1, 2013, DBPR granted 38 military fee waivers and the fiscal impact to DBPR was $5,830.

2. Expenditures:

According to the DOH, there will be a non-recurring increase in work associated with the modification of the Customer Oriented Medical Practitioner Administration System (COMPAS) licensure system to accommodate the new requirements in the bill. The DOH states that current resources are adequate to absorb this one-time workload increase.[21]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill eliminates fees associated with initial health care licensure or certification for military veterans who have been honorably discharged from the United States Armed Forces within 24 months prior to applying for licensure or certification.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

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[20] Florida Department of Health, CS/HB 115 Agency Bill Analysis, February 19, 2013, on file with the Health Care Appropriations Subcommittee.

[21] *Id.*

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Sufficient rule-making authority currently exists under ss. 456.004(5) and 468.303, F.S., to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 7, 2013, the Health Quality Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment:

- Requires supporting documentation for an application to waive initial licensure fees to demonstrate the applicant was honorably discharged.
- Requires the DOH to waive initial fees for applicants seeking certification in a radiology profession if the applicant is a military veteran who was honorably discharged within 24 months from the application. The applicant must use a form prescribed by the DOH, submit supporting documentation, and still pay the fee for purchasing the examination from a national organization.

This analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.

1 A bill to be entitled
2 An act relating to professional licensure of military
3 veterans by the Department of Health; amending ss.
4 456.013 and 468.304, F.S.; requiring the Department of
5 Health to waive specified fees relating to licensure
6 and certification of professions within the
7 jurisdiction of the department for honorably
8 discharged military veterans; providing for
9 application and waiver requirements; providing an
10 effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Subsection (13) is added to section 456.013,
15 Florida Statutes, to read:
16 456.013 Department; general licensing provisions.—
17 (13) The department shall waive the initial licensing fee,
18 initial application fee, and initial unlicensed activity fee for
19 a military veteran who applies to the department for an initial
20 license within 24 months after being honorably discharged from
21 any branch of the United States Armed Forces. The applicant must
22 apply for the fee waiver using a form prescribed by the
23 department and must submit supporting documentation as required
24 by the department.
25 Section 2. Subsection (1) of section 468.304, Florida
26 Statutes, is amended to read:
27 468.304 Certification.—The department shall certify any
28 applicant who meets the following criteria:

29 (1) Pays to the department a nonrefundable fee that may
30 not exceed $100, plus the actual per-applicant cost to the
31 department for purchasing the examination from a national
32 organization. The department shall waive the initial application
33 fee for a military veteran who applies to the department for an
34 initial certification within 24 months after being honorably
35 discharged from any branch of the United States Armed Forces.
36 The applicant must apply for the fee waiver using a form
37 prescribed by the department and must submit supporting
38 documentation as required by the department. This waiver does
39 not include the fee for purchasing the examination from a
40 national organization.
41
42 The department may not certify any applicant who has committed
43 an offense that would constitute a violation of any of the
44 provisions of s. 468.3101 or applicable rules if the applicant
45 had been certified by the department at the time of the offense.
46 An application for a limited computed tomography certificate may
47 not be accepted. A person holding a valid computed tomography
48 certificate as of October 1, 1984, is subject to s. 468.309.
49 Section 3. This act shall take effect July 1, 2013.

HB 195

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 195 Emergency Medical Services
SPONSOR(S): Perry
TIED BILLS: **IDEN./SIM. BILLS:** SB 520

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	11 Y, 0 N	Holt	O'Callaghan
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Rodriguez	Pridgeon
3) Health & Human Services Committee		Holt	Calamas

SUMMARY ANALYSIS

In 2009, the U.S. Department of Transportation released the new National Emergency Medical Services Education Standards (National EMS Education Standards) for emergency medical technicians (EMTs) and paramedics. The bill updates Florida's EMT and paramedic training requirements to reflect the new 2009 national training standards.

HB 195 amends part III of ch. 401, F.S., to update the definitions and training standards to reflect the new EMT-Paramedic National Standard Curriculum or the National EMS Education Standards. The bill removes outdated competencies and makes conforming changes throughout the bill. The bill increases the timeframe within which EMTs and paramedics can take the state examination following successful completion of an approved training program from 1 to 2 years.

The bill amends s. 381.0034, F.S., to delete the requirement that EMTs and paramedics obtain HIV/AIDS continuing education instruction. The bill amends the timeline that the state emergency medical services plan is updated from biennially to every five years.

The bill has an insignificant fiscal impact that can be absorbed within existing agency resources and no fiscal impact to local governments.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

The Department of Health (DOH), Division of Emergency Operations regulates emergency medical technicians (EMTs) and paramedics. EMTs and paramedics are regulated pursuant to ch. 401, Part III, F.S. As of November 1, 2012, there were 36,578 active in-state licensed EMTs and 26,989 active in-state licensed paramedics in Florida.[1]

"Emergency Medical Technician" is defined under s. 401.23, F.S., to mean a person who is certified by the DOH to perform basic life support, which is the treatment of medical emergencies through the use of techniques described in the Emergency Medical Technician Basic Training Course Curriculum of the U.S. Department of Transportation. "Paramedic" means a person who is certified by the DOH to perform basic and advanced life support.

"Basic life support" means treatment of medical emergencies by a qualified person through the use of techniques such as patient assessment, cardiopulmonary resuscitation (CPR), splinting, obstetrical assistance, bandaging, administration of oxygen, application of medical antishock trousers, administration of a subcutaneous injection using a premeasured autoinjector of epinephrine to a person suffering an anaphylactic reaction, and other techniques described in the Emergency Medical Technician Basic Training Course Curriculum of the United States Department of Transportation.[2] "Advanced life support" means the treatment of life-threatening medical emergencies through the use of techniques such as endotracheal intubation, the administration of drugs or intravenous fluids, telemetry, cardiac monitoring, and cardiac defibrillation by a qualified person.[3]

Currently, the DOH is responsible for the improvement and regulation of basic and advanced life support programs and is required to biennially develop and revise a comprehensive state plan for basic and advanced life support services.[4]

HIV and AIDS Training Requirements

In 2006, the Legislature revised the requirements for HIV/AIDS continuing education instruction in the general licensing provisions for health care practitioners[5] regulated by s. 456.033, F.S.[6] The law removed the requirement that the HIV/AIDS continuing education course be completed at each biennial license renewal. Instead, licensees are required to submit confirmation that he or she has completed a course in HIV/AIDS instruction at the time of the first licensure renewal or recertification.[7]

Section 381.0034, F.S., requires the following practitioner groups to complete an HIV/AIDS educational course at the time of biennial licensure renewal or recertification:

- EMTs and paramedics;
- Midwives;

[1] Florida Department of Health, Division of Medical Quality Assurance, Annual Report and Long Range Plan: 2011-2012, available at: http://www.doh.state.fl.us/mqa/reports.htm (last viewed February 6, 2013).
[2] S. 401.23(7), F.S.
[3] S. 401.23(1), F.S.
[4] S. 401.24, F.S.
[5] Acupuncturist, physician, osteopathic physician, chiropractic physician, podiatric physician, certified optometrist, advanced registered nurse practitioner, registered nurse, clinical nurse specialist, pharmacist, dentist, nursing home administrator, occupational therapist, respiratory therapist, or nutritionist, and physical therapist.
[6] *See* section 2, ch. 2006-251, L.O.F.
[7] S. 456.033, F.S.

- Radiologic personnel; and
- Laboratory personnel.

Failure to complete the HIV/AIDS continuing education requirement is grounds for disciplinary action.[8]

National EMS Education Standards

In 1996, the National Highway Traffic Safety Administration (NHTSA) and the Health Resources and Services Administration published the highly regarded consensus document titled the Emergency Medical Service (EMS) Agenda for the Future, commonly referred to as the Agenda.[9] This was a federally funded position paper completed by the National Association of EMS Physicians in conjunction with the National Association of State EMS Directors. The intent of the Agenda was to create a common vision for the future of EMS. The Agenda addressed 14 attributes of EMS, including the EMS education system. Other components of the EMS national agenda included creating a single National EMS Accreditation Agency and a single National EMS Certification Agency to ensure consistency and quality of EMS personnel.[10] In December 1996, NHTSA convened an EMS Education Conference with representatives of more than 30 EMS-related organizations to identify the next logical Agenda implementation steps for the EMS community. At the conclusion of the conference, a general outline of the proposed next steps was published. One recommendation was that the NHTSA support and facilitate the development of the National EMS Education Standards.[11]

In 2009, the U.S. Department of Transportation released the new National Emergency Medical Services Education Standards (National EMS Education Standards), which replaces the National Highway Traffic Safety Administration, National Standard Curricula (or Emergency Medical Technician-Basic Standard Curriculum) at all licensure levels.[12]

The National EMS Education Standards define the minimal entry-level educational competencies, clinical behaviors, and judgments that must be met by Emergency Medical Service (EMS) personnel to meet national practice guidelines.[13] The National EMS Education Standards provide guidance to instructors, regulators, and publishers to provide interim support as EMS programs across the nation transition from the National Standard Curricula to the National EMS Education Standards.

The National EMS Education Standards assume there is a progression in practice from the entry-level Emergency Medical Responder level to the Paramedic level.[14] That is, licensed personnel at each level are responsible for all knowledge, judgments, and behaviors at their level and at all levels preceding their level.[15] According to the Standards, there are four licensure levels of EMS personnel: Emergency Medical Responder; Emergency Medical Technician; Advanced Emergency Medical Technician; and Paramedic.[16] For example, a Paramedic is responsible for knowing and doing everything identified in that specific area, as well as knowing and doing all tasks in the three preceding levels.

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[8] S. 381.0034(2), F.S.
[9] The EMS Agenda for the Future project was supported by the National Highway Traffic Safety Administration and the Health Resources and Services Administration, Maternal and Child Health Bureau. The project reviewed the lessons learned during the past 30 years in the field of emergency medical services (EMS) and provided direction to strengthen the EMS system, *available at*: http://www.nhtsa.gov/people/injury/ems/agenda/emsman.html#SUMMARY (last viewed February 8, 2013).
[10] National EMS Research Agenda, available at: www.ems.gov/education/EducationAgenda.pdf (last viewed February 10, 2013).
[11] *Id.*
[12] National Highway Traffic Safety Administration, Emergency Medical Services, Educational Standards and NSC: National Emergency Medical Services Education Standards, available at: http://www.ems.gov/EducationStandards.htm (last viewed February 8, 2013).
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Id.*

Effect of Proposed Changes

The bill removes the requirement that EMTs and paramedics complete HIV/AIDS continuing education instruction. EMTs and paramedics currently employ "universal precautions" in the field. Under the concept of "universal precautions," all patients are considered to be carriers of blood-borne pathogens, including HIV/AIDS. Therefore, additional continuing education regarding HIV/AIDS could be considered duplicative and unnecessary.[17]

The bill amends s.401.23, F.S., to update the definition of "advanced life support" providing that assessments are provided by a qualified person. Additionally, the bill adds to the definitions of "advanced life support" and "basic life support" the "EMT-Paramedic National Standard Curriculum or the National EMS Education Standards" and removes outdated competencies that are captured within the definitions to ensure that all techniques used by EMS personnel meet the national standards. The bill makes conforming changes throughout by removing "emergency medical technician basic training course" and replacing the phrase with "EMT-Basic National Standard Curriculum or the National EMS Education Standards," to align with the new education program.

The bill amends s. 401.27, F.S., to increase the timeframe that EMTs and paramedics can take the state examination following successful completion of an approved training program from 1 to 2 years.

The bill amends the timeline that the state emergency medical services plan is updated from biennially to every five years. The bill makes technical changes by restructuring the language to improve readability and deleting unnecessary words.

B. SECTION DIRECTORY:

Section 1. Amends s. 381.0034, F.S., relating to the requirements for instruction on HIV and AIDS.
Section 2. Amends s. 401.23, F.S., relating to definitions.
Section 3. Amends s. 401.24, F.S., relating to emergency medical services state plan.
Section 4. Amends s. 401.27, F.S., relating to personnel standards and certification.
Section 5. Amends s. 401.2701, F.S., relating to emergency medical services training programs.
Section 6. Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   An insignificant increase in state expenditures is possible due to the cost of rule promulgation. This increase may be absorbed within the agency's existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[17] DOH, Division of Emergency Operations, per telephone conversation with professional staff in February 2013.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Positive impact may occur due to the elimination of duplicative instruction related to HIV/AIDS certification and associated training.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The 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 shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The department has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

1 A bill to be entitled
2 An act relating to emergency medical services;
3 amending s. 381.0034, F.S.; deleting a requirement
4 that emergency medical technicians, paramedics, and
5 911 public safety telecommunicators complete an
6 educational course on HIV and AIDS; amending s.
7 401.23, F.S.; redefining the terms "basic life
8 support" and "advanced life support" for purposes of
9 the Raymond H. Alexander, M.D., Emergency Medical
10 Transportation Services Act; amending s. 401.24, F.S.;
11 revising the period for review of the comprehensive
12 state plan for emergency medical services and
13 programs; amending s. 401.27, F.S.; revising
14 requirements for the certification and recertification
15 of emergency medical technicians and paramedics;
16 revising requirements for the certification of
17 emergency medical technicians and paramedics trained
18 outside the state; revising the time limit by which
19 applicants trained outside the state must complete the
20 certification examination without having to submit a
21 new application and meet all eligibility and fee
22 requirements; amending s. 401.2701, F.S.; revising
23 requirements for institutions that conduct approved
24 programs for the education of emergency medical
25 technicians and paramedics; revising requirements that
26 students must meet in order to receive a certificate
27 of completion from an approved program; providing an
28 effective date.

