Health Innovation Subcommittee

Wednesday, January 23, 2018
1:30 PM – 2:30 PM
Mashburn Hall (306 HOB)

Richard Corcoran
Speaker

MaryLynn Magar
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time:	Tuesday, January 23, 2018 01:30 pm
End Date and Time:	Tuesday, January 23, 2018 02:30 pm
Location:	Mashburn Hall (306 HOB)
Duration:	1.00 hrs

Consideration of the following bill(s):

HB 303 Alternative Treatment Options for Veterans Pilot Program by Burgess, White
HB 497 Hospice Care by Stone
HB 937 Perinatal Mental Health by Nuñez

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Monday, January 22, 2018.

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., Monday, January 22, 2018

NOTICE FINALIZED on 01/19/2018 4:07PM by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 303 Alternative Treatment Options for Veterans Pilot Program
SPONSOR(S): Burgess, Jr. and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Beattie	Drosier
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) are known as "signature wounds" for service members returning from the conflicts in Iraq and Afghanistan. According to the federal Department of Veterans Affairs (VA), between 11 percent and 20 percent of the individuals who served in these conflicts are diagnosed with PTSD each year.

Complementary and Alternative Medicine (CAM) is a class of therapy that includes treatments not considered standard in the current practice of Western medicine, such as acupuncture, yoga, meditation, and relaxation.

The efficacy of using CAM to treat TBI and PTSD is limited. However, the VA does recognize that many veterans are turning to CAM treatments as an adjunct to other traditional treatments. For example, CAM techniques such as relaxation and mindfulness are used in supporting cognitive behavioral therapies. Additionally, the use of CAM therapies, specifically for the management and treatment of mental health problems such as PTSD, is becoming more common and is increasing in usage.

HB 303 requires the Florida Department of Veterans Affairs (DVA) to contract with one or more individuals, non-profit corporations , state universities, or Florida College System institutions for a period of two years to provide alternative treatment options for veterans who have been certified by the VA, or any branch of the U.S. Armed Forces, as having a TBI or PTSD.

The contracted entity or entities may select the alternative treatments to be offered to veterans with TBI or PTSD, however, they are limited to those which have at least one scientific or medical peer-reviewed study that shows the treatment has a positive effect on TBI or PTSD. Additionally, the bill requires alternative treatment to be provided under the direction or supervision of a licensed physician, osteopathic physician, chiropractic physician, nurse, psychologist, or a clinical social worker, marriage and family therapist or mental health counselor. Each contracted entity must submit an annual report to DVA on each alternative treatment provided to a veteran, the number of veterans served, and the treatment outcomes.

This bill would have an indeterminate, negative fiscal impact on state government. The bill would not have a fiscal impact on local governments.

The bill provides an expiration date of June 30, 2020, and an effective date of July 1, 2018.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Department of Veterans' Affairs

Florida has the nation's third largest veteran population with more than 1.5 million veterans, comprising 12 percent of the state's population aged 18 and older.[1]

In 1988, Florida citizens approved a constitutional amendment to create the Florida Department of Veterans Affairs (DVA) as a separate agency charged with providing advocacy and representation for Florida's veterans and to intercede on their behalf with the VA.[2] The DVA is the state agency that has statutory authority and responsibility for the provision of assistance to all former, present, and future members of the armed forces. Section 292.05(7), F.S., gives the DVA the authority and responsibility to apply for and administer any federal programs and develop and coordinate such state programs as may be beneficial to the interests of the veterans of this state. The DVA helps veterans gain access to federal benefits, including federally funded medical care, to improve their quality of life.[3]

Traumatic Brain Injury and Post-Traumatic Stress Disorder

Traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) are known as "signature wounds" for service members returning from the conflicts in Iraq and Afghanistan. The nature of these conflicts, particularly the use of improvised explosive devices, increases the likelihood that active duty service members will be exposed to incidents, such as blasts, that can result in TBI or PTSD.[4]

The Department of Defense (DoD) and the Defense and Veteran's Brain Injury Center estimate that 22 percent of all combat casualties from these conflicts are brain injuries.[5] The total number of veterans who have experienced TBI is not known, in part because TBI is difficult to identify, and in part because some veterans have not accessed United States Department of Veterans Affairs (VA) health care services.[6] According to the VA, between 11 and 20 percent of the individuals who served in these conflicts have PTSD in a given year.[7]

A TBI is caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.[8] TBIs vary in terms of severity. Mild TBI may cause headaches, fatigue, lethargy, dizziness, and lightheadedness.[9] More serious TBI can result in the same signs and symptoms as mild TBI, as well as repeated nausea or vomiting, a persistent or worsening headache, seizures, numbness or weakness in the hands and feet, and loss of coordination.[10] The majority of TBIs sustained by

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[1] Florida Department of Veterans' Affairs, *Our Veterans: Fast Facts*, available at http://floridavets.org/our-veterans/profilefast-facts/ (last visited January 18, 2018).
[2] Florida Department of Veterans' Affairs, *About Us*, available at http://floridavets.org/about-us/ (last visited January 18, 2018).
[3] *Id.*
[4] United States Government Accountability Office, *Defense Health Care, Research on Hyperbaric Oxygen Therapy to Treat Traumatic Brain Injury and Post-Traumatic Stress Disorder*, at 1, available at http://www.gao.gov/assets/680/674334.pdf (last visited January 18, 2018).
[5] United States Department of Veterans Affairs, *PTSD: National Center for PTSD, Traumatic Brain Injury and PTSD*, available at http://www.ptsd.va.gov/professional/co-occurring/traumatic-brain-injury-ptsd.asp (last visited January 18, 2018).
[6] Erin Bagalman, *Traumatic Brain Injury Among Veterans*, Congressional Research Service, Jan. 4, 2013, at 4 available at http://www.ncsl.org/documents/statefed/health/TBI_Vets2013.pdf (last visited January 18, 2018).
[7] United States Department of Veterans Affairs, *PTSD: National Center for PTSD,* available at http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp (last visited January 18, 2018).
[8] Centers for Disease Control and Prevention, *Basic Information about Traumatic Brain Injury and Concussion,* available at http://www.cdc.gov/traumaticbraininjury/basics.html (last visited January 18, 2018).
[9] *Supra* n. 6.
[10] *Id.*

service members are classified as mild TBI, also known as concussion.[11] Regardless of the severity of the TBI, it can have adverse effects on all aspects of social functioning, including employment, social relationships, independent living, functional status, and leisure activities.