29
30 Be It Enacted by the Legislature of the State of Florida:
31
32 Section 1. Subsection (1) of section 381.0034, Florida
33 Statutes, is amended to read:
34 381.0034 Requirement for instruction on HIV and AIDS.—
35 (1) The Department of Health shall require each person
36 licensed or certified under ~~chapter 401,~~ chapter 467, part IV of
37 chapter 468, or chapter 483, as a condition of biennial
38 relicensure, to complete an educational course approved by the
39 department on the modes of transmission, infection control
40 procedures, clinical management, and prevention of human
41 immunodeficiency virus and acquired immune deficiency syndrome.
42 Such course shall include information on current state ~~Florida~~
43 law on acquired immune deficiency syndrome and its impact on
44 testing, confidentiality of test results, and treatment of
45 patients. Each such licensee or certificateholder shall submit
46 confirmation of having completed the ~~said~~ course, on a form
47 provided by the department, when submitting fees or application
48 for each biennial renewal.
49 Section 2. Subsections (1) and (7) of section 401.23,
50 Florida Statutes, are amended to read:
51 401.23 Definitions.—As used in this part, the term:
52 (1) "Advanced life support" means assessment or treatment
53 by a person qualified under this part ~~of life-threatening~~
54 ~~medical emergencies~~ through the use of techniques such as
55 endotracheal intubation, the administration of drugs or
56 intravenous fluids, telemetry, cardiac monitoring, ~~and~~ cardiac

57 defibrillation and other techniques described in the EMT-
58 Paramedic National Standard Curriculum or the National EMS
59 Education Standards ~~by a qualified person~~, pursuant to rules of
60 the department.
61 (7) "Basic life support" means the assessment or treatment
62 by a person qualified under this part ~~of medical emergencies by~~
63 ~~a qualified person~~ through the use of techniques ~~such as patient~~
64 ~~assessment, cardiopulmonary resuscitation (CPR), splinting,~~
65 ~~obstetrical assistance, bandaging, administration of oxygen,~~
66 ~~application of medical antishock trousers, administration of a~~
67 ~~subcutaneous injection using a premeasured autoinjector of~~
68 ~~epinephrine to a person suffering an anaphylactic reaction, and~~
69 ~~other techniques~~ described in the EMT-Basic National Standard
70 ~~Emergency Medical Technician Basic Training Course~~ Curriculum or
71 the National EMS Education Standards of the United States
72 Department of Transportation and approved by the department. The
73 term ~~"basic life support" also~~ includes the administration of
74 oxygen and other techniques that ~~which~~ have been approved and
75 are performed under conditions specified by rules of the
76 department.
77 Section 3. Section 401.24, Florida Statutes, is amended to
78 read:
79 401.24 Emergency medical services state plan.—The
80 department is responsible, at a minimum, for the improvement and
81 regulation of basic and advanced life support programs. The
82 department shall develop, and ~~biennially~~ revise every 5 years, a
83 comprehensive state plan for basic and advanced life support
84 services, the emergency medical services grants program, trauma

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

85 centers, the injury control program, and medical disaster
86 preparedness. The state plan shall include, but need not be
87 limited to:
88 (1) Emergency medical systems planning, including the
89 prehospital and hospital phases of patient care, and injury
90 control effort and unification of such services into a total
91 delivery system to include air, water, and land services.
92 (2) Requirements for the operation, coordination, and
93 ongoing development of emergency medical services, which
94 includes: basic life support or advanced life support vehicles,
95 equipment, and supplies; communications; personnel; training;
96 public education; state trauma system; injury control; and other
97 medical care components.
98 (3) The definition of areas of responsibility for
99 regulating and planning the ongoing and developing delivery
100 service requirements.
101 Section 4. Subsections (4) and (12) of section 401.27,
102 Florida Statutes, are amended to read:
103 401.27 Personnel; standards and certification.—
104 (4) An applicant for certification or recertification as
105 an emergency medical technician or paramedic must:
106 (a) Have completed an appropriate training program ~~course~~
107 as follows:
108 1. For an emergency medical technician, an emergency
109 medical technician training program approved by the department
110 as ~~course~~ equivalent to the most recent EMT-Basic National
111 Standard Curriculum or the National EMS Education Standards
112 ~~emergency medical technician basic training course~~ of the United

113 States Department of Transportation ~~as approved by the~~
114 ~~department~~;
115 2. For a paramedic, a paramedic training program approved
116 by the department as equivalent to the most recent EMT-Paramedic
117 National Standard Curriculum or the National EMS Education
118 Standards ~~paramedic course~~ of the United States Department of
119 Transportation ~~as approved by the department~~;
120 (b) Certify under oath that he or she is not addicted to
121 alcohol or any controlled substance;
122 (c) Certify under oath that he or she is free from any
123 physical or mental defect or disease that might impair the
124 applicant's ability to perform his or her duties;
125 (d) Within 2 years ~~1 year~~ after program ~~course~~ completion
126 have passed an examination developed or required by the
127 department;
128 (e)1. For an emergency medical technician, hold ~~either~~ a
129 current American Heart Association cardiopulmonary resuscitation
130 course card or an American Red Cross cardiopulmonary
131 resuscitation course card or its equivalent as defined by
132 department rule;
133 2. For a paramedic, hold a certificate of successful
134 course completion in advanced cardiac life support from the
135 American Heart Association or its equivalent as defined by
136 department rule;
137 (f) Submit the certification fee and the nonrefundable
138 examination fee prescribed in s. 401.34, which examination fee
139 will be required for each examination administered to an
140 applicant; and

141 (g) Submit a completed application to the department,
142 which application documents compliance with paragraphs (a), (b),
143 (c), (e), (f), (g), and, if applicable, (d). The application
144 must be submitted so as to be received by the department at
145 least 30 calendar days before the next regularly scheduled
146 examination for which the applicant desires to be scheduled.
147 (12) An applicant for certification as ~~who is~~ an ~~out-of-~~
148 ~~state trained~~ emergency medical technician or paramedic who is
149 trained outside the state must provide proof of current
150 emergency medical technician or paramedic certification or
151 registration based upon successful completion of a training
152 program approved by the department as equivalent to the most
153 recent EMT-Basic or EMT-Paramedic National Standard Curriculum
154 or the National EMS Education Standards of the United States
155 Department of Transportation ~~emergency medical technician or~~
156 ~~paramedic training curriculum~~ and hold a current certificate of
157 successful course completion in cardiopulmonary resuscitation
158 (CPR) or advanced cardiac life support for emergency medical
159 technicians or paramedics, respectively, to be eligible for the
160 certification examination. The applicant must successfully
161 complete the certification examination within 2 years ~~1 year~~
162 after the date of the receipt of his or her application by the
163 department. After 2 years ~~1 year~~, the applicant must submit a
164 new application, meet all eligibility requirements, and submit
165 all fees to reestablish eligibility to take the certification
166 examination.
167 Section 5. Paragraph (a) of subsection (1) and subsection
168 (5) of section 401.2701, Florida Statutes, are amended to read:

169 401.2701 Emergency medical services training programs.—
170 (1) Any private or public institution in Florida desiring
171 to conduct an approved program for the education of emergency
172 medical technicians and paramedics shall:
173 (a) Submit a completed application on a form provided by
174 the department, which must include:
175 1. Evidence that the institution is in compliance with all
176 applicable requirements of the Department of Education.
177 2. Evidence of an affiliation agreement with a hospital
178 that has an emergency department staffed by at least one
179 physician and one registered nurse.
180 3. Evidence of an affiliation agreement with a current
181 ~~Florida-licensed~~ emergency medical services provider that is
182 licensed in this state. Such agreement shall include, at a
183 minimum, a commitment by the provider to conduct the field
184 experience portion of the education program.
185 4. Documentation verifying faculty, including:
186 a. A medical director who is a licensed physician meeting
187 the applicable requirements for emergency medical services
188 medical directors as outlined in this chapter and rules of the
189 department. The medical director shall have the duty and
190 responsibility of certifying that graduates have successfully
191 completed all phases of the education program and are proficient
192 in basic or advanced life support techniques, as applicable.
193 b. A program director responsible for the operation,
194 organization, periodic review, administration, development, and
195 approval of the program.
196 5. Documentation verifying that the curriculum:

197 a. Meets the ~~course guides and instructor's lesson plans~~
198 ~~in the~~ most recent Emergency Medical Technician-Basic National
199 Standard Curriculum or the National EMS Education Standards
200 approved by the department ~~Curricula~~ for emergency medical
201 technician programs and Emergency Medical Technician-Paramedic
202 National Standard Curriculum or the National EMS Education
203 Standards approved by the department ~~Curricula~~ for paramedic
204 programs.
205 b. Includes 2 hours of instruction on the trauma scorecard
206 methodologies for assessment of adult trauma patients and
207 pediatric trauma patients as specified by the department by
208 rule.
209 ~~c. Includes 4 hours of instruction on HIV/AIDS training~~
210 ~~consistent with the requirements of chapter 381.~~
211 6. Evidence of sufficient medical and educational
212 equipment to meet emergency medical services training program
213 needs.
214 (5) Each approved program must notify the department
215 within 30 days after ~~of~~ any change in the professional or
216 employment status of faculty. Each approved program must require
217 its students to pass a comprehensive final written and practical
218 examination evaluating the skills described in the current
219 United States Department of Transportation EMT-Basic or EMT-
220 Paramedic~~,~~ National Standard Curriculum or the National EMS
221 Education Standards and approved by the department. Each
222 approved program must issue a certificate of completion to
223 program graduates within 14 days after ~~of~~ completion.
224 Section 6. This act shall take effect July 1, 2013.

CS/HB 349

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 349 Treatment Programs for Impaired Professionals
SPONSOR(S): Health Quality Subcommittee; Renuart
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	13 Y, 0 N, As CS	Holt	O'Callaghan
2) Health & Human Services Committee		Holt	Calamas

SUMMARY ANALYSIS

Currently, health care practitioners who are impaired as a result of drug or alcohol abuse or because of mental or physical conditions which could affect their ability to practice with skill and safety, are eligible for services provided by the impaired practitioner treatment program (program). By entering and successfully completing the program, a practitioner may avoid formal disciplinary action. Currently, the Department of Health (DOH) contracts with the Professionals Resource Network (PRN) and the Impairment Project for Nurses (IPN) to provide program services to impaired health care practitioners.

The bill statutorily authorizes radiological personnel to utilize the services provided by a program under the jurisdiction of the Division of Medical Quality Assurance (MQA) within DOH. According to DOH, any person who holds a license issued by DOH is allowed to receive impairment services provided by a consultant under the current contract terms with PRN and IPN. According to DOH, authorizing radiological personnel to participate in the program will have no effect.

The bill expands the entities that a consultant may contract with to include programs for students enrolled in a school for licensure as a health care practitioner regulated under ch. 456, F.S., or a veterinarian under ch. 474, F.S. Section 456.076(2), F.S., provides that DOH is not responsible under any circumstances to pay for impairment services provided to students.

The bill specifies that an entity providing consultant services must employ either a medical director who is a physician or a nurse or nurse practitioner as the executive director. In addition, the bill specifies that the medical director or executive director does not have to possess a Florida license as a substance abuse provider or a mental health provider if the entity hires appropriately trained staff to provide the treatment or evaluation of an impaired individual.

The bill clarifies that impaired practitioner consultants shall serve as record custodians for any licensee they monitor, and any records they maintain shall not be shared with the impaired licensee or a designee unless a disciplinary proceeding is pending.

The bill amends statutory construction to improve readability and conforms cross-references.

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

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medical Quality Assurance

The Department of Health (DOH) is created under the authority of s. 20.43, F.S., which outlines the composition of the agency structure to include the Division of Medical Quality Assurance (MQA). MQA is statutorily responsible for the following boards and professions established within the division:

- The Board of Acupuncture, created under chapter 457.
- The Board of Medicine, created under chapter 458.
- The Board of Osteopathic Medicine, created under chapter 459.
- The Board of Chiropractic Medicine, created under chapter 460.
- The Board of Podiatric Medicine, created under chapter 461.
- Naturopathy, as provided under chapter 462.
- The Board of Optometry, created under chapter 463.
- The Board of Nursing, created under part I of chapter 464.
- Nursing assistants, as provided under part II of chapter 464.
- The Board of Pharmacy, created under chapter 465.
- The Board of Dentistry, created under chapter 466.
- Midwifery, as provided under chapter 467.
- The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.
- The Board of Nursing Home Administrators, created under part II of chapter 468.
- The Board of Occupational Therapy, created under part III of chapter 468.
- Respiratory therapy, as provided under part V of chapter 468.
- Dietetics and nutrition practice, as provided under part X of chapter 468.
- The Board of Athletic Training, created under part XIII of chapter 468.
- The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.
- Electrolysis, as provided under chapter 478.
- The Board of Massage Therapy, created under chapter 480.
- The Board of Clinical Laboratory Personnel, created under part III of chapter 483.
- Medical physicists, as provided under part IV of chapter 483.
- The Board of Opticianry, created under part I of chapter 484.
- The Board of Hearing Aid Specialists, created under part II of chapter 484.
- The Board of Physical Therapy Practice, created under chapter 486.
- The Board of Psychology, created under chapter 490.
- School psychologists, as provided under chapter 490.
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.
- Emergency medical technicians and paramedics, as provided under part III of chapter 401.