The high rate of TBI and blast-related concussion events resulting from current combat operations directly impacts the health and safety of individual service members and, subsequently, the level of unit readiness and troop retention.[12] As a result, the effects of TBIs impact each branch of the military, and throughout both the DoD and the VA health care systems.[13]

Generally, PTSD can occur after an individual has experienced a trauma. According to the Mayo Clinic, PTSD is a mental health condition that is triggered by either experiencing or witnessing a terrifying event.[14] Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event.[15] PTSD may have a delayed onset, which is described as a clinically significant presentation of symptoms at least six months after exposure to trauma, and is one of the most prevalent mental disorders arising from combat.[16]

Patients with TBI often meet the criteria for PTSD, and vice versa.[17] Many service members returning from the conflicts in Iraq and Afghanistan have experienced a mild TBI, and also have PTSD related to their combat experience.[18] Studies have found that one-third or more of service members with mild TBI also have PTSD.[19]

As of August 2016, 27,015 veterans claiming Florida as their home state have been diagnosed with having either PTSD or TBI. Of that total, 2,779 veterans have been diagnosed as having TBI and 25,018 have been diagnosed as having PTSD. In 2015, 57,309 veterans were diagnosed with having either PTSD or TBI. Of that total, 2,839 veterans were diagnosed as having TBI and 56,064 veterans were diagnosed as having PTSD.[20]

VA Benefits and Treatment

An individual who served in the active military, naval, or air service, and who was not dishonorably discharged, may qualify for VA health care benefits.[21] VA health benefits include necessary inpatient hospital care and outpatient services to promote, preserve, or restore a veteran's health.[22] VA medical facilities provide a wide range of services, including mental health services.[23] The VA provides specialty inpatient and outpatient mental health services at its medical centers and community-based outpatient clinics; additionally, readjustment counseling services may be available at veteran centers across the nation.[24] For veterans with serious mental illness, the VA offers care tailored to help with their specific

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[11] Defense and Veterans Brain Injury Center, *DoD Worldwide Numbers for TBI,* available at http://dvbic.dcoe.mil/dod-worldwide-numbers-tbi (last visited January 18, 2018).
[12] Defense and Veterans Brain Injury Center, *TBI and the Military*, available at http://dvbic.dcoe.mil/about/tbi-military (last visited January 18, 2018).
[13] *Id.*
[14] Mayo Clinic, *Diseases and Conditions, Post-traumatic stress disorder (PTSD),* available at http://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/basics/definition/con-20022540 (last visited January 18, 2018).
[15] *Id.*
[16] *Supra* n. 4 at 5.
[17] United States Department of Veterans Affairs, *PTSD: National Center for PTSD, Traumatic Brain Injury and PTSD,* available at http://www.ptsd.va.gov/professional/co-occurring/traumatic-brain-injury-ptsd.asp (last visited January 18, 2018).
[18] *Id.*
[19] *Supra* n. 4 at 2.
[20] Data obtained from FDVA. (on file with Health Innovation Subcommittee staff).
[21] U.S. Department of Veterans Affairs, *Federal Benefits for Veterans, Dependents and Survivors*, available at http://www.va.gov/opa/publications/benefits_book/benefits_chap01.asp (last visited January 18, 2018).
[22] U.S. Department of Veterans Affairs, *Health Benefits*, available at http://www.va.gov/HEALTHBENEFITS/access/medical_benefits_package.asp (last visited January 18, 2018).
[23] *Id.*
[24] *Id.*

diagnosis and to promote recovery.[25] Serious mental illnesses include a variety of diagnoses that result in significant problems functioning in the community.[26]

Once a veteran is enrolled, a veteran will remain enrolled in the VA health care system unless they formally wish to disenroll.[27] An enrolled veteran may seek care at any VA facility without being required or requested to reestablish eligibility for VA health care enrollment purposes.[28] Veterans who are enrolled in the VA health care system do not pay premiums.[29] However, some do have to pay copayments for medical services and outpatient medications related to the treatment of nonservice-connected conditions.[30] Additionally, the VA classifies veterans into eight enrollment priority groups based on varying factors[31] and, depending on which priority group a veteran is in, the veteran can be charged copayments for inpatient and outpatient care, outpatient medication, and long-term care services.

The VA may pay the necessary expense of travel, including lodging and subsistence, or an allowance based on mileage for eligible veterans going to vocational rehabilitation, counseling, examinations, treatment or care at a VA facility.[32]

The VA and the DoD have worked together to develop joint clinical practice guidelines including guidelines for treatment for PTSD and TBI.[33] These guidelines provide scientific evidence-based practice evaluations and interventions.[34] The VA recommends considering and offering as appropriate, a primary care, symptom-driven approach in the evaluation and treatment of patients with TBI and persistent symptoms.[35] To treat the behavioral symptoms of TBI, the VA recommends assessing for commonly associated conditions such as depression, PTSD, and other mental health problems and treating those conditions according to the guidelines set out by those clinical practice groups.[36] To treat patients with PTSD, the VA recommends individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring.[37] These may include Prolonged Exposure, Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing, Brief Eclectic Psychotherapy, Narrative Exposure Therapy, written narrative exposure, and specific cognitive behavioral therapies for PTSD.[38]

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[25] *Supra* n. 21.
[26] *Id.*
[27] Sidath Viranga Panangala, *Health Care for Veterans: Answers to Frequently Asked Questions,* Congressional Research Service, Apr. 21, 2016, at 4, available at https://fas.org/sgp/crs/misc/R42747.pdf (last visited January 18, 2018).
[28] *Id.*
[29] *Id.* at *Summary*.
[30] *Id.*
[31] *Id.* at 26. Factors include, but are not limited to, service-connected disabilities or exposures, prisoner of war status, receipt of a Purple Heart of Medal of Honor, and income.
[32] 38 C.F.R. § 111 (2008).
[33] Katherine Blakeley and Don J. Jansen, *Post-Traumatic Stress Disorder and Other Mental Health Problems in the Military: Oversight Issues for Congress*, Congressional Research Service, Aug. 8, 2013, at 12 available at: https://www.fas.org/sgp/crs/natsec/R43175.pdf (last visited January 18, 2018).
[34] *Id.*
[35] U.S. Department of Veterans Affairs, *VA/DoD Clinical Practice Guideline for the Management of Concussion-Mild Traumatic Brain Injury*. at 28, available at: https://www.healthquality.va.gov/guidelines/Rehab/mtbi/mTBICPGFullCPG50821816.pdf (last visited January 18, 2018).
[36] *Id.* at 35.
[37] *Id.* at 36.
[38] U.S. Department of Veterans Affairs, *VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder*, at 34, available at: https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal082917.pdf (last visited January 18, 2018).

Choice Program (Non-VA Care)

The Veterans Access, Choice, and Accountability Act of 2014[39] (Choice Program) was signed by President Obama on August 7, 2014. Under the Choice Program, veterans may be authorized by the VA to seek care outside of the VA health system if they meet any of the following requirements:[40]

- **30 day wait list:** A veteran is informed by their local VA medical facility that an appointment may not be scheduled either:
  - Within 30 days of when the veteran's clinician determines he or she needs to be seen, or
  - Within 30 days of when the veteran wishes to see a provider.
- **40 miles or more distance:** A veteran lives 40 miles from a VA medical facility that has a full-time primary care physician.
- **40 miles or less distance:** A veteran does not reside in Guam, American Samoa, or the Republic of the Philippines, and:
  - Travels by air, boat, or ferry in order to receive care from their local VA facility; or
  - Incurs traveling burden based on environmental factors, geographic challenges, or a medical condition.
- **State or territory without a VA facility that provides impatient, emergency and complex surgical care:** A veteran resides more than 20 miles from a VA medical facility and is in either:
  - Alaska
  - Hawaii
  - New Hampshire
  - A U.S. territory, excluding Puerto Rico.

The Choice Program is administered by two private third-party contractors: Health Net Federal Services, LLC, and TriWest Healthcare Alliance Corporation.[41] Either contractor will provide information to eligible veterans and schedule their appointments.[42] All appointments must be within 30 calendar days. The contractor informs the VA when the appointment is scheduled.[43] Additionally, all authorizations of care issued by either contractor must be pre-authorized prior to being delivered to veterans.[44] Any service given to a veteran without prior authorization may not be covered by the VA.[45] Lastly, a veteran's out-of-pocket expenses are the same as those under the VA health care system.[46]

The Comprehensive Addiction and Recovery Act of 2016

The Comprehensive Addiction and Recovery Act of 2016 (CARA),[47] in part, established the "Creating Options for Veterans' Expedited Recovery" Commission (Commission) to examine the evidence-based therapy treatment model used by the VA for treating mental health conditions of veterans. CARA also directs the Commission to examine available research on the use of the following Complementary and Alternative Medicine (CAM) therapies for mental health issues and identify the benefits for veterans:[48]

- Music therapy;
- Equine therapy;
- Training and caring for service dogs;
- Yoga therapy;
- Acupuncture therapy;

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[39] Pub. L. No. 113-146, H.R. 3230, 113th Cong. (Aug. 7, 2014).
[40] *Supra* n. 27 at 20.
[41] *Id.* at 21.
[42] *Id.*
[43] *Id.*
[44] *Id.* at 22.
[45] *Id.*
[46] *Id.*
[47] Pub. L. No. 114-198, S. 524, 114th Cong. (July 22, 2016).
[48] *Id.*

- Meditation therapy;
- Outdoor sports therapy;
- Hyperbaric oxygen therapy;
- Accelerated resolution therapy; and
- Other therapies the Commission deems appropriate.

No later than 18 months after the first meeting, the Commission must submit a report on its findings and must include, among other things:[49]

- Recommendations;
- An analysis of the evidence-based therapy model used by the VA for treating veterans with mental issues; and
- An examination of the CAM treatments and the potential benefits of incorporating those treatments in the VA model for treating veterans with mental health issues.

Lastly, no later than 90 days after the submission of the report, the Secretary of the VA must submit an action plan for implementing any recommendations made by the Commission and a timeframe for implementing CAM treatments department-wide.[50]

Accelerated Resolution Therapy

Accelerated resolution therapy (ART) eliminates distressing memories of traumatic experiences and replaces the distressing memories and images with more pleasing ones.[51] ART accomplishes this through sets of rapid eye movements similar to eye movements that occur during dreaming.[52] The length of treatment with ART is based on the processing of one or more traumatic memories that contributes to symptoms of PTSD.[53] Depending on circumstances, it is possible to process up to three memories in a one-hour session.[54]

Acupuncture

Section 457.102(1), F.S., defines acupuncture as a form of primary health care, based on traditional Chinese medical concepts and modern oriental medical techniques, that employs acupuncture diagnosis and treatment, as well as adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease. The statute defines acupuncture to include, but not be limited to:

- The insertion of acupuncture needles and the application of moxibustion[55] to specific areas of the human body;
- The use of electroacupuncture;
- Qi Gong;[56]
- Oriental massage;
- Herbal therapy;

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[49] *Id.*
[50] *Id.*
[51] Kevin Kip, et al., Brief Treatment of Symptoms of Post-Traumatic Stress Disorder (PTSD) by Use of Accelerated Resolution Therapy (ART®), Behavioral Sci., Vol. 2, Issue 2, (2012), available at http://www.mdpi.com/2076-328X/2/2/115/htm (last visited January 19, 2018).
[52] Id.
[53] Id.
[54] Id.
[55] Moxibustion is a form of heat therapy in which dried plant materials called "moxa" are burned on or very near the surface of the skin. University of Minnesota, *Taking Charge of Your Health and Wellbeing: Moxibustion*, available at https://www.takingcharge.csh.umn.edu/explore-healing-practices/moxibustion (last visited January 19, 2018).
[56] Qi Gong is made up of mind-body-breathing techniques; it uses a combination of movement, self-massage, meditation, and breathing to relax the body. Qi Gong includes a number of Taoist and Buddhist meditative practices, including Tai Chi. Qigong Institute, *What is Qigong*, available at https://www.qigonginstitute.org/category/5/what-is-qigong (last visited January 19, 2018).

- Dietary guidelines; and
- Other adjunctive therapies, as defined the Board of Acupuncture.

Acupuncture may help ease chronic pain such as low-back pain, neck pain, and osteoarthritis; it may also help reduce the frequency of tension headaches and prevent migraine headaches.[57] However, clinical practice guidelines for acupuncture are inconsistent.[58]

Hyperbaric oxygen therapy

Hyperbaric oxygen therapy involves breathing pure oxygen in a pressurized room or tube.[59] In a hyperbaric oxygen therapy chamber, the air pressure is increased to three times higher than normal air pressure so that an individual's lungs can gather more oxygen.[60] An increase in blood oxygen temporarily restores normal levels of blood gases and tissue function to promote healing and fight infection.[61] To benefit from hyperbaric oxygen therapy, an individual typically needs 20 to 40 treatments.[62]

The Food and Drug Administration has not approved HBOT as a treatment for TBI or PTSD. However, HBOT is currently in use for the following 14 FDA-accepted indications:[63]

- Air or gas embolism.
- Carbon monoxide poisoning.
- Clostridial myositis and myonecrosis (gas gangrene).
- Crush injury, compartment syndrome, and other acute traumatic ischemias.
- Decompression sickness.
- Arterial insufficiency which includes non-healing wounds, diabetic foot wounds, hypoxic wounds, and other non-healing wounds.
- Exceptional blood loss anemia.
- Intracranial abscess.
- Necrotizing soft tissue infections.
- Osteomyelitis.
- Radiation tissue damage.
- Skin grafts and flaps.
- Thermal burns.
- Idiopathic sudden sensorineural hearing loss.