DOH regulates most health care professions.[1] Each profession is governed by an individual practice act and by ch. 456, F.S., which is considered the core licensure statute for all health care practitioners within MQA.

Section 456.001(4), F.S., defines "health care practitioner" to mean any person licensed under: ch. 457, F.S., (acupuncture); ch. 458, F.S., (medicine); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathic medicine); ch.

[1] The Department of Business and Professional Regulation regulates veterinarians pursuant to ch. 474, F.S.

463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy); ch. 466, F.S., (dentistry and dental hygiene); ch. 467, F.S., (midwifery); parts I, II, III, V, X, XIII, and XIV of ch. 468, F.S., (speech-language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, and orthotics, prosthetics, and pedorthics); ch. 478, F.S., (electrology or electrolysis); ch. 480, F.S., (massage therapy); parts III and IV of ch. 483, F.S., (clinical laboratory personnel or medical physics); ch. 484, F.S., (opticianry and hearing aid specialists); ch. 486, F.S., (physical therapy); ch. 490, F.S., (psychology); and ch. 491, F.S. (psychotherapy).

The definition of health care practitioner does not include emergency medical technicians (EMTs), paramedics[2] or radiology technologists.[3] However, s. 456.001, F.S., defines the term "profession" to mean any activity, occupation, profession, or vocation regulated by the DOH within MQA, and EMTs and paramedics are listed as a "profession" regulated by MQA under s. 20.43, F.S. Therefore, EMTs and paramedics are a profession governed by ch. 456, F.S. On the other hand, radiology technologists are not listed as a profession within MQA pursuant to s. 20.43, F.S., and are not governed by ch. 456, F.S.

Impaired Practitioner Treatment Program

The impaired practitioner treatment program (program) was created to help rehabilitate health care practitioners regulated by the MQA, within DOH.[4] Health care practitioners (practitioners), who are impaired as a result of drug or alcohol abuse or because of mental or physical conditions which could affect their ability to practice with skill and safety, are eligible for the program.[5] For professions that do not have programs established within their individual practice act, DOH is required by rule, to designate an approved program.

Section 456.076, F.S., authorizes DOH to contract with impaired practitioner consultants for services relating to intervention, evaluation, referral, and monitoring of impaired practitioners who have voluntarily agreed to treatment through a program.[6] The cost of the actual treatment is the responsibility of the impaired person. Currently, there are two vendors under contract with DOH to support the program: the Intervention Project for Nurses (IPN)[7] and the Professionals Resource Network (PRN).[8] The PRN provides services to all eligible professions except nurses. The PRN program is affiliated with the Florida Medical Association.

By entering and successfully completing the program, a practitioner may avoid formal disciplinary action, if the only violation of the licensing statute under which the practitioner is regulated is the impairment.[9] If the practitioner is unable to complete the program, DOH has authority to issue an emergency order suspending or restricting the license of the practitioner.[10]

Currently, DOH licenses over 40 health care professions[11] and has a contract with PRN to provide services to the following professions:[12]

[2] EMT and paramedics are governed by part III of ch. 401, F.S.
[3] Radiation technologists are governed by part IV of ch. 468, F.S.
[4] Section 456.076, (1), F.S.
[5] Section 456.076 (3)(a), F.S.
[6] Rules 64B31-10.10.001 and 64B31-10.002, F.A.C.
[7] Department of Health, Bill Analysis, Economic Statement and Fiscal Note on HB 349, dated January 22, 2013.
[8] *Id.*
[9] Section 456.076(3)(a), F.S.
[10] Section 456.074, F.S.
[11] Department of Health, Medical Quality Assurance, Annual Report, July 2010-June 2011, *available at*: http://www.doh.state.fl.us/Mqa/reports.htm (last visited March 10, 2013).
[12] Department of Health Contract with PRN, signed July 01, 2010, on file with Health & Human Services Quality Subcommittee staff.

Medical Doctors	Chiropractic Physicians
Physician Assistants	Clinical Social Workers
Osteopathic Physicians	Marriage and Family Therapists
Pharmacists	Mental Health Counselors
Podiatric Physicians	Optometrists
Psychologists	Nursing Home Administrators
Dentists	Medical Physicists
Opticians	Dieticians
Occupational Therapists	Nutritionists
Physical Therapists	Respiratory Therapists
Electrologists	Midwives
Acupuncturists	Speech Language Pathologists
Audiologists	Clinical Laboratory Personnel
Massage Therapists	Athletic Trainers
Orthotists	Orthotists
Prosthetists	Hearing Aid Specialists
Radiologic Technologists	Pharmacy Technicians
Anesthesia Assistants	

Section 456.076(2), F.S., specifically states that DOH is not responsible under any circumstances for paying the costs of care provided by approved treatment providers, and DOH is not responsible for paying the costs of consultants' services provided for students. Moreover, a school that is governed by accreditation standards requiring notice and the provision of due process procedures to students, is not liable in any civil action for referring a student to the consultant or for any disciplinary action that adversely affects the status of a student when the disciplinary actions are instituted in reasonable reliance on the recommendations, reports, or conclusions provide by a consultant.

The DOH contract with PRN states that the vendor agrees to include all legislatively added professions to the list of practitioners served and recognizes any contract entered into by the vendor with a school for enrolled students in a health practitioner profession is within the scope of the vendor's duties under the contract with DOH.[13]

Referrals to the program must be based upon at least one of the following criteria:[14]

- An identified informant has observed specific behavior of a licensee or has knowledge of other evidence suggesting impairment of the licensee.
- The informant identifies a witness who knows the licensee and has observed the licensee's behavior and that witness corroborates the information provided.
- Admission of impairment by the licensee, which corroborates the information provided.

Once in the program, the licensee is monitored by an impairment consultant. The consultant is required to monitor the practitioner's participation and ensure compliance.[15] Consultants do not provide medical treatment, nor do they have the authority to render decisions relating to licensure of a particular practitioner. However, the consultant is required to make recommendations to DOH regarding a practitioner patient's ability to practice.[16]

In Fiscal Year 2012-2013, there were approximately 1,088 practitioners enrolled in the PRN program.[17] In the month of January, IPN had 1,648 individuals licensed under ch. 464, F.S., the Practice of Nursing, enrolled in the program.[18]

[13] Department of Health Contract with PRN, signed July 01, 2010, on file with Health & Human Services Quality Subcommittee staff.
[14] 64B31-10.002, F.A.C.
[15] *Id.*
[16] Section 456.076(5)(a), F.S.
[17] Email correspondence with MQA staff dated March 1, 2013, on file with the Health Quality Subcommittee staff.
[18] *Id.*

Currently, DOH has a 3-year contract with PRN to provide consultant services for impaired practitioners for $5,415,615.00 for the contract term of July 1, 2010 to June 20, 2013. The current contract with IPN to provide consultant services to impaired nurses is for $4,670,097.00 for the contract term of July 1, 2012 to June 30, 2015. The funds to support these contracts come from the Medical Quality Assurance Trust Fund which is supported by the collection of regulatory fees.

Veterinary Medicine – Department of Business and Professional Regulation

Currently, the Board of Veterinary Medicine and the Board of Pilot Commissioners, within the Department of Business and Professional Regulation (DBPR), provide impaired practitioner treatment programs for licensees.

Section 474.221, F.S., provides that licensed veterinarians shall be governed by the treatment of impaired practitioner provisions as if they were under the jurisdiction of the MQA at DOH.

Currently, DBPR has a contract with PRN to provide consultant services for impaired veterinarians. In 2012, the DBPR contract with PRN was $48,132 annually. In Fiscal Year 2011-2012, an average of 25 licensees participated in the program.[19] The contract is in the process of being amended to reflect an annual payment of $42,121.20.[20]

Records

A DOH rule requires that consultants utilized for these programs serve as the official records custodians of the licensees they monitor.[21] An approved treatment provider must provide information regarding the impairment of a licensee and the licensee's participation in a program to a consultant on request. The information obtained by the consultant is confidential and exempt from public records requirements.[22] If a treatment provider fails to provide such information to the consultant, the treatment provider may no longer provide services under the program.[23] Recently, there was litigation in the Sixth Circuit, in which a medical doctor sued PRN for the production of the investigative file relating to the practitioner's participation in a treatment program.[24] The court held that because there was not a disciplinary proceeding by the board against the practitioner, the release of information was prohibited and the claim was dismissed with prejudice in October, 2010.[25]

Effect of Proposed Changes

The bill statutorily authorizes radiological personnel to utilize the services provided by a program under the jurisdiction of MQA. According to DOH, any person who holds a license issued by DOH is allowed to receive impairment services provided by a consultant under the current contract terms with PRN and IPN.[26] Authorizing radiological personnel regulated under part IV of ch. 468, F.S., to participate in the program will have no effect on MQA.[27]

The bill expands the entities that a consultant may contract with to include programs for students enrolled in a school for licensure as a health care practitioner regulated under ch. 456, F.S., or a veterinarian under ch. 474, F.S. Current law, states that DOH is not responsible under any circumstances for paying the costs of care provided by an approved treatment provider or a consultant for services provided to students.[28]

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[19] Email correspondence with DBPR staff dated February 18, 2013, on file with the Health Quality Subcommittee staff.
[20] *Id.*
[21] Rule 64B31-10.10.004, F.A.C.
[22] Section 456.076(5)(a), F.S.
[23] *Id.*
[24] *Doe, M.D., v. Rivenbark*, case no. 10-6495-CI-21 (Fla. 6th Cir. Ct.) (2010).
[25] *Id.*
[26] Per telephone conversation with DOH staff.
[27] Department of Health Bill Analysis for HB 349 dated January 22, 2013, on file with Health Quality Subcommittee staff.
[28] Section 456.076(2), F.S.

The bill specifies that an entity providing consultant services must employ either a medical director who is a physician or a nurse or nurse practitioner as the executive director. In addition, the bill specifies that the medical director or executive director does not have to possess a Florida license as a substance abuse provider or a mental health provider if the entity hires appropriately trained staff to provide the treatment or evaluation of an impaired individual.

The bill clarifies that impaired practitioner consultants shall serve as record custodians for any licensee they monitor, and any records they maintain shall not be shared with the impaired licensee or a designee unless a disciplinary proceeding is pending.

The bill amends statutory construction to improve readability and conforms cross-references.

B. SECTION DIRECTORY:

Section 1. Amends s. 456.076, F.S., relating to treatment programs for impaired practitioners.
Section 2. Amends s. 458.331, F.S., relating to grounds for disciplinary action and action by the board and department.
Section 3. Amends s. 459.015, F.S., relating to grounds for disciplinary action and action by the board and department.
Section 4. Creates s. 468.315, F.S., relating to treatment program for impaired radiological personnel.
Section 5. Provides an effective date of July 1, 2013.

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:

Approved treatment providers may experience an increase in demand for services with the additional eligibility groups who may receive services offered by a program. Based on impairment contracts for licensed practitioners, an impaired person may be required to enter into a contract with a program for up to 5-years.

While in an impairment program, a participant is required to pay for all treatment services such as initial evaluations, urinalysis testing and ongoing psychotherapy. Initial evaluations can range from $300-$500 and up to $1000 if chronic pain evaluation is required. The average cost is $42 per urinalysis, the number per month varies depending upon the recovery process. The cost of four group therapy meetings per month can range from $50-$150 per month. If the impairment is found to be physical, then

the cost may be nominal. All participants are required to have a primary care physician, but no visits are required. The PRN program offers a loan forgiveness option to eligible participants.

All treatment services are paid directly to the provider or third party administrator and not through the PRN program.

D. FISCAL COMMENTS:

The costs of the impaired practitioner program are twofold: the cost incurred by the impaired practitioner (person receiving treatment services); and the cost incurred by DOH to implement the program (monitoring and enforcement). The bill increases the number of persons eligible to seek treatment offered by the program. The bill also adds radiologic technologist as an eligible group; however, they are currently included in the current contract with PRN. For this reason, it is expected that there will be no fiscal impact to DOH. However, the contract with PRN expires June 30, 2013, and the contract may be renegotiated at a higher rate.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

There does not appear to be any statutory provision that prohibits an impaired practitioner consultant from directly contracting with a school to perform treatment services. It is unclear what the effect is of the bill expressly stating in statute that consultants may contract with a school to provide treatment services to enrolled students.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 12, 2013, the Health Quality Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment:

- Amends the catchline to s. 456.076, F.S., to capture health professionals and students.
- Deletes the requirement that DOH forward an applicant's information to the consultant when a legally sufficient complaint is received.
- Restructures Section 1 of the bill to improve readability and remove unnecessary words.

This analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.