Some researchers have reported positive results with using HBOT to treat PTSD or TBI. In contrast, the DoD, in conjunction with the VA, conducted a clinical trial that was published in January 2015 that concluded that HBOT showed no benefits for treating PTSD and/or TBI.[64]

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[57] National Institute of Health: National Center for Complementary and Integrative Health, *Acupuncture: In Depth*, available at https://nccih.nih.gov/health/acupuncture/introduction (last visited January 19, 2018).
[58] Id.
[59] Mayo Clinic, *Hyperbaric oxygen therapy: Definition*, available at http://www.mayoclinic.org/tests-procedures/hyperbaric-oxygen-therapy/basics/definition/prc-20019167 (last visited January 19, 2018).
[60] Id.
[61] Mayo Clinic, *Hyperbaric oxygen therapy: Why it's done,* available at http://www.mayoclinic.org/tests-procedures/hyperbaric-oxygen-therapy/basics/why-its-done/prc-20019167 (last visited January 19, 2018).
[62] Mayo Clinic, *Hyperbaric oxygen therapy: Results,* available at http://www.mayoclinic.org/tests-procedures/hyperbaric-oxygen-therapy/basics/results/prc-20019167 (last visited January 19, 2018).
[63] United States Food and Drug Administration, *Hyperbaric Oxygen Therapy: Don't Be Misled*, available at http://www.fda.gov/forconsumers/consumerupdates/ucm364687.htm (last visited January 19, 2018).
[64] R. Scott Miller, *Effects of Hyperbaric Oxygen on Symptoms and Quality of Life Among Service Members with Persistent Postconcussion Symptoms,* JAMA Internal Medicine, January 2015, available at http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1935931 (last visited January 19, 2018).

Music therapy

Music therapy is the specialized use of music to address an individual's social, communication, emotional, physical, cognitive, sensory and spiritual needs.[65] After assessing the strengths and needs of each client, a qualified music therapist provides treatment, which may include creating, singing, moving to, or listening to music.[66] Music therapy also provides a method of communication that can be helpful to those who find it difficult to express themselves in words.[67] Research in music therapy supports its effectiveness in many areas, such as:

- Overall physical rehabilitation and facilitating movement;
- Increasing people's motivation to become engaged in their treatment;
- Providing emotional support for clients and their families; and
- Providing an outlet for expression of feelings.[68]

Yoga therapy

Yoga is a mind and body practice with origins in ancient Indian philosophy.[69] The various styles of yoga typically combine physical postures, breathing techniques, and meditation or relaxation.[70] Yoga therapy is the appropriate application of the practice of yoga in a therapeutic context to support a consistent yoga practice that will increase self-awareness and engage an individual's energy in the direction of desired goals.[71] The goals of yoga therapy include:

- Eliminating, reducing, or managing symptoms that cause suffering;
- Improving function;
- Helping to prevent the occurrence or reoccurrence of underlying causes of illness; and
- Moving toward improved health and wellbeing.[72]

Current Use of Complementary and Alternative Medicine (CAM)

CAM is a class of therapy that includes treatments not considered standard in the current practice of Western medicine. Complementary refers to the use of these techniques in conjunction with conventional approaches. Alternative refers to their use in lieu of conventional practices.[73] The efficacy of using CAM to treat TBI and PTSD is limited, but evidence suggests that some CAM approaches have modest beneficial effects.[74] CAM techniques such as relaxation and mindfulness are already incorporated in conventional cognitive and behavioral therapy for PTSD.[75]

The VA does recognize that many veterans are turning to CAM treatments as an adjunct to other traditional treatments.[76] One study found that veterans with PTSD were 25% more likely than veterans

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[65] The Certified Board for Music Therapists, available at http://www.cbmt.org/ (last visited January 19, 2018).
[66] American Music Therapy Association, *What is Music Therapy*, available at http://www.musictherapy.org/about/musictherapy/ (last visited January 19, 2018).
[67] American Music Therapy Association, *What is Music Therapy: Definitions and Quotes About Music Therapy*, available at http://www.musictherapy.org/about/quotes/ (last visited January 19, 2018).
[68] Id.
[69] National Institute of Health: National Center for Complementary and Integrative Health, *Yoga*, available at https://nccih.nih.gov/health/yoga (last visited January 19, 2018).
[70] Id.
[71] The International Association of Yoga Therapists, *Educational Standards for the Training of Yoga Therapists: Definition of Yoga Therapy*, Jul. 1, 2012, available at, http://c.ymcdn.com/sites/www.iayt.org/resource/resmgr/Docs_Articles/IAYTDef_YogaTherapy_Ed_Stand.pdf (last visited January 19, 2018).
[72] Id.
[73] United States Department of Veterans Affairs, *Complementary and Alternative Medicine (CAM) for PTSD*, http://www.ptsd.va.gov/professional/treatment/overview/complementary_alternative_for_ptsd.asp (last visited January 18, 2018).
[74] *Id.*
[75] *Id.*
[76] *Id.*

without PTSD to report CAM use, in particular, biofeedback and relaxation.[77] A 2011 survey of all 141 VA facilities found that 89% of VA facilities offered CAM and 1% were in the process of developing CAM programs.[78] Despite the widespread use of CAM among individuals with PTSD, there is limited available evidence supporting the efficacy of CAM for treating PTSD is limited.[79] Additionally, the VA does not have specific policies or guidance related to these alternative therapies.[80] However, the VA is implementing mechanisms to track use and effectiveness of CAM among VA patients to inform future clinical guidance, policies, and best practices for the use of CAM.[81]

CAM in Other States

Five states (Colorado, Indiana, Minnesota, North Dakota, and Oklahoma) have enacted legislation regarding the use of CAM.[82] Of these states, only Colorado has developed a program to study the efficacy of CAM. Results of the study will be published in 2020.[83]

Effect of Proposed Changes

HB 303 requires the DVA to contract with one or more individuals, non-profit corporations, state universities, or Florida College System institutions for a period of two years to provide alternative treatment options for veterans who have been certified by the VA, or any branch of the U.S. Armed Forces, as having a TBI or PTSD.

The contracted entity or entities may select the alternative treatments to be offered to veterans with TBI or PTSD, however, they are limited to those which have at least one scientific or medical peer-reviewed study that shows the treatment has some positive effect on TBI or PTSD. Additionally, the bill requires alternative treatment to be provided under the direction or supervision of a licensed physician, osteopathic physician, chiropractic physician, nurse, psychologist, or a clinical social worker, marriage and family therapist or mental health counselor.

Each contracted entity must submit an annual report to DVA on each alternative treatment provided to a veteran, the number of veterans served, and the treatment outcomes.

The bill provides an expiration date of June 30, 2020 and an effective date of July 1, 2018.

B. SECTION DIRECTORY:

Section 1: Creates s. 295.156, relating to alterative treatment options for veterans.
Section 2: Provides an effective date of July 1, 2018.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

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[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] *Id.*
[82] Information obtained via email from National Conference of State Legislatures, August 3, 2016. (on file with Health Innovation Subcommittee staff).
[83] Bailit Health, *State Spinal Cord Injury Programs, A Research Report For the Colorado Department of Health Care Policy and Financing*, https://www.colorado.gov/pacific/sites/default/files/Spinal%20Cord%20Injury%20Research%20Report-November%202016.pdf (last visited January 18, 2018).

2. Expenditures:

The bill would have an indeterminate, negative impact on DVA. The bill directs DVA to contract with one or more individuals, non-profit corporations, state universities or colleges to provide alternative treatment options for veterans but there is no appropriation in the bill.