1 A bill to be entitled
2 An act relating to treatment programs for impaired
3 licensees and applicants; amending s. 456.076, F.S.;
4 exempting an entity retained by the Department of
5 Health as an impaired practitioner consultant from
6 certain licensure requirements; authorizing impaired
7 practitioner consultants to contract with schools or
8 programs to provide services to impaired students who
9 are enrolled for the purpose of preparing for
10 licensure as a specified health care practitioner or
11 as a veterinarian; limiting the liability of those
12 schools or programs when they refer a student to an
13 impaired practitioner consultant; providing that the
14 impaired practitioner consultant is the official
15 custodian of records relating to the referral of the
16 licensee or applicant to the consultant and any other
17 interaction between them; clarifying the circumstances
18 under which an impaired practitioner consultant may
19 disclose certain information concerning an impaired
20 licensee or applicant; authorizing the Department of
21 Health and others that contract with an impaired
22 practitioner consultant to have administrative control
23 over the consultant to the extent necessary to receive
24 disclosures allowed under federal law; authorizing an
25 impaired licensee or applicant to obtain confidential
26 information from the department regarding a pending
27 disciplinary proceeding; amending ss. 458.331 and
28 459.015, F.S.; conforming cross-references; creating

29 s. 468.315, F.S.; providing that radiological
30 personnel are subject to a treatment program for
31 impaired licensees; providing an effective date.
32
33 Be It Enacted by the Legislature of the State of Florida:
34
35 Section 1. Subsection (2) and paragraph (e) of subsection
36 (3) of section 456.076, Florida Statutes, are amended, and
37 subsection (8) is added to that section, to read:
38 456.076 Treatment programs for impaired health
39 professionals and students ~~practitioners~~.—
40 (2)(a) The department shall retain one or more impaired
41 practitioner consultants who are each licensees~~. The consultant~~
42 ~~shall be a licensee~~ under the jurisdiction of the Division of
43 Medical Quality Assurance within the department and who must be:
44 1. A practitioner or recovered practitioner licensed under
45 chapter 458, chapter 459, or part I of chapter 464;~~,~~ or
46 2. An entity that employs: ~~employing~~
47 a. A medical director who must be a practitioner or
48 recovered practitioner licensed under chapter 458 or~~,~~ chapter
49 459;~~,~~ or
50 b. An executive director who must be a registered nurse or
51 a recovered registered nurse licensed under part I of chapter
52 464.
53 (b) An entity retained as an impaired practitioner
54 consultant under this section that employs a medical director or
55 an executive director is not required to be licensed as a
56 substance abuse provider or mental health treatment provider

57 under chapter 394, chapter 395, or chapter 397.
58 (c)1. The consultant shall assist the probable cause panel
59 and the department in carrying out the responsibilities of this
60 section. This includes ~~shall include~~ working with department
61 investigators to determine whether a practitioner is, in fact,
62 impaired.
63 2. The consultant may contract with a school or program to
64 provide ~~for~~ services to a student ~~be provided, for appropriate~~
65 ~~compensation, if requested by the school, for students~~ enrolled
66 for the purpose of preparing ~~in schools~~ for licensure as a
67 health care practitioner under this chapter or as a veterinarian
68 under chapter 474 if the student is allegedly ~~allopathic~~
69 ~~physicians or physician assistants under chapter 458,~~
70 ~~osteopathic physicians or physician assistants under chapter~~
71 ~~459, nurses under chapter 464, or pharmacists under chapter 465~~
72 ~~who are alleged to be~~ impaired as a result of the misuse or
73 abuse of alcohol or drugs, or both, or due to a mental or
74 physical condition. The department is not responsible ~~under any~~
75 ~~circumstances~~ for paying for the ~~costs of~~ care provided by an
76 approved treatment provider or a consultant ~~providers, and the~~
77 ~~department is not responsible for paying the costs of~~
78 ~~consultants' services provided for students~~.
79 (d) A medical school accredited by the Liaison Committee
80 on Medical Education or ~~of~~ the Commission on Osteopathic College
81 Accreditation, or another ~~other~~ school providing for the
82 education of students enrolled in preparation for licensure as a
83 health care practitioner under this chapter or a veterinarian
84 under chapter 474 ~~allopathic physicians under chapter 458 or~~

85 ~~osteopathic physicians under chapter 459,~~ which is governed by
86 accreditation standards requiring notice and the provision of
87 due process procedures to students, is not liable in any civil
88 action for referring a student to the consultant retained by the
89 department or for disciplinary actions that adversely affect the
90 status of a student when the disciplinary actions are instituted
91 in reasonable reliance on the recommendations, reports, or
92 conclusions provided by such consultant, if the school, in
93 referring the student or taking disciplinary action, adheres to
94 the due process procedures adopted by the applicable
95 accreditation entities and if the school committed no
96 intentional fraud in carrying out the provisions of this
97 section.
98 (3)
99 (e) The probable cause panel, or the department when there
100 is no board, shall work directly with the consultant, and all
101 information concerning a practitioner obtained from the
102 consultant by the panel, or the department when there is no
103 board, shall remain confidential and exempt from the provisions
104 of s. 119.07(1), subject to the provisions of subsections (5)<u>,</u>
105 ~~and~~ (6)<u>, and (8)</u>.
106 <u>(8) An impaired practitioner consultant is the official</u>
107 <u>custodian of records relating to the referral of an impaired</u>
108 <u>licensee or applicant to that consultant and any other</u>
109 <u>interaction between the licensee or applicant and the</u>
110 <u>consultant. The consultant may disclose to the impaired licensee</u>
111 <u>or applicant or his or her designee any information that is</u>
112 <u>disclosed to or obtained by the consultant or that is</u>

113 confidential under paragraph (5)(a), but only to the extent that
114 it is necessary to do so to carry out the consultant's duties
115 under this section. The department, and any other entity that
116 enters into a contract with the consultant to receive the
117 services of the consultant, has direct administrative control
118 over the consultant to the extent necessary to receive
119 disclosures from the consultant as allowed by federal law. If a
120 disciplinary proceeding is pending, an impaired licensee may
121 obtain such information from the department under s. 456.073.
122 Section 2. Paragraph (e) of subsection (1) of section
123 458.331, Florida Statutes, is amended to read:
124 458.331 Grounds for disciplinary action; action by the
125 board and department.—
126 (1) The following acts constitute grounds for denial of a
127 license or disciplinary action, as specified in s. 456.072(2):
128 (e) Failing to report to the department any person who the
129 licensee knows is in violation of this chapter or of the rules
130 of the department or the board. A treatment provider approved
131 pursuant to s. 456.076 shall provide the department or
132 consultant with information in accordance with the requirements
133 of s. 456.076(3), (4), (5), ~~and~~ (6), and (8).
134 Section 3. Paragraph (e) of subsection (1) of section
135 459.015, Florida Statutes, is amended to read:
136 459.015 Grounds for disciplinary action; action by the
137 board and department.—
138 (1) The following acts constitute grounds for denial of a
139 license or disciplinary action, as specified in s. 456.072(2):
140 (e) Failing to report to the department or the

141 department's impaired professional consultant any person who the
142 licensee or certificateholder knows is in violation of this
143 chapter or of the rules of the department or the board. A
144 treatment provider, approved pursuant to s. 456.076, shall
145 provide the department or consultant with information in
146 accordance with the requirements of s. 456.076(3), (4), (5), ~~and~~
147 (6), and (8).

148 Section 4. Section 468.315, Florida Statutes, is created
149 to read:

150 468.315 Treatment program for impaired radiological
151 personnel.—Radiological personnel who are subject to
152 certification under this part are governed by s. 456.076 as if
153 they were under the jurisdiction of the Division of Medical
154 Quality Assurance.

155 Section 5. This act shall take effect July 1, 2013.

HB 463

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 463 Examination of Dentists
SPONSOR(S): Rodríguez
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N	Holt	O'Callaghan
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Rodriguez	Pridgeon
3) Health & Human Services Committee		Holt	Calamas

SUMMARY ANALYSIS

In 2012, the Legislature changed the educational standards for graduates of dental schools not accredited by American Dental Association Commission on Dental Accreditation (e.g. foreign-trained dentists) and specified that the required 2-year supplemental educational program must be in general dentistry, not a specialty program. The new requirement became effective on March 3, 2012. At that time, the Board of Dentistry had approximately 25 applicants who had completed a 2-year specialty program and there were other individuals enrolled in a specialty program at the time the bill became effective. The new law did not include a grandfather clause for these applicants or students.

The bill amends s. 466.006(3)(b), F.S., to allow individuals enrolled in an accredited 2-year supplemental education specialty program in Dentistry on March 23, 2013, to sit for the national examination. The bill authorizes the exception until October 1, 2014. The bill also clarifies what types of programs fulfill the 2-year supplemental program requirements.

This bill has an insignificant positive fiscal impact on state revenues and no fiscal impact on local governments.

The bill provides an effect date of upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Accredited Dental Schools

The American Dental Association, Commission on Dental Accreditation (CODA), established in 1975, is nationally recognized by the United States Department of Education to accredit dental and dental-related education programs conducted at the post-secondary level. The CODA functions independently and autonomously in matters of developing and approving accreditation standards, making accreditation decisions on educational programs and developing and approving procedures that are used in the accreditation process.[1]

Dental education, dental assisting, dental hygiene, dental laboratory technology, and advanced dental education programs, including dental specialties, general practice residencies, and advanced education in general dentistry are evaluated in accordance with published accreditation standards by the CODA.[2]

Florida Dental Exam

Each applicant applying for a Florida dental license is required to successfully pass three examinations. The examinations consist of a Written Examination, a Practical or Clinical Examination, and a Diagnostic Skills Examination. All three examinations are required to be conducted in English. The practical or clinical examination and the diagnostic skills examination covering the full scope of the practice of dentistry are included in the American Dental Licensing Examination (ADLEX).[3] The ADLEX is administered by the State of Florida and graded by Florida licensed dentists. All parts of the ADLEX are required to be completed within 18 months from the initial start of any portion of the examination.[4]

An applicant seeking a Florida dental license is permitted to sit to take the ADLEX if the applicant is at least 18 years of age or older and:[5]

- Is a graduate of a CODA accredited dental school; or
- Is a dental student in the final year of a program at an accredited dental school and has completed all the coursework necessary to successfully pass the examinations;
  or
- Has successfully completed the National Board of Dental Examiners dental examination[6];
  or
- Has an active health access dental license in this state; and
- Has at least 5,000 hours within 4 consecutive years of clinical practice experience providing direct patient care in a health access setting as defined in s. 466.003; the applicant is a retired veteran dentist of any branch of the United States Armed Services who has practiced dentistry while on active duty and has at least 3,000 hours within 3 consecutive years of clinical practice experience providing direct patient care in a health access setting as defined in s. 466.003; or the applicant has provided a portion of his or her salaried time teaching health profession students in any public education setting, including, but not limited to, a community college,

[1] America Dental Association, Dental Education: Schools & Programs, available at: http://www.ada.org/103.aspx (last viewed February 10, 2013).
[2] *Id.*
[3] Rule 64B5-2.013, F.A.C.
[4] *Id.*
[5] S. 466.006(2), F.S.
[6] Prior to October 1, 2011, the National Board of Dental Examiners dental examination was required for Florida licensure. *See* Rule 64B5-2.013, F.A.C.

college, or university, and has at least 3,000 hours within 3 consecutive years of clinical practice experience providing direct patient care in a health access setting as defined in s. 466.003;
- Has not been disciplined by the board, except for citation offenses or minor violations;
- Has not filed a report pursuant to s. 456.049; and
- Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession.

In Florida prior to 2012, graduates of dental schools not accredited by CODA were required to complete a 2-year supplemental program at an accredited dental school and receive a dental diploma as evidence of program completion in order to sit for the ADLEX.[7] The Board of Dentistry (board), by rule, defined the supplemental dental education program as any American Dental Association (ADA) recognized dental specialty program.[8]

The 9 ADA recognized specialties are: dental public health, endodontics, periodontics, pediatric dentistry, orthodontics and dentofacial orthopedics, prosthodontics, oral and maxillofacial surgery, oral and maxillofacial pathology, and oral and maxillofacial radiology.[9] The board permitted applicants, who filed for a variance of and waiver to this rule[10], to sit for the ADLEX with the completion of 2 one-year accredited programs in an ADA specialty.[11]

In 2012, the Legislature passed SB 1040, specifying that the 2-year supplemental educational program must be in General Dentistry.[12] The bill became a law March 3, 2012. At that time, the board had approximately 25 applications of individuals who had completed a 2-year specialty program and there were other individuals enrolled in a specialty program at the time the bill became effective. The bill did not include a grandfather clause for these applicants or students.[13]

According to DOH, the board has discussed this issue and the members are in agreement that any applicants that were "in the pipeline" at the time of the effective date of the law should be permitted to sit for the ADLEX upon completion of their specialty program.[14]

Foreign Trained Dentists

Section 466.08, F.S., provides guidelines for certifying foreign dental schools. The foreign schools must prove that their educational program is reasonably comparable to that of similar accredited institutions in the United States and that the program adequately prepares its students for the practice of dentistry.[15]

In Florida, any dentist who did not attend a CODA accredited dental program (e.g., foreign trained dentists) is required to complete a 2-year supplemental education program at a CODA accredited dental school before they can sit for the Florida dental licensure examinations.[16] The 2-year supplemental program must provide didactic and clinical education at the level of a D.D.S. or D.M.D.

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[7] S. 466.006(3)(b), F.S. (2011)
[8] Rule 64B5-2.0146(2)(a), F.A.C.
[9] American Dental Association, Definitions of Recognized Dental Specialties. Available at: http://www.ada.org/495.aspx (last viewed February 10, 2013).
[10] Rule 64B5-2.0146(2)(a), F.A.C.
[11] Department of Health, Bill Analysis HB 463 relating to the Examination of Dentists, dated January 25, 2013, on file with the Health Quality Subcommittee staff.
[12] Section 1, Ch. 2012-14, L.O.F.
[13] *Id.*
[14] *Supra fn 14.*
[15] S. 466.008(4), F.S.
[16] S. 466.006(3), F.S. and ch. 64B5-2.0146, F.A.C.

Four states and the U.S. Virgin Islands do not grant an unrestricted dental license by credentials (grant reciprocity): Delaware, Florida, Hawaii, and Nevada.[17]

EFFECT OF PROPOSED CHANGES

The bill amends s. 466.006(3)(b), F.S., to provide a grandfather clause for individuals continually enrolled in a CODA accredited dental specialty program on March 23, 3012, if they:

- Complete a full-time, matriculated specialty training program accredited by CODA in an approved specialty area; and
- Present to the board official transcripts that verify completion of all didactic and clinical requirements, and an official certificate from the sponsoring institution indicating successful completion of the program.

The bill provides that the grandfather clause expires on October 1, 2014.

The bill provides further clarification that a supplemental general dentistry does not include a dental specialty program, but may include a 2-year advanced education in general dentistry or a 2-year general practice residency. But, the program must be specifically designed as a supplemental general dentistry program that provides didactic and clinical education at the level of a D.D.S. or D.M.D. program.

B. SECTION DIRECTORY:

Section 1. Amends s. 466.006, F.S., relating to examination of dentists.
Section 2. Provides an effective date of becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   This bill has an insignificant positive impact on state revenues that may be realized if additional prospective dentists, as identified in the bill, are allowed to take the Florida Dental Exam. If these applicants pass the examination, they will be eligible for a dental license. Dental license application, renewal and other fees are deposited into the state's Medical Quality Assurance Trust Fund. The total initial dental licensure fee is $485. $485 x 25 = $12,125.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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[17] American Dental Association, Department of State Government Affairs, April 6, 2011, available at: http://www.ada.org/sections/advocacy/pdfs/licensure_recognition.pdf (last viewed February 10, 2013).

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The board has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

1 A bill to be entitled
2 An act relating to examination of dentists; amending
3 s. 466.006, F.S.; revising the eligibility
4 requirements for taking examinations required to
5 practice dentistry; authorizing applicants enrolled in
6 a recognized dental specialty program on a specified
7 date to take the examinations if specified conditions
8 are met; providing for future expiration of such
9 authorization; providing an effective date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Subsection (3) of section 466.006, Florida
14 Statutes, is amended to read:
15 466.006 Examination of dentists.—
16 (3) If an applicant is a graduate of a dental college or
17 school not accredited in accordance with paragraph (2)(b) or of
18 a dental college or school not approved by the board, the
19 applicant is not entitled to take the examinations required in
20 this section to practice dentistry unless the applicant ~~until~~
21 ~~she or he~~ satisfies one of the following requirements:
22 (a) Completes a program of study, as defined by the board
23 by rule, at an accredited American dental school and
24 demonstrates receipt of a D.D.S. or D.M.D. from that ~~said~~
25 school; ~~or~~
26 (b) Submits proof of having successfully completed at
27 least 2 consecutive academic years in ~~at~~ a full-time
28 supplemental general dentistry program taught at an institution

29 accredited by the ~~American Dental Association~~ Commission on
30 Dental Accreditation. This program must provide didactic and
31 clinical education at the level of a D.D.S. or D.M.D. program
32 ~~accredited by the American Dental Association Commission on~~
33 ~~Dental Accreditation~~. For purposes of this paragraph, a
34 supplemental general dentistry program does not include dental
35 specialty programs. A supplemental general dentistry program may
36 include a 2-year advanced education in general dentistry program
37 or a 2-year general practice residency program if the program is
38 specifically designed as a supplemental general dentistry
39 program that provides didactic and clinical education at the
40 level of a D.D.S. or D.M.D. program; or
41 (c) Was enrolled on March 23, 2012, in a dental specialty
42 program recognized by the American Dental Association,
43 maintained continuous enrollment until successfully completing
44 the program, and meets the following requirements:
45 1. Completes a full-time, matriculated specialty training
46 program accredited by the Commission on Dental Accreditation in
47 a specialty area recognized by the American Dental Association.
48 2. Presents to the board official transcripts that verify
49 completion of all didactic and clinical requirements and an
50 official certificate from the sponsoring institution indicating
51 successful completion of the program.
52
53 This paragraph expires October 1, 2014.
54 Section 2. This act shall take effect upon becoming a law.

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Rodríguez, J. offered the following:
4
5 **Amendment**
6 Remove lines 41-53 and insert:
7 (c)1. Was enrolled on March 23, 2012, in a dental
8 specialty program recognized by the American Dental Association,
9 maintained continuous enrollment until successfully completing
10 the program, and meets the following requirements:
11 a. Completes a full-time matriculated specialty training
12 program accredited by the Commission on Dental Accreditation in
13 a specialty area recognized by the American Dental Association;
14 and
15 b. Presents to the board official transcripts that verify
16 completion of all didactic and clinical requirements and an
17 official certificate from the sponsoring institution indicating
18 successful completion of the program.

19 2. All eligible applicants for licensure under this
20 paragraph must be licensed on or before January 15, 2015.
21 3. This paragraph expires January 15, 2015.

CS/HB 529

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 529 Public Records
SPONSOR(S): Health Quality Subcommittee; Renuart
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 60

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	11 Y, 0 N, As CS	Guzzo	O'Callaghan
2) Government Operations Subcommittee	9 Y, 0 N	Stramski	Williamson
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

CS/HB 529 creates a public record exemption for information relating to the identification and location of current or former personnel of the Department of Health (DOH), whose duties include the:

- Investigation or prosecution of complaints filed against health care practitioners; or
- Inspection of practitioners or facilities licensed by DOH.

In addition to providing a public record exemption for DOH personnel, the bill provides that the following information relating to the families of such personnel is exempt from public record requirements:

- Names, home addresses, telephone numbers, and places of employment of the spouses and children of such personnel; and
- Names and locations of schools and day care facilities attended by the children of such personnel.

The bill provides for repeal of the exemption on October 2, 2018, unless reviewed and saved from repeal by the Legislature. In addition, the bill provides a statement of public necessity as required by the State Constitution.

The bill does not appear to have a fiscal impact.

The bill provides an effective date of upon becoming a law.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Public Records

Article I, s. 24(a) of the State Constitution sets forth the state's public policy regarding access to government records. This 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 Article I, s. 24(a) of the State 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), F.S., 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 than is necessary to meet one of the following purposes:

- 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.

Public Record Exemptions

Current law provides public record exemptions for identification and location information of certain current or former public employees and their spouses and children.[3] Examples of public employees covered by these exemptions include law enforcement personnel, firefighters, local government personnel who are responsible for revenue collection and enforcement or child support enforcement, justices and judges, and local and statewide prosecuting attorneys. Legislation was passed in 2012 to provide a public record exemption for personal and identifying information of current or former county tax collectors, and investigators or inspectors of the Department of Business and Professional Regulation.[4]

Although the types of exempt information vary, the following information is exempt from public record requirements for all of the above-listed public employees:

- Home addresses and telephone numbers of the public employees;
- Home addresses, telephone numbers, and places of employment of the spouses and children of public employees; and

[1] Section 24(c), Art. I of the State Constitution.
[2] *See* s. 119.15, F.S.
[3] *See* s. 119.071(4)(d), F.S.
[4] CS/CS/HB1089; Chapter 2012-214, L.O.F.

- Names and locations of schools and day care facilities attended by the children of the public employees.

If exempt information is held by an agency[5] that is not the employer of the public employee, the public employee must submit a written request to that agency to maintain the public record exemption.[6]

Currently, personal information of Department of Health investigative staff and their spouses and children is not exempt from public disclosure.[7]

Department of Health – Complaints and Investigations

The Department of Health (DOH) is responsible for the regulation of health care practitioners pursuant to chapter 456, F.S. Specific facilities and professions regulated by DOH require inspections prior to beginning practice and on a periodic basis. Specifically, these facilities and professionals include:[8]

- Pain Management Clinics;
- Pharmacies;
- Dental Laboratories;
- Massage Establishments;
- Electrolysis Establishments;
- Optical Establishments;
- Dispensing Practitioners; and
- Any place in which drugs and medical supplies are manufactured, packed, packaged, made, stored, sold, offered for sale, exposed for sale, or kept for sale.

Many individuals may be involved in some fashion throughout the investigation process. Section 456.073(1), F.S., requires DOH inspectors and investigators to investigate any complaint that is determined to be legally sufficient. After review of a complaint, if the allegations and supporting documentation show that a violation may have occurred, the complaint is considered legally sufficient for investigation. A complaint is legally sufficient if it contains ultimate facts that show a violation of chapter 456, F.S., any of the practice acts relating to the professions regulated by DOH, or of any rule adopted by DOH or a regulatory board has occurred.

The Investigative Services Unit (ISU) functions as the investigative arm of DOH as it investigates complaints against health care practitioners and facilities regulated by DOH. ISU includes staff of professional investigators and senior pharmacists who conduct interviews, collect documents and evidence, prepare investigative reports for the Prosecution Services Unit (PSU), and serve subpoenas and official orders of DOH. Upon completion of collecting information and conducting interviews, the investigator writes an investigative report and the report is forwarded to DOH's attorneys for legal review.[9]

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[5] Section 119.011(2), F.S., defines "agency" to mean any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency.

[6] Section 119.071(4)(d)3., F.S.

[7] *But See* s. 119.071(4)(d)2.a., F.S., re: Department of Health investigators of child abuse.

[8] Sections 456.069 and 465.017, F.S.

[9] Florida Department of Health, Division of Medical Quality Assurance, http://www.doh.state.fl.us/mqa/enforcement/enforce_csu.html (last visited March 8, 2013).

Attorneys within the PSU then review the investigative report to recommend a course of action, which may include:[10]

- Emergency orders against licensees who pose an immediate threat to the health, safety, and welfare of individuals;
- Expert reviews for complex cases that require professional health care experts to render an opinion;
- Closing orders if the investigation or the expert review does not support the allegations;[11] or
- Administrative complaints when the investigation supports the allegations.

When an administrative complaint is filed, the subject has the right to choose a hearing, consent/stipulation agreement, or voluntarily relinquish their license. In all of these instances, the case is then presented to the professional board or DOH for final agency action. If the subject appeals the final decision, the PSU attorney defends the final order before the appropriate appellate court.

According to DOH, investigators have recently had to be involved in more investigations that include criminal elements.[12] Investigators who inspect massage establishments are identifying and reporting to law enforcement possible human trafficking activities. Further, investigators have forged strong relationships with law enforcement in an effort to combat the health care concerns caused by illegal pill mills and controlled substance abuse in Florida. As DOH investigators are exposed to more and more potentially dangerous criminal situations, they have become concerned about the release of personal information that may be used by criminals, or individuals under investigation by DOH, to target investigative staff and their families.

Effect of Proposed Changes

The bill further expands the current public record exemption for identification and location information of public employees to include current and former DOH personnel whose duties include the investigation or prosecution of complaints filed against health care practitioners or the inspection of practitioners or facilities licensed by DOH. The bill provides that the following information is exempt[13] from public record requirements if such personnel make a reasonable effort to protect the information from being accessible through other means available to the public:

- Home addresses, telephone numbers, and photographs of current or former DOH personnel whose duties include investigating or prosecuting complaints against health care practitioners, or inspecting practitioners or facilities licensed by DOH;
- Names, home addresses, telephone numbers, and places of employment of the spouses and children of such personnel; and

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[10] *Id.*

[11] Cases closed with no finding of probable cause are generally confidential and are not available through a public records request.

[12] HB 529 Bill Analysis, Economic Statement and Fiscal Note, Department of Health, at page 3, February 1, 2013 (on file with the Health Quality subcommittee).

[13] 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 Riviera 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 designates 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 exemption. *See* Attorney General Opinion 85-62 (August 1, 1985).

- Names and locations of schools and day care facilities attended by the children of such personnel.

The bill provides for repeal of the exemption on October 2, 2018, unless reviewed and saved from repeal by the Legislature.

The bill provides a statement of public necessity as required by the State Constitution.[14]

B. SECTION DIRECTORY:

Section 1: Amends s. 119.071, F.S., relating to general exemptions from inspection or copying of public records.
Section 2: Provides a public necessity statement.
Section 3: Provides that the bill shall be effective upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See FISCAL COMMENTS.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   See FISCAL COMMENTS.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill could create a minimal fiscal impact on state or local agencies with staff responsible for complying with public record requests as staff could require training related to the expansion of the public record exemption. In addition, an agency 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 agency.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

[14] *See* s. 24(c), Art. I of the State Constitution.

2. Other:

Vote Requirement
Article I, s. 24(c) of the State Constitution, requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record or public meeting exemption. The bill expands current public record exemptions; thus, it requires a two-thirds vote for final passage.