However, HB 3783 would appropriate $2,000,000 in non-recurring general revenue funds to the DVA to fund the Alternative Treatment for Veterans-University of South Florida.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will have a positive impact on veterans opting to receive alternative treatments for PTSD or TBI in lieu of or in addition to traditional treatments.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides DVA with sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Alternative Treatment Options for Veterans Pilot Program; creating s. 295.156, F.S.; creating the pilot program within the Department of Veterans' Affairs; requiring the department to contract with individuals and entities to provide alternative treatment options for certain veterans; defining the term "alternative treatment"; requiring alternative treatment to be provided under the direction and supervision of certain licensed individuals; requiring annual reports to the department, the Governor, and the Legislature; providing for expiration of the pilot program; providing an effective date.

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

Section 1. Section 295.156, Florida Statutes, is created to read:

295.156 Alternative Treatment Options for Veterans Pilot Program.—

(1) The Alternative Treatment Options for Veterans Pilot Program is created within the Department of Veterans' Affairs.

(2) The Department of Veterans' Affairs shall contract with one or more individuals, corporations not for profit, state

universities, or Florida College System institutions for a period of 2 years to provide alternative treatment options for veterans who have been certified by the United States Department of Veterans Affairs or any branch of the United States Armed Forces as having a traumatic brain injury or posttraumatic stress disorder. For purposes of this section, the term "alternative treatment" means a therapeutic service that is not part of the standard of medical care established by the United States Department of Veterans Affairs for treating traumatic brain injury or posttraumatic stress disorder but has been shown by at least one scientific or medical peer-reviewed study to have some positive effect on traumatic brain injury or posttraumatic stress disorder.

(3) Alternative treatment under the pilot program must be provided under the direction and supervision of an individual licensed under chapter 458, chapter 459, chapter 460, chapter 464, chapter 490, or chapter 491.

(4) By January 1 of each year, each contracted individual or entity shall report to the department each alternative treatment provided under the pilot program, the number of veterans served, and the treatment outcomes. The department shall report such information to the Governor, the President of the Senate, and the Speaker of the House of Representatives by March 1 of each year.

(5) This section expires June 30, 2020.

Section 2. This act shall take effect July 1, 2018.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 497 Hospice Care
SPONSOR(S): Stone
TIED BILLS: **IDEN./SIM. BILLS:** SB 724

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Royal	Crosier
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Hospice is a program of care and support for terminally ill patients. A specially trained team of professionals and caregivers provide care for the patient's physical, emotional, social, and spiritual needs, and provides support to family caregivers. In Florida, the Agency for Health Care (AHCA) and the Department of Elder Affairs (DOEA) regulate hospices. A hospice is defined as a corporation or limited liability company that provides a continuum of palliative and supportive care for a terminally ill patient and his or her family members. As of January 18, 2018, there are 47 licensed hospice providers in the state.

HB 497 permits a hospice to provide palliative care to seriously ill patients and their families. This broadens the patient population to which a hospice will be allowed to provide services. The bill gives a hospice the option to provide community palliative care services to seriously ill persons and their families directly or through a contracted provider. The bill defines a "seriously ill" person as someone with a persistent medical condition that materially and adversely affects the person's quality of life, that is burdensome in its symptoms, pain, or caregiver stress, and that may be managed through palliative care.

The bill has no fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2018.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Hospice

Hospice is a program of care and support for terminally ill patients, which helps them to live comfortably.[1] A specially trained team of professionals and caregivers provide care for the terminally ill patient's physical, emotional, social, and spiritual needs, and provide support to family caregivers.[2] The team that provides hospice services includes physicians, nurses, medical social workers, spiritual and pastoral counselors, home health aides, therapists, bereavement counselors, and specially trained volunteers.[3] Hospice care includes the following items and services:

- Nursing care;
- Physical or occupational therapy, or speech-language pathology services;
- Medical social services;
- Home health aide and homemaker services;
- Medical supplies, including prescription drugs and biologicals, and the use of medical appliances;
- Physician services;
- Short-term inpatient care; and
- Counseling.[4]

Hospice care may be provided to a patient in an inpatient hospice facility, with licensed beds;[5] it may also be provided to the patient in the patient's home or in another facility, such as a hospital or a nursing home. Hospices provide four levels of care:

- **Routine care** provides the patient with hospice services at home or in a home-like setting. The patient's family provides primary care, with the assistance of the hospice team.
- **Continuous care** provides the patient with skilled nursing services in his or her home during a medical crisis.
- **Inpatient care** is provided in a healthcare facility for symptoms of a medical crisis that cannot be managed in the patient's home. Inpatient care is provided on a temporary basis as determined by the patient's physician and the hospice team.
- **Respite care** is provided in a healthcare facility and is primarily to provide the patient's family members and caretakers with a period of relief.[6]

To be eligible for hospice services under Medicaid or Medicare,[7] a patient must have a prognosis of living six months or less and no longer be seeking curative care.[8] However, Medicare coverage does

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[1] Centers for Medicare and Medicaid Services, *Medicare Hospice Benefits*, available at https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF (last visited January 18, 2018).
[2] Id.
[3] Florida Hospice and Palliative Care Association, *About Hospice*, http://www.floridahospices.org/hospice-palliative-care/about-hospice/, (last visited January 18, 2018).
[4] 42 U.S.C. § 1395x(dd).
[5] A hospice must obtain a Certificate of Need (CON) to increase the number of licensed beds in an inpatient facility, see the discussion of CON below.
[6] Id.
[7] Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease. Medicare Part A covers hospice care.
[8] 42 U.S.C. § 1395d, 1395x.

not end if a patient lives beyond six months after admission; the patient can continue to receive services as long as a physician continues to document the patient's eligibility.[9]

Hospice Care in Florida

Regulation of Hospices

In Florida, the Agency for Health Care Administration (AHCA) and the Department of Elder Affairs (DOEA) regulate hospices pursuant to part IV of Chapter 400, F.S., part II of Chapter 408, F.S., and Chapter 58A-2, F.A.C. A hospice is defined as a corporation or limited liability company that provides a continuum of palliative[10] and supportive care for a terminally ill[11] patient and his or her family members.[12] Section 400.601(6), F.S., defines "hospice services" as the items and services furnished to a patient and his or her family by a hospice and specifies where those services may be provided.[13]

Hospices are subject to the Certificate of Need (CON) program.[14] A CON is a written statement issued by AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service. The Florida CON program has three levels of review: full, expedited, and exempt.[15] Unless a hospital project is exempt from the CON program, it must undergo a full comparative review.[16] Projects required to undergo full comparative review include building a hospice and establishing a hospice program or hospice inpatient facility.[17] Section 408.036(3), F.S., provides exemptions to CON review for certain projects, which includes adding hospice services or swing beds[18] in a rural hospital, the total of which does not exceed one-half of its licensed beds.

As of January 18, 2018, there are 47 licensed hospice providers in Florida, with 1,038 licensed beds.[19]

Effect of Proposed Changes

Palliative Care for Seriously Ill Patients

HB 497 permits a hospice to provide palliative care to seriously ill patients and their families. This broadens the patient population to which a hospice will be allowed to provide services. The bill defines a "seriously ill" patient as someone who has a life-threatening medical condition which may be irreversible and which may continue indefinitely, and which may be managed through palliative care.

The bill creates s. 400.6093, F.S., to allow a hospice to provide community palliative care services to seriously ill persons and their families directly or through a contracted provider. It also allows for community palliative care of a seriously ill patient to manage the side effects of treatment for a progressive disease, medical condition, or surgical condition. The bill specifies that it does not preclude

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[9] Id.
[10] Palliative care means services or interventions which are not curative but are provided for the reduction or abatement of pain and human suffering. S. 400.601(7), F.S.
[11] Rule 59C-1.0355, F.A.C.; s. 400.601(10), F.S. In Florida, a "terminally ill" patient, for hospice purposes, is as a patient with a medical prognosis that his or her life expectancy is 1 year or less if the illness runs its normal course.
[12] S. 400.601(4), F.S.
[13] Hospice services may be provided in a place of temporary or permanent residence used as the patient's home for the purpose of maintaining the patient at home; or, if the patient needs short-term institutionalization, the services shall be furnished in cooperation with those contracted institutions or in the hospice inpatient facility.
[14] S. 408.036, F.S. CON programs are designed to restrain health care costs and provide for directed, measured planning for new services and facilities National Conference of State Legislators, *CON-Certificate of Need State Laws,* available at http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx (last visited January 18, 2018).
[15] S. 408.036, F.S.
[16] Id.
[17] Id.
[18] S. 395.602(2)(g), F.S., defines "swing bed" as a bed which can be used interchangeably as a hospital, skilled nursing facility, or intermediate care facility bed pursuant to 42 C.F.R. parts 405, 435, 440, 442, and 447.
[19] AGENCY FOR HEALTH CARE ADMINISTRATION, *Facility/Provider Search Results – Hospice,* http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (last visited January 18, 2018).

any other providers from being able to provide community palliative care, nor does it mandate or prescribe additional Medicaid coverage for community palliative care.

The bill distinguishes community palliative care services from hospice services, which are limited to terminally ill patients. The bill defines a hospice program as a continuum of palliative and supportive care that is provided to terminally ill patients and their families.

The bill provides an effective date of July 1, 2018.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.6005, F.S., relating to legislative findings and intent.
Section 2: Amends s. 400.601, F.S., relating to definitions.
Section 3: Amends s. 400.609, F.S., relating to hospice services.
Section 4: Creates s. 400.6093, F.S., relating to community palliative care services.
Section 5: Amends s. 400.6095, F.S. relating to patient admission; assessment; plan of care; discharge; death.
Section 6: Provides an effective date of July 1, 2018.

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:

More patients will have access to palliative care services in a hospice setting. Seriously ill patients receiving palliative care in a hospice may have a cost savings associated with less need for care in a hospital and hospices may benefit from providing palliative care to a new patient population.

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:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to hospice care; amending s. 400.6005, F.S.; revising legislative findings and intent; amending s. 400.601, F.S.; redefining the term "hospice"; defining the terms "hospice program" and "seriously ill"; creating s. 400.6093, F.S.; authorizing hospices, or providers operating under contract with a hospice, to provide palliative care to seriously ill patients and their family members; providing construction; amending ss. 400.609 and 400.6095, F.S.; conforming terminology; providing an effective date.

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

Section 1. Section 400.6005, Florida Statutes, is amended to read:

400.6005 Legislative findings and intent.—The Legislature finds that a terminally ill patient ~~individuals and their families,~~ who is ~~are~~ no longer pursuing curative medical treatment and his or her family~~,~~ should have the opportunity to select a support system that allows ~~permits~~ the patient to exercise maximum independence and dignity during the final days of life. The Legislature also finds that a seriously ill patient and his or her family should have the opportunity to select a

support system that provides palliative care and supportive care and allows the patient to exercise maximum independence while receiving such care. The Legislature finds that hospice care provides a cost-effective and less intrusive form of medical care while meeting the social, psychological, and spiritual needs of terminally ill and seriously ill patients and their families. The intent of this part is to provide for the development, establishment, and enforcement of basic standards to ensure the safe and adequate care of persons receiving hospice services.

Section 2. Section 400.601, Florida Statutes, is amended to read:

400.601 Definitions.—As used in this part, the term:

(1) "Agency" means the Agency for Health Care Administration.

(2) "Department" means the Department of Elderly Affairs.

(3) "Hospice" means a centrally administered corporation or a limited liability company that provides a continuum of palliative care and supportive care for a ~~the terminally ill~~ patient and his or her family.

(4) "Hospice care team" means an interdisciplinary team of qualified professionals and volunteers who, in consultation with a ~~the~~ patient, the patient's family, and the patient's primary or attending physician, collectively assess, coordinate, and provide the appropriate palliative care and supportive care to

hospice patients and their families.

(5) "Hospice program" means a program offered by a hospice which provides a continuum of palliative care and supportive care for a patient and his or her family.

(6)~~(5)~~ "Hospice residential unit" means a homelike living facility, other than a facility licensed under other parts of this chapter, under chapter 395, or under chapter 429, which ~~that~~ is operated by a hospice for the benefit of its patients and is considered by a patient who lives there to be his or her primary residence.

(7)~~(6)~~ "Hospice services" means items and services furnished to a patient and family by a hospice, or by others under arrangements with such a program, in a place of temporary or permanent residence used as the patient's home for the purpose of maintaining the patient at home; or, if the patient needs short-term institutionalization, the services shall be furnished in cooperation with those contracted institutions or in the hospice inpatient facility.

(8)~~(7)~~ "Palliative care" means services or interventions furnished to a patient and his or her family which are not curative but are provided for the reduction or abatement of pain and human suffering.

(9)~~(8)~~ "Patient" means the terminally ill or seriously ill individual receiving ~~hospice~~ services from a hospice.

(10)~~(9)~~ "Plan of care" means a written assessment by the

hospice of each patient's and family's needs and preferences, and the services to be provided by the hospice to meet those needs.

(11) "Seriously ill" or "serious illness" means that the patient has a life-threatening medical condition that may continue indefinitely and may be managed through palliative care.

(12) ~~(10)~~ "Terminally ill" or "terminal illness" means that the patient has a medical prognosis that his or her life expectancy is 1 year or less if the illness runs its normal course.