Public Necessity Statement
Article I, s. 24(c) of the State Constitution, requires a public necessity statement for a newly created or expanded public record or public meeting exemption. The bill expands current public record exemptions; thus, it includes a public necessity statement.

Breadth of Exemption
Article I, s. 24(c) of the State Constitution, requires a newly created public record or public meeting exemption to be no broader than necessary to accomplish the stated purpose of the law. The bill creates a public record exemption for information relating to the identification and location of certain personnel of the Department of Health. The exemption does not appear to be in conflict with the constitutional requirement that the exemption must be no broader than necessary to accomplish its purpose.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

It is unclear what the term "reasonable efforts" on line 191 of the bill means and what actions personnel would have to take to protect identifying information.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 19, 2013, the Health Quality Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment narrows the scope of the public record exemption and clarifies whose identifying information is exempt from disclosure.

This analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.

1 A bill to be entitled
2 An act relating to public records; amending s.
3 119.071, F.S.; providing an exemption from public
4 records requirements for certain identifying
5 information of specific current and former personnel
6 of the Department of Health and the spouses and
7 children of such personnel, under specified
8 circumstances; providing for future legislative review
9 and repeal of the exemption under the Open Government
10 Sunset Review Act; providing a statement of public
11 necessity; providing an effective date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. Paragraph (d) of subsection (4) of section
16 119.071, Florida Statutes, is amended to read:
17 119.071 General exemptions from inspection or copying of
18 public records.—
19 (4) AGENCY PERSONNEL INFORMATION.—
20 (d)1. For purposes of this paragraph, the term "telephone
21 numbers" includes home telephone numbers, personal cellular
22 telephone numbers, personal pager telephone numbers, and
23 telephone numbers associated with personal communications
24 devices.
25 2.a. The home addresses, telephone numbers, social
26 security numbers, dates of birth, and photographs of active or
27 former sworn or civilian law enforcement personnel, including
28 correctional and correctional probation officers, personnel of

29 the Department of Children and Families ~~Family Services~~ whose
30 duties include the investigation of abuse, neglect,
31 exploitation, fraud, theft, or other criminal activities,
32 personnel of the Department of Health whose duties are to
33 support the investigation of child abuse or neglect, and
34 personnel of the Department of Revenue or local governments
35 whose responsibilities include revenue collection and
36 enforcement or child support enforcement; the home addresses,
37 telephone numbers, social security numbers, photographs, dates
38 of birth, and places of employment of the spouses and children
39 of such personnel; and the names and locations of schools and
40 day care facilities attended by the children of such personnel
41 are exempt from s. 119.07(1).
42 b. The home addresses, telephone numbers, dates of birth,
43 and photographs of firefighters certified in compliance with s.
44 633.35; the home addresses, telephone numbers, photographs,
45 dates of birth, and places of employment of the spouses and
46 children of such firefighters; and the names and locations of
47 schools and day care facilities attended by the children of such
48 firefighters are exempt from s. 119.07(1).
49 c. The home addresses, dates of birth, and telephone
50 numbers of current or former justices of the Supreme Court,
51 district court of appeal judges, circuit court judges, and
52 county court judges; the home addresses, telephone numbers,
53 dates of birth, and places of employment of the spouses and
54 children of current or former justices and judges; and the names
55 and locations of schools and day care facilities attended by the
56 children of current or former justices and judges are exempt

57 from s. 119.07(1).
58 d. The home addresses, telephone numbers, social security
59 numbers, dates of birth, and photographs of current or former
60 state attorneys, assistant state attorneys, statewide
61 prosecutors, or assistant statewide prosecutors; the home
62 addresses, telephone numbers, social security numbers,
63 photographs, dates of birth, and places of employment of the
64 spouses and children of current or former state attorneys,
65 assistant state attorneys, statewide prosecutors, or assistant
66 statewide prosecutors; and the names and locations of schools
67 and day care facilities attended by the children of current or
68 former state attorneys, assistant state attorneys, statewide
69 prosecutors, or assistant statewide prosecutors are exempt from
70 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
71 e. The home addresses, dates of birth, and telephone
72 numbers of general magistrates, special magistrates, judges of
73 compensation claims, administrative law judges of the Division
74 of Administrative Hearings, and child support enforcement
75 hearing officers; the home addresses, telephone numbers, dates
76 of birth, and places of employment of the spouses and children
77 of general magistrates, special magistrates, judges of
78 compensation claims, administrative law judges of the Division
79 of Administrative Hearings, and child support enforcement
80 hearing officers; and the names and locations of schools and day
81 care facilities attended by the children of general magistrates,
82 special magistrates, judges of compensation claims,
83 administrative law judges of the Division of Administrative
84 Hearings, and child support enforcement hearing officers are

85 exempt from s. 119.07(1) and s. 24(a), Art. I of the State
86 Constitution if the general magistrate, special magistrate,
87 judge of compensation claims, administrative law judge of the
88 Division of Administrative Hearings, or child support hearing
89 officer provides a written statement that the general
90 magistrate, special magistrate, judge of compensation claims,
91 administrative law judge of the Division of Administrative
92 Hearings, or child support hearing officer has made reasonable
93 efforts to protect such information from being accessible
94 through other means available to the public.
95 f. The home addresses, telephone numbers, dates of birth,
96 and photographs of current or former human resource, labor
97 relations, or employee relations directors, assistant directors,
98 managers, or assistant managers of any local government agency
99 or water management district whose duties include hiring and
100 firing employees, labor contract negotiation, administration, or
101 other personnel-related duties; the names, home addresses,
102 telephone numbers, dates of birth, and places of employment of
103 the spouses and children of such personnel; and the names and
104 locations of schools and day care facilities attended by the
105 children of such personnel are exempt from s. 119.07(1) and s.
106 24(a), Art. I of the State Constitution.
107 g. The home addresses, telephone numbers, dates of birth,
108 and photographs of current or former code enforcement officers;
109 the names, home addresses, telephone numbers, dates of birth,
110 and places of employment of the spouses and children of such
111 personnel; and the names and locations of schools and day care
112 facilities attended by the children of such personnel are exempt

113 from s. 119.07(1) and s. 24(a), Art. I of the State
114 Constitution.
115 h. The home addresses, telephone numbers, places of
116 employment, dates of birth, and photographs of current or former
117 guardians ad litem, as defined in s. 39.820; the names, home
118 addresses, telephone numbers, dates of birth, and places of
119 employment of the spouses and children of such persons; and the
120 names and locations of schools and day care facilities attended
121 by the children of such persons are exempt from s. 119.07(1) and
122 s. 24(a), Art. I of the State Constitution, if the guardian ad
123 litem provides a written statement that the guardian ad litem
124 has made reasonable efforts to protect such information from
125 being accessible through other means available to the public.
126 i. The home addresses, telephone numbers, dates of birth,
127 and photographs of current or former juvenile probation
128 officers, juvenile probation supervisors, detention
129 superintendents, assistant detention superintendents, juvenile
130 justice detention officers I and II, juvenile justice detention
131 officer supervisors, juvenile justice residential officers,
132 juvenile justice residential officer supervisors I and II,
133 juvenile justice counselors, juvenile justice counselor
134 supervisors, human services counselor administrators, senior
135 human services counselor administrators, rehabilitation
136 therapists, and social services counselors of the Department of
137 Juvenile Justice; the names, home addresses, telephone numbers,
138 dates of birth, and places of employment of spouses and children
139 of such personnel; and the names and locations of schools and
140 day care facilities attended by the children of such personnel

141 are exempt from s. 119.07(1) and s. 24(a), Art. I of the State
142 Constitution.
143 j. The home addresses, telephone numbers, dates of birth,
144 and photographs of current or former public defenders, assistant
145 public defenders, criminal conflict and civil regional counsel,
146 and assistant criminal conflict and civil regional counsel; the
147 home addresses, telephone numbers, dates of birth, and places of
148 employment of the spouses and children of such defenders or
149 counsel; and the names and locations of schools and day care
150 facilities attended by the children of such defenders or counsel
151 are exempt from s. 119.07(1) and s. 24(a), Art. I of the State
152 Constitution.
153 k. The home addresses, telephone numbers, and photographs
154 of current or former investigators or inspectors of the
155 Department of Business and Professional Regulation; the names,
156 home addresses, telephone numbers, and places of employment of
157 the spouses and children of such current or former investigators
158 and inspectors; and the names and locations of schools and day
159 care facilities attended by the children of such current or
160 former investigators and inspectors are exempt from s. 119.07(1)
161 and s. 24(a), Art. I of the State Constitution if the
162 investigator or inspector has made reasonable efforts to protect
163 such information from being accessible through other means
164 available to the public. This sub-subparagraph is subject to the
165 Open Government Sunset Review Act in accordance with s. 119.15
166 and shall stand repealed on October 2, 2017, unless reviewed and
167 saved from repeal through reenactment by the Legislature.
168 l. The home addresses and telephone numbers of county tax

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

169 collectors; the names, home addresses, telephone numbers, and
170 places of employment of the spouses and children of such tax
171 collectors; and the names and locations of schools and day care
172 facilities attended by the children of such tax collectors are
173 exempt from s. 119.07(1) and s. 24(a), Art. I of the State
174 Constitution if the county tax collector has made reasonable
175 efforts to protect such information from being accessible
176 through other means available to the public. This sub-
177 subparagraph is subject to the Open Government Sunset Review Act
178 in accordance with s. 119.15 and shall stand repealed on October
179 2, 2017, unless reviewed and saved from repeal through
180 reenactment by the Legislature.
181 m. The home addresses, telephone numbers, and photographs
182 of current or former personnel of the Department of Health whose
183 duties include the investigation or prosecution of complaints
184 filed against health care practitioners or the inspection of
185 practitioners or facilities licensed by the Department of
186 Health; the names, home addresses, telephone numbers, and places
187 of employment of the spouses and children of such personnel; and
188 the names and locations of schools and day care facilities
189 attended by the children of such personnel are exempt from s.
190 119.07(1) and s. 24(a), Art. I of the State Constitution if the
191 personnel have made reasonable efforts to protect such
192 information from being accessible through other means available
193 to the public.
194 3. An agency that is the custodian of the information
195 specified in subparagraph 2. and that is not the employer of the
196 officer, employee, justice, judge, or other person specified in

197 subparagraph 2. shall maintain the exempt status of that
198 information only if the officer, employee, justice, judge, other
199 person, or employing agency of the designated employee submits a
200 written request for maintenance of the exemption to the
201 custodial agency.
202 4. The exemptions in this paragraph apply to information
203 held by an agency before, on, or after the effective date of the
204 exemption.
205 5.a. Sub-subparagraphs 2.a.-l. are ~~This paragraph is~~
206 subject to the Open Government Sunset Review Act in accordance
207 with s. 119.15, and shall stand repealed on October 2, 2017,
208 unless reviewed and saved from repeal through reenactment by the
209 Legislature.
210 b. Sub-subparagraph 2.m. is subject to the Open Government
211 Sunset Review Act in accordance with s. 119.15, and shall stand
212 repealed on October 2, 2018, unless reviewed and saved from
213 repeal through reenactment by the Legislature.
214 Section 2. The Legislature finds that it is a public
215 necessity that the home addresses, telephone numbers, and
216 photographs of current or former personnel of the Department of
217 Health whose duties include the investigation or prosecution of
218 complaints filed against health care practitioners or the
219 inspection of practitioners or facilities licensed by the
220 Department of Health; that the names, home addresses, telephone
221 numbers, and places of employment of the spouses and children of
222 such personnel; and that the names and locations of schools and
223 day care facilities attended by the children of such personnel
224 be made exempt from public record requirements. The Legislature

225 finds that the release of such identifying and location
226 information might place current or former personnel of the
227 Department of Health whose duties include the investigation or
228 prosecution of complaints filed against health care
229 practitioners or the inspection of practitioners or facilities
230 licensed by the Department of Health and their family members in
231 danger of physical and emotional harm from disgruntled
232 individuals who have contentious reactions to actions carried
233 out by personnel of the Department of Health, or whose business
234 or professional practices have come under the scrutiny of
235 investigators and inspectors of the Department of Health. The
236 Legislature further finds that the harm that may result from the
237 release of such personal identifying and location information
238 outweighs any public benefit that may be derived from the
239 disclosure of the information.
240 Section 3. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 625 Physician Assistants
SPONSOR(S): Health Quality Subcommittee; Renuart and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 398

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	13 Y, 0 N, As CS	Holt	O'Callaghan
2) Health & Human Services Committee		Holt	Calamas

SUMMARY ANALYSIS

The bill deletes current law that is written in the negative tense to "not prohibit" a supervisory physician from delegating to a physician assistant (PA) the authority to order medications for a hospitalized patient. The bill rewords the same provision in the affirmative, to authorize a supervisory physician to delegate to a PA the authority to order medications for a supervisory physician's patient during the patient's care in a hospital, ambulatory surgical center, or mobile surgical facility. Additionally, the bill states that an order is not considered a prescription in this context. Lastly, the bill expressly states that a PA may order any medication under the direction of the supervisory physician while working in such a facility.

The bill makes the aforementioned changes to both the Medical Practice Act and the Osteopathic Practice Act.

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

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Physician Assistants

A physician assistant (PA) is a person licensed to perform medical services in the specialty areas in which he or she has been trained enabling them to perform health care tasks delegated by a supervising physician.[1] Currently, there are a total of 5,348 in-state, active licensed PAs in Florida.[2]

PA regulations are located in the respective physician practice acts for medical doctors (MDs) and doctors of osteopathic medicine (DOs), because PAs may only practice under the supervision of a MD or DO.[3] Specifically, sections 458.347(7) and 459.022(7), F.S., govern the licensure of PAs. PAs are regulated by the Florida Council on Physician Assistants (Council) in conjunction with the Board of Medicine for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine for PAs licensed under ch. 459, F.S.

Physician Assistant Council

The Council was created in 1995 to recommend the licensure requirements (including educational and training requirements) for PAs, establish a formulary of drugs that PAs are prohibited to prescribe, and develop rules for the use of PAs by physicians to ensure that the continuity of supervision is maintained in each practice setting throughout the state.[4] The Council does not discipline PAs. Disciplinary action is the responsibility of either the Board of Medicine or the Board of Osteopathic Medicine (boards).

Supervising Physician

A PA practices under the delegated authority of a supervising physician. A physician supervising a PA must be qualified in the medical area(s) in which the PA is to perform health care tasks and is responsible and liable for the performance and acts and omissions of the PA.[5] A physician is not allowed to supervise more than four PAs at any one time.[6]

Supervision is defined to mean the responsible supervision and control that requires the easy availability or physical presence of the physician for consultation and direction of actions performed by a PA.[7] Easy availability is defined to include the ability to use telecommunication. The respective board is delegated the authority to establish by rule what constitutes responsible supervision.

Responsible supervision, defined by rule, is the ability of the supervising physician to responsibly exercise control and provide direction over the services or tasks performed by the PA.[8] In providing supervision, the supervising physician is required to periodically review the PA's performance.

In determining whether supervision is adequate, the following factors are to be considered:[9]

[1] Section 458.347(1), F.S.
[2] Department of Health, 2011-2012 Medical Quality Assurance Annual Report.
[3] Chapters 458 and 459, F.S.
[4] Sections 458.347(9) and 459.02 2(9), F.S.
[5] Section 458.347(3), F.S. and Rule 64B8-30.012, F.A.C.
[6] *Id.*
[7] Section 458.347 (1)(f), F.S.
[8] Rule 64B8-30.001, F.A.C.
[9] *Id.*

- The complexity of the task;
- The risk to the patient;
- The background, training and skill of the PA;
- The adequacy of the direction in terms of its form;
- The setting in which the tasks are performed;
- The availability of the supervising physician;
- The necessity for immediate attention; and
- The number of other persons that the supervising physician must supervise.

The respective board is authorized to adopt by rule the general principles that supervising physicians must use in developing the scope of practice of a PA under "direct" and "indirect" supervision. The principles are to take into consideration the diversity of the specialty and the practice setting.

Direct supervision refers to the physical presence of the supervising physician on the premises so that the supervising physician is immediately available to the PA when needed; whereas, indirect supervision refers to the easy availability of the supervising physician, such that the supervising physician must be within reasonable physical proximity.[10]

The decision to permit the PA to perform a task or procedure under direct or indirect supervision is made by the supervising physician based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.[11] Additionally, it is the responsibility of the supervising physician to be certain that the PA is knowledgeable and skilled in performing the tasks and procedures assigned.

Delegated Tasks

Determination of the final diagnosis must be performed by the supervising physician, and may not be delegated to a PA.[12]

Per rule, the following tasks are not permitted to be performed under indirect supervision:[13]

- Routine insertion of chest tubes and removal of pacer wires or left atrial monitoring lines.
- Performance of cardiac stress testing.
- Routine insertion of central venous catheters.
- Injection of intrathecal medication without prior approval of the supervising physician.
- Interpretation of laboratory tests, X-ray studies and EKG's without the supervising physician interpretation and final review.
- Administration of general, spinal, and epidural anesthetics; this may be performed under direct supervision only by PA who graduated from a board-approved anesthesiology assistants program.

Moreover, a supervisory physician may delegate to a PA the authority:

- To prescribe or dispense any medicinal drug used in the supervisory physician's practice.[14]
- To order medicinal drugs for a hospitalized patient of the supervising physician.
- To administer a medicinal drug under the direction and supervision of the physician.[15]

However, the formulary prohibits a PA from prescribing controlled substances (Schedule I-V), general anesthetics, and radiographic contrast material.[16]

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[10] Rules 64B8-30.012 and 64B15-6.010, F.A.C.
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] Sections 458.347(4)(e) and 459.022(4)(e), F.S.
[15] Rules 64B8-30.008 and 64B15-6.0038.
[16] Sections 458.347(4)(f) and 459.022(4)(f), F.S.

Interpreting the Scope of Practice of a PA

Through the years there have been a few Attorney General Advisory Opinions and declaratory statements written to clarify whether a PA is authorized to perform certain health care tasks. For example, in 2008, there was an inquiry as to whether a PA could refer a patient for involuntary evaluation pursuant to the Baker Act.[17] The advisory opinion concluded that a PA may refer a patient for involuntary evaluation, provided that the PA has experience regarding the diagnosis and treatment of mental and nervous disorders and such tasks are within the supervising physician's scope of practice. More recently in 2010, the Attorney General's Office opined whether a PA may order controlled substances in a hospital setting. The opinion concluded that the boards and the council have consistently held that a supervisory physician may delegate to a PA the authority to order controlled substances for patients in hospital settings.[18] However, there appears to be confusion with the interpretation of the terms "prescribing" and "ordering," and have been misinterpreted to be synonymous. Neither term is defined within the Medical Practice Act or the Osteopathic Medical Practice Act.

An "order" is a term of art generally used in a hospital or institutional setting where an authorized practitioner orders a medication for an inpatient rather than prescribes a medication.[19]

Under the Florida Pharmacy Act, a "prescription" includes any order for drugs or medicinal supplies written or transmitted by any means of communication by a duly licensed practitioner authorized by the laws of the state to prescribe such drugs or medicinal supplies and intended to be dispensed by a pharmacist.[20] The Florida Comprehensive Drug Abuse and Prevention and Control Act, ch. 893, F.S., provides a similar definition for the term "prescription."[21]

Effect of Proposed Changes

The bill deletes current law that is written in the negative tense to "not prohibit" a supervisory physician from delegating to a physician assistant (PA) the authority to order medications for a hospitalized patient. The bill rewords the same provision in the affirmative, to authorize a supervisory physician to delegate to a PA the authority to order medications for a supervisory physician's patient during the patient's care in a hospital, ambulatory surgical center, or mobile surgical facility. Additionally, the bill states that an order is not considered a prescription in this context. Lastly, the bill expressly states that a PA may order any medication under the direction of the supervisory physician while working in such a facility.

The bill makes the aforementioned changes to both the Medical Practice Act and the Osteopathic Practice Act.

B. SECTION DIRECTORY:

Section 1. Amends s. 458.347, F.S., relating to physician assistants.
Section 2. Amends s. 459.022, F.S., relating to physician assistants.
Section 3. Provides an effective date of July 1, 2013.

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[17] Florida Attorney General advisory Legal Opinion (AGO 2008-31) dated May 30, 2008, on file with the Health Quality Subcommittee staff.
[18] Florida Attorney General Office correspondence to Patricia Draper, Esq., dated August 25, 2010, on file with the Health Quality Subcommittee staff.
[19] See for example: 42 C.F.R. 482.23(c) relating to Conditions of Participation for Hospitals under Medicare, Standard: Preparation and administration of drugs and Rule 64B16-28.602, F.A.C., relating to the rules of the Board of Pharmacy for Institutional Class II Dispensing.
[20] Section 465.003(14), F.S.
[21] Section 893.02(22), F.S.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The DOH has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 12, 2013, the Health Quality Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment:

- Deletes a provision authorizing a PA to execute all practice-related activities delegated by a supervisory physician, unless expressly prohibited.
- Clarifies a PA may be delegated the authority to order medications for a supervisory physician's patient during his or her care in a hospital, ambulatory surgical center, or mobile surgical facility.
- Provides that an order is not a prescription.
- Provides that a PA may order any medication under the direction of a supervisory physician.

This analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.

1 A bill to be entitled
2 An act relating to physician assistants; amending ss.
3 458.347 and 459.022, F.S.; authorizing a supervisory
4 physician to delegate to a licensed physician
5 assistant the authority to order medications for the
6 supervisory physician's patient during the patient's
7 care in a facility licensed under ch. 395, F.S.;
8 providing that an order is not a prescription;
9 authorizing a licensed physician assistant to order
10 medication under the direction of the supervisory
11 physician; providing an effective date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. Paragraph (e) of subsection (4) of section
16 458.347, Florida Statutes, is amended, and paragraph (g) is
17 added to that subsection, to read:
18 458.347 Physician assistants.—
19 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—
20 (e) A supervisory physician may delegate to a fully
21 licensed physician assistant the authority to prescribe or
22 dispense any medication used in the supervisory physician's
23 practice unless such medication is listed on the formulary
24 created pursuant to paragraph (f). A fully licensed physician
25 assistant may only prescribe or dispense such medication under
26 the following circumstances:
27 1. A physician assistant must clearly identify to the
28 patient that he or she is a physician assistant. Furthermore,

29 the physician assistant must inform the patient that the patient
30 has the right to see the physician prior to any prescription
31 being prescribed or dispensed by the physician assistant.
32 2. The supervisory physician must notify the department of
33 his or her intent to delegate, on a department-approved form,
34 before delegating such authority and notify the department of
35 any change in prescriptive privileges of the physician
36 assistant. Authority to dispense may be delegated only by a
37 supervising physician who is registered as a dispensing
38 practitioner in compliance with s. 465.0276.
39 3. The physician assistant must file with the department a
40 signed affidavit that he or she has completed a minimum of 10
41 continuing medical education hours in the specialty practice in
42 which the physician assistant has prescriptive privileges with
43 each licensure renewal application.
44 4. The department may issue a prescriber number to the
45 physician assistant granting authority for the prescribing of
46 medicinal drugs authorized within this paragraph upon completion
47 of the foregoing requirements. The physician assistant shall not
48 be required to independently register pursuant to s. 465.0276.
49 5. The prescription must be written in a form that
50 complies with chapter 499 and must contain, in addition to the
51 supervisory physician's name, address, and telephone number, the
52 physician assistant's prescriber number. Unless it is a drug or
53 drug sample dispensed by the physician assistant, the
54 prescription must be filled in a pharmacy permitted under
55 chapter 465 and must be dispensed in that pharmacy by a
56 pharmacist licensed under chapter 465. The appearance of the

57 prescriber number creates a presumption that the physician
58 assistant is authorized to prescribe the medicinal drug and the
59 prescription is valid.
60 6. The physician assistant must note the prescription or
61 dispensing of medication in the appropriate medical record.
62 ~~7. This paragraph does not prohibit a supervisory~~
63 ~~physician from delegating to a physician assistant the authority~~
64 ~~to order medication for a hospitalized patient of the~~
65 ~~supervisory physician.~~
66
67 ~~This paragraph does not apply to facilities licensed pursuant to~~
68 ~~chapter 395.~~
69 (g) A supervisory physician may delegate to a licensed
70 physician assistant the authority to order medications for the
71 supervisory physician's patient during the patient's care in a
72 facility licensed under chapter 395, notwithstanding any
73 provision in chapter 465 or chapter 893 that may prohibit such
74 delegation. For the purpose of this paragraph, an order is not
75 considered a prescription. A licensed physician assistant
76 working in a facility that is licensed under chapter 395 may
77 order any medication under the direction of the supervisory
78 physician.
79 Section 2. Paragraph (e) of subsection (4) of section
80 459.022, Florida Statutes, is amended, and paragraph (f) is
81 added to that subsection, to read:
82 459.022 Physician assistants.—
83 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—
84 (e) A supervisory physician may delegate to a fully

85 licensed physician assistant the authority to prescribe or
86 dispense any medication used in the supervisory physician's
87 practice unless such medication is listed on the formulary
88 created pursuant to s. 458.347. A fully licensed physician
89 assistant may only prescribe or dispense such medication under
90 the following circumstances:
91 1. A physician assistant must clearly identify to the
92 patient that she or he is a physician assistant. Furthermore,
93 the physician assistant must inform the patient that the patient
94 has the right to see the physician prior to any prescription
95 being prescribed or dispensed by the physician assistant.
96 2. The supervisory physician must notify the department of
97 her or his intent to delegate, on a department-approved form,
98 before delegating such authority and notify the department of
99 any change in prescriptive privileges of the physician
100 assistant. Authority to dispense may be delegated only by a
101 supervisory physician who is registered as a dispensing
102 practitioner in compliance with s. 465.0276.
103 3. The physician assistant must file with the department a
104 signed affidavit that she or he has completed a minimum of 10
105 continuing medical education hours in the specialty practice in
106 which the physician assistant has prescriptive privileges with
107 each licensure renewal application.
108 4. The department may issue a prescriber number to the
109 physician assistant granting authority for the prescribing of
110 medicinal drugs authorized within this paragraph upon completion
111 of the foregoing requirements. The physician assistant shall not
112 be required to independently register pursuant to s. 465.0276.