Section 3. Section 400.609, Florida Statutes, is amended to read:

400.609 Hospice services.—Each hospice shall provide a continuum of hospice services which affords ~~afford~~ the terminally ill patient and his or her ~~the~~ family ~~of the patient~~ a range of service delivery which can be tailored to specific needs and preferences of the patient and his or her family at any point ~~in time~~ throughout the length of care ~~for the terminally ill patient~~ and during the bereavement period. These services must be available 24 hours a day, 7 days a week, and must include:

(1) SERVICES.—

(a) The hospice care team shall directly provide the following core services: nursing services, social work services,

pastoral or counseling services, dietary counseling, and bereavement counseling services. Physician services may be provided by the hospice directly or through contract. A hospice may also use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances.

(b) Each hospice must also provide or arrange for such additional services as are needed to meet the palliative and support needs of the patient and <u>his or her</u> family. These services may include, but are not limited to, physical therapy, occupational therapy, speech therapy, massage therapy, home health aide services, infusion therapy, provision of medical supplies and durable medical equipment, day care, homemaker and chore services, and funeral services.

(2) HOSPICE HOME CARE.—Hospice care and services provided in a private home shall be the primary form of care. The goal of hospice home care shall be to provide adequate training and support to encourage self-sufficiency and allow patients and families to maintain the patient comfortably at home for as long as possible. The services of the hospice home care program shall be of the highest quality and shall be provided by the hospice care team.

(3) HOSPICE RESIDENTIAL CARE.—Hospice care and services, to the extent practicable and compatible with the needs and preferences of the patient, may be provided by the hospice care

team to a patient living in an assisted living facility, adult family-care home, nursing home, hospice residential unit or facility, or other nondomestic place of permanent or temporary residence. A resident or patient living in an assisted living facility, adult family-care home, nursing home, or other facility subject to state licensing who has been admitted to a hospice program shall be considered a hospice patient, and the hospice program shall be responsible for coordinating and ensuring the delivery of hospice care and services to such person pursuant to the standards and requirements of this part and rules adopted under this part.

(4) HOSPICE INPATIENT CARE.—The inpatient component of care is a short-term adjunct to hospice home care and hospice residential care and shall be used only for pain control, symptom management, or respite care. The total number of inpatient days for all hospice patients in any 12-month period may not exceed 20 percent of the total number of hospice days for all the hospice patients of the licensed hospice. Hospice inpatient care shall be under the direct administration of the hospice, whether the inpatient facility is a freestanding hospice facility or part of a facility licensed pursuant to chapter 395 or part II of this chapter. The facility or rooms within a facility used for the hospice inpatient component of care shall be arranged, administered, and managed in such a manner as to provide privacy, dignity, comfort, warmth, and

safety for the ~~terminally ill~~ patient and his or her ~~the~~ family. Every possible accommodation must be made to create as homelike an atmosphere as practicable. To facilitate overnight family visitation within the facility, rooms must be limited to no more than double occupancy; and, whenever possible, both occupants must be hospice patients. There must be a continuum of care and a continuity of caregivers between the hospice home program and the inpatient aspect of care to the extent practicable and compatible with the preferences of the patient and his or her family. Fees charged for hospice inpatient care, whether provided directly by the hospice or through contract, must be made available upon request to the Agency for Health Care Administration. The hours for daily operation and the location of the place where the services are provided must be determined, to the extent practicable, by the accessibility of such services to the patients and families served by the hospice.

(5) BEREAVEMENT COUNSELING.—The hospice bereavement program must be a comprehensive program, under professional supervision, that provides a continuum of formal and informal supportive services to the family for a minimum of 1 year after the patient's death. This subsection does not constitute an additional exemption from chapter 490 or chapter 491.

Section 4. Section 400.6093, Florida Statutes, is created to read:

400.6093 Community palliative care services.—A hospice may

provide palliative care to a seriously ill patient and his or her family. Such palliative care may be provided to manage the side effects of treatment for a progressive disease or a medical or surgical condition. Such care may also be provided directly by the hospice or by other providers under contract with the hospice. This section does not preclude the provision of palliative care to seriously ill patients by any other health care provider or health care facility that is otherwise authorized to provide such care. This section does not mandate or prescribe additional Medicaid coverage.

Section 5. Subsections (1) and (2) of section 400.6095, Florida Statutes, are amended to read:

400.6095 Patient admission; assessment; plan of care; discharge; death.—

(1) Each hospice shall make its services available to all terminally ill and seriously ill patients ~~persons~~ and their families without regard to age, gender, national origin, sexual orientation, disability, diagnosis, cost of therapy, ability to pay, or life circumstances. A hospice may ~~shall~~ not impose any value or belief system on its patients or their families and shall respect the values and belief systems of its patients and their families.

(2) Admission of a patient to a hospice program shall be made upon a diagnosis and prognosis of terminal illness or serious illness by a physician licensed pursuant to chapter 458

or chapter 459 and must ~~shall~~ be dependent on the expressed request and informed consent of the patient.

Section 6. This act shall take effect July 1, 2018.

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	_____

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Stone offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 400.6005, Florida Statutes, is amended to read:

400.6005 Legislative findings and intent.—The Legislature finds that a terminally ill patient ~~individuals and their families,~~ who is ~~are~~ no longer pursuing curative medical treatment and his or her family~~,~~ should have the opportunity to select a support system that allows ~~permits~~ the patient to exercise maximum independence and dignity during the final days of life. The Legislature also finds that a seriously ill patient and his or her family should have the opportunity to select a

support system that provides palliative care and supportive care and allows the patient to exercise maximum independence while receiving such care. The Legislature finds that hospice care provides a cost-effective and less intrusive form of medical care while meeting the social, psychological, and spiritual needs of terminally ill and seriously ill patients and their families. The intent of this part is to provide for the development, establishment, and enforcement of basic standards to ensure the safe and adequate care of persons receiving hospice services.

Section 2. Section 400.601, Florida Statutes, is amended to read:

400.601 Definitions.—As used in this part, the term:

(1) "Agency" means the Agency for Health Care Administration.

(2) "Department" means the Department of Elderly Affairs.

(3) "Community palliative care" means consultative palliative care for a seriously ill patient and his or her family, to address physical, emotional, psychosocial, and spiritual needs, that is delivered across care settings.

(4) ~~(3)~~ "Hospice" means a centrally administered corporation or a limited liability company that provides a continuum of palliative care and supportive care for a ~~the terminally ill~~ patient and his or her family.

(5) ~~(4)~~ "Hospice care team" means an interdisciplinary team of qualified professionals and volunteers who, in consultation with a ~~the~~ patient, the patient's family, and the patient's primary or attending physician, collectively assess, coordinate, and provide the appropriate palliative care and supportive care to hospice patients and their families.

(6) "Hospice program" means a program offered by a hospice which provides a continuum of palliative care and supportive care for a patient and his or her family.

(7) ~~(5)~~ "Hospice residential unit" means a homelike living facility, other than a facility licensed under other parts of this chapter, under chapter 395, or under chapter 429, which ~~that~~ is operated by a hospice for the benefit of its patients and is considered by a patient who lives there to be his or her primary residence.

(8) ~~(6)~~ "Hospice services" means items and services furnished to a patient and family by a hospice, or by others under arrangements with such a program, in a place of temporary or permanent residence used as the patient's home for the purpose of maintaining the patient at home; or, if the patient needs short-term institutionalization, the services shall be furnished in cooperation with those contracted institutions or in the hospice inpatient facility.

(9) ~~(7)~~ "Palliative care" means services or interventions which are not curative but are provided for the reduction or

abatement of pain and human suffering.

(10)~~(8)~~ "Patient" means the terminally ill or seriously ill individual receiving ~~hospice~~ services from a hospice.

(11)~~(9)~~ "Plan of care" means a written assessment by the hospice of each patient's and family's needs and preferences, and the services to be provided by the hospice to meet those needs.

(12) "Seriously ill" means that the patient has a life-threatening medical condition that may continue indefinitely and may be managed through palliative care.

(13)~~(10)~~ "Terminally ill" means that the patient has a medical prognosis that his or her life expectancy is 1 year or less if the illness runs its normal course.

Section 3. Section 400.609, Florida Statutes, is amended to read:

400.609 Hospice services.— Each hospice shall provide a continuum of hospice services which affords ~~afford~~ the terminally ill patient and his or her ~~the~~ family ~~of the patient~~ a range of service delivery which can be tailored to specific needs and preferences of the patient and his or her family at any point ~~in time~~ throughout the length of care ~~for the terminally ill patient~~ and during the bereavement period. These services must be available 24 hours a day, 7 days a week, and must include:

(1) SERVICES.—

(a) The hospice care team shall directly provide the following core services: nursing services, social work services, pastoral or counseling services, dietary counseling, and bereavement counseling services. Physician services may be provided by the hospice directly or through contract. A hospice may also use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances.

(b) Each hospice must also provide or arrange for such additional services as are needed to meet the palliative and support needs of the patient and his or her family. These services may include, but are not limited to, physical therapy, occupational therapy, speech therapy, massage therapy, home health aide services, infusion therapy, provision of medical supplies and durable medical equipment, day care, homemaker and chore services, and identifying the intended or contracted licensed funeral services provider.

(2) HOSPICE HOME CARE.—Hospice care and services provided in a private home shall be the primary form of care. The goal of hospice home care shall be to provide adequate training and support to encourage self-sufficiency and allow patients and families to maintain the patient comfortably at home for as long as possible. The services of the hospice home care program shall be of the highest quality and shall be provided by the hospice care team.

(3) HOSPICE RESIDENTIAL CARE.—Hospice care and services, to the extent practicable and compatible with the needs and preferences of the patient, may be provided by the hospice care team to a patient living in an assisted living facility, adult family-care home, nursing home, hospice residential unit or facility, or other nondomestic place of permanent or temporary residence. A resident or patient living in an assisted living facility, adult family-care home, nursing home, or other facility subject to state licensing who has been admitted to a hospice program shall be considered a hospice patient, and the hospice program shall be responsible for coordinating and ensuring the delivery of hospice care and services to such person pursuant to the standards and requirements of this part and rules adopted under this part.

(4) HOSPICE INPATIENT CARE.—The inpatient component of care is a short-term adjunct to hospice home care and hospice residential care and shall be used only for pain control, symptom management, or respite care. The total number of inpatient days for all hospice patients in any 12-month period may not exceed 20 percent of the total number of hospice days for all the hospice patients of the licensed hospice. Hospice inpatient care shall be under the direct administration of the hospice, whether the inpatient facility is a freestanding hospice facility or part of a facility licensed pursuant to chapter 395 or part II of this chapter. The facility or rooms

within a facility used for the hospice inpatient component of care shall be arranged, administered, and managed in such a manner as to provide privacy, dignity, comfort, warmth, and safety for the ~~terminally ill~~ patient and his or her ~~the~~ family. Every possible accommodation must be made to create as homelike an atmosphere as practicable. To facilitate overnight family visitation within the facility, rooms must be limited to no more than double occupancy; and, whenever possible, both occupants must be hospice patients. There must be a continuum of care and a continuity of caregivers between the hospice home program and the inpatient aspect of care to the extent practicable and compatible with the preferences of the patient and his or her family. Fees charged for hospice inpatient care, whether provided directly by the hospice or through contract, must be made available upon request to the Agency for Health Care Administration. The hours for daily operation and the location of the place where the services are provided must be determined, to the extent practicable, by the accessibility of such services to the patients and families served by the hospice.

(5) BEREAVEMENT COUNSELING.—The hospice bereavement program must be a comprehensive program, under professional supervision, that provides a continuum of formal and informal supportive services to the family for a minimum of 1 year after the patient's death. This subsection does not constitute an additional exemption from chapter 490 or chapter 491.

Section 4. Section 400.6093, Florida Statutes, is created to read:

400.6093 Community palliative care services for seriously ill patients.—A hospice may provide community palliative care to a seriously ill patient and his or her family, including but not limited to consultation by a licensed, board certified hospice and palliative care physician, a licensed, board certified hospice and palliative care osteopathic physician, or advanced registered nurse practitioner for care planning, pain or symptom management, and care goals; assistance with advance care planning, grief support for the patient and caregiver, and adjustment to the illness and other psychosocial and emotional needs by a licensed clinical social worker; assistance with spiritual needs by a clergy, chaplain or spiritual counselor; and the use of volunteers. Community palliative care, excluding personal care as defined in s. 400.462(24), may be provided to manage the side effects of treatment for a progressive disease or a medical or surgical condition. Community palliative care may also be provided directly by the hospice or by other providers under contract with the hospice. This section does not preclude the provision of palliative care to seriously ill patients by any other health care provider or health care facility that is otherwise authorized to provide such care. This section does not mandate or prescribe additional Medicaid coverage.

Section 5. Subsections (1) and (2) of section 400.6095, Florida Statutes, are amended to read:

400.6095 Patient admission; assessment; plan of care; discharge; death.—

(1) Each hospice shall make its services available to all terminally ill patients ~~persons~~ and their families without regard to age, gender, national origin, sexual orientation, disability, diagnosis, cost of therapy, ability to pay, or life circumstances. A hospice may ~~shall~~ not impose any value or belief system on its patients or their families and shall respect the values and belief systems of its patients and their families.

(2) Admission of a patient to a hospice program shall be made upon a diagnosis and prognosis of terminal illness by a physician licensed pursuant to chapter 458 or chapter 459 and must ~~shall~~ be dependent on the expressed request and informed consent of the patient.

Section 6. This act shall take effect July 1, 2018.

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

Remove lines 5-12 and insert:

"hospice"; defining the terms "community palliative care", "hospice program" and "seriously ill"; amending s. 400.609, F.S.; authorizing hospices to identify licensed funeral service

providers for patients; conforming terminology; creating s. 400.6093, F.S.; authorizing hospices, or providers operating under contract with a hospice, to provide community palliative care to seriously ill patients and their family members; providing construction; amending s. 400.6095, F.S.; conforming terminology; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 937 Perinatal Mental Health
SPONSOR(S): Nuñez