113 5. The prescription must be written in a form that
114 complies with chapter 499 and must contain, in addition to the
115 supervisory physician's name, address, and telephone number, the
116 physician assistant's prescriber number. Unless it is a drug or
117 drug sample dispensed by the physician assistant, the
118 prescription must be filled in a pharmacy permitted under
119 chapter 465, and must be dispensed in that pharmacy by a
120 pharmacist licensed under chapter 465. The appearance of the
121 prescriber number creates a presumption that the physician
122 assistant is authorized to prescribe the medicinal drug and the
123 prescription is valid.
124 6. The physician assistant must note the prescription or
125 dispensing of medication in the appropriate medical record.
126 ~~7. This paragraph does not prohibit a supervisory~~
127 ~~physician from delegating to a physician assistant the authority~~
128 ~~to order medication for a hospitalized patient of the~~
129 ~~supervisory physician.~~
130
131 ~~This paragraph does not apply to facilities licensed pursuant to~~
132 ~~chapter 395.~~
133 (f) A supervisory physician may delegate to a licensed
134 physician assistant the authority to order medications for the
135 supervisory physician's patient during the patient's care in a
136 facility licensed under chapter 395, notwithstanding any
137 provision in chapter 465 or chapter 893 that may prohibit such
138 delegation. For the purpose of this paragraph, an order is not
139 considered a prescription. A licensed physician assistant
140 working in a facility that is licensed under chapter 395 may

141 order any medication under the direction of the supervisory
142 physician.
143 Section 3. This act shall take effect July 1, 2013.

HB 671

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 671 Pharmacy Technicians
SPONSOR(S): Hutson
TIED BILLS: **IDEN./SIM. BILLS:** SB 818

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	13 Y, 0 N	O'Callaghan	O'Callaghan
2) Health & Human Services Committee		O'Callaghan	Calamas

SUMMARY ANALYSIS

Currently, Florida's laws prohibit a licensed pharmacist from supervising more than one registered pharmacy technician. HB 671 increases the number of registered pharmacy technicians a licensed pharmacist may supervise to six. Additional registered pharmacy technicians may be supervised if permitted by guidelines adopted by the Department of Health's (DOH) Board of Pharmacy (Board).

To conform to the aforementioned changes, the bill deletes a provision that directs the Board to establish guidelines to determine when a licensed pharmacist may supervise more than one, but not more than three, registered pharmacy technicians.

The bill has an indeterminate, insignificant fiscal impact on the DOH.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Pharmacist and Pharmacy Technician Workforce Demand

Pharmacy technicians assist, and work under the supervision of, licensed pharmacists. Their duties may include dispensing, measuring, or compounding medications; taking information needed to fill a prescription; packaging and labeling prescriptions; accepting payment for prescriptions; answering phones; or referring patients with questions to the pharmacist. Ultimately, the pharmacist reviews all prescriptions. Some reports suggest that the utilization of educated and certified pharmacy technicians allows pharmacists to focus more on direct patient care.[1]

Factors that contribute to a high demand for pharmacists and pharmacy technicians include:

- Increased use of prescription medications and the number of prescription medications available;
- Market growth and competition among retail pharmacies resulting in increased job openings and expanded store hours;
- The aging of the U.S. population; and
- An increase in time spent on non-patient care activities, such as office administration.[2]

Employment of pharmacy technicians in the U.S. has been projected by the U.S. Department of Labor, Bureau of Labor Statistics to increase by 32% between 2010 and 2020.[3]

To address pharmacist workforce shortages, the U.S. House of Representatives introduced the Pharmacy Technician Training and Registration Act or "Emily's Act," suggesting to State Boards of Pharmacy that they strive to ensure 1:2 pharmacist-to-pharmacist technician ratios in hospital settings and 1:3 ratios in other settings, including drug stores.[4]

As of 2009, Florida was among 18 states allowing a maximum 1:3 pharmacist-to-pharmacist technician ratio.[5] Seventeen states and the District of Columbia had no ratio limits; 8 states allowed a maximum 1:2 pharmacist-to-pharmacist technician ratio; 7 states allowed a 1:4 ratio; and 1 state allowed a 1:1 ratio. More recently, Indiana and Idaho have allowed a 1:6 ratio.[6] Some states require that higher

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[1] *See* "ASHP Long-Range Vision for the Pharmacy Work Force in Hospitals and Health Systems: Ensuring the Best Use of Medicines in Hospitals and Health Systems," *American Journal of Health-System Pharmacy,* 64(12):1320-1330, June 15, 2007, available at: www.ashp.org/DocLibrary/BestPractices/HRRptWorkForceVision.aspx (visited March 7, 2013); "White Paper on Pharmacy Technicians 2002: Needed changes can no longer wait," *American Journal of Health-System Pharmacy*, 60(1): 37-51, January 1, 2003, available at: www.acpe-accredit.org/pdf/whitePaper.pdf (last visited March 7, 2013); and "The Adequacy of Pharmacist Supply: 2004 to 2030," Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, December 2008, available at: bhpr.hrsa.gov/healthworkforce/reports/pharmsupply20042030.pdf (last visited March 7, 2013).

[2] "The Pharmacist Workforce, A Study of the Supply and Demand for Pharmacists," Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, December 2000, available at: bhpr.hrsa.gov/healthworkforce/reports/pharmaciststudy.pdf (last visited March 7, 2013).

[3] Occupational Outlook Handbook: Pharmacy Technicians, Bureau of Labor Statistics, U.S. Department of Labor, available at: http://www.bls.gov/ooh/healthcare/pharmacy-technicians.htm (last visited March 7, 2013).

[4] U.S. House of Representatives, H.R. 5491, February 26, 2008. Library of Congress Summary available at: http://www.govtrack.us/congress/bills/110/hr5491#summary/libraryofcongress (last visited March 7, 2013).

[5] National Association of Chain Drug Stores, *Standardized Pharmacy Technician Education and Training,* May 2009.

[6] Indiana changed their ratio July 2, 2012. *See* Indiana Code, 25-26-13-18. *See also*, Idaho Board of Pharmacy Rule 251, Pharmacy Technicians.

ratios are contingent on certification or licensure of technicians, or other quality assurance measures.[7]

According to the December 2012 Aggregate Demand Index compiled by the Pharmacy Manpower Project, Inc., Florida has a ranking of 2.86, meaning Florida does not have a shortage of pharmacists. Specifically, this ranking falls between "demand is less than the pharmacist supply available" and "demand is in balance with supply."[8]

Pharmacy Technicians in Florida

In 2008, the Florida Legislature passed CS/CS 1360, which amended s. 465.014, F.S., to require pharmacy technician applicants to complete a pharmacy technician training program to become a registered pharmacy technician. The bill also provided for the direct supervision of a registered pharmacy technician by a licensed pharmacist.[9]

Section 465.014, F.S., authorizes a licensed pharmacist to delegate to registered pharmacy technicians those duties, tasks, and functions that do not fall within the definition of the practice of the profession of pharmacy. Registered pharmacy technicians' responsibilities include: [10]

- Retrieval of prescription files;
- Data entry;
- Label preparation;
- Counting, weighing, measuring, pouring, and mixing prescription medication;
- Initiation of communication with a prescribing practitioner or medical staff regarding requests for prescription refill authorization, clarification of missing information on prescriptions, and confirmation of information such as names, medication, and strength; and
- Acceptance of authorization for prescription renewals.

The Board specifies by rule[11] certain acts that pharmacy technicians are prohibited from performing. Those acts include:

- Receiving new verbal prescriptions or any change in the medication, strength, or directions;
- Interpreting a prescription or medication order for therapeutic acceptability and appropriateness;
- Conducting a final verification of dosage and directions;
- Engaging in prospective drug review;
- Providing patient counseling;
- Monitoring prescription drug usage; and
- Overriding clinical alerts without first notifying the pharmacist.

All registered pharmacy technicians must identify themselves as registered pharmacy technicians by wearing an identification badge with a designation as a "registered pharmacy technician" and verbally identifying themselves as a registered pharmacy technician over the telephone.[12]

The licensed pharmacist is responsible for acts performed by persons under his or her supervision.[13] Licensed pharmacists may not supervise more than one registered pharmacy technician unless authorized by the Board under guidelines it has established to determine circumstances when a licensed pharmacist may supervise more than one, but not more than three, registered pharmacy

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[7] *See* National Association of Boards of Pharmacy: *Kansas News: Pharmacy Technician Ratio (2006), Minnesota Board of Pharmacy (2000), Idaho State Board of Pharmacy News (2009)*, available at: http://www.nabp.net/ (last visited March 7, 2013).
[8] Aggregate Demand Index, Supported by Pharmacy Manpower Project Inc., available at: http://www.pharmacymanpower.com/about.jsp (last visited March 7, 2013).
[9] 2008-216, L.O.F.
[10] Rule, 64B16-27.420, F.A.C.
[11] *Id.*
[12] *Id.*
[13] Rule 64B16-27.1001(7), F.A.C.

technicians.[14] A prescription department manager or consultant pharmacist of record who seeks to have more than one registered pharmacy technician must submit a written request to the Board for approval and demonstrate workflow needs to justify the increased ratio.[15]

At the end of Fiscal Year 2011-2012, there were 37,379 registered pharmacy technicians and 29,311 licensed pharmacists in Florida.[16] As of February 2013, 4,358 Florida licensed pharmacies had a ratio of three pharmacy technicians to one pharmacist, and 588 pharmacies had a ratio of two pharmacy technicians to one pharmacist.[17]

Effect of Proposed Changes

Currently, Florida's laws prohibit a licensed pharmacist from supervising more than one registered pharmacy technician. HB 671 increases the number of registered pharmacy technicians a licensed pharmacist may supervise to authorize the supervision of up to six registered pharmacy technicians. Additional registered pharmacy technicians may be supervised if permitted by guidelines adopted by the Board.

The bill makes a conforming change by deleting a provision that directs the Board to establish guidelines to determine when a licensed pharmacist may supervise more than one, but not more than three, registered pharmacy technicians.

B. SECTION DIRECTORY:

Section 1: Amends s. 465.014, F.S., relating to pharmacy technicians.
Section 2: Provides an effective date of July 1, 2013.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill does not appear to have any impact on state revenues.

2. Expenditures:

   The bill will have an indeterminate, insignificant impact on the DOH, associated with the cost of rulemaking.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   The bill does not appear to have any impact on local government revenues.

2. Expenditures:

   The bill does not appear to have any impact on local government expenditures.

[14] Section 465.014, F.S.
[15] Rule 64B16-27.410, F.A.C.
[16] Department of Health, Bill Analysis of HB 671, February 17, 2013, on file with committee staff.
[17] *Id.*

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is necessary to implement this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to pharmacy technicians; amending s. 465.014, F.S.; revising the number of pharmacy technicians that a pharmacist may supervise; providing an effective date.

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

Section 1. Subsection (1) of section 465.014, Florida Statutes, is amended to read:

465.014 Pharmacy technician.—

(1) A person other than a licensed pharmacist or pharmacy intern may not engage in the practice of the profession of pharmacy, except that a licensed pharmacist may delegate to pharmacy technicians who are registered pursuant to this section those duties, tasks, and functions that do not fall within the purview of s. 465.003(13). All such delegated acts shall be performed under the direct supervision of a licensed pharmacist who shall be responsible for all such acts performed by persons under his or her supervision. A pharmacy registered technician, under the supervision of a pharmacist, may initiate or receive communications with a practitioner or his or her agent, on behalf of a patient, regarding refill authorization requests. A licensed pharmacist may not supervise more than six ~~one~~ registered pharmacy technicians ~~technician~~ unless otherwise permitted by the guidelines adopted by the board. ~~The board shall establish guidelines to be followed by licensees or permittees in determining the circumstances under which a~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

29 ~~licensed pharmacist may supervise more than one but not more~~
30 ~~than three pharmacy technicians.~~
31 Section 2. This act shall take effect July 1, 2013.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED ___ (Y/N)

ADOPTED AS AMENDED ___ (Y/N)

ADOPTED W/O OBJECTION ___ (Y/N)

FAILED TO ADOPT ___ (Y/N)

WITHDRAWN ___ (Y/N)

OTHER ___

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1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Hutson offered the following:
4
5 **Amendment (with title amendment)**
6 Between lines 8 and 9, insert:
7 Section 1. Subsection (2) of section 456.42, Florida
8 Statutes, is amended to read:
9 456.42 Written prescriptions for medicinal drugs.—
10 (2) A written prescription for a controlled substance
11 listed in chapter 893 must have the quantity of the drug
12 prescribed in both textual and numerical formats, must be dated
13 <u>using a legible numeric month/day/year format</u> or ~~with~~ the
14 abbreviated month written out on the face of the prescription,
15 and must be either written on a standardized counterfeit-proof
16 prescription pad produced by a vendor approved by the department
17 or electronically prescribed as that term is used in s.
18 408.0611. As a condition of being an approved vendor, a
19 prescription pad vendor must submit a monthly report to the
20 department which, at a minimum, documents the number of

21 prescription pads sold and identifies the purchasers. The
22 department may, by rule, require the reporting of additional
23 information.
24
25
26
27
28 ---
29 **T I T L E A M E N D M E N T**
30 Remove line 2 and insert:
31 An act relating to the practice of pharmacy; amending s. 456.42,
32 F.S.; requires the written date on a prescription to be legible
33 and in a certain format; amending s.
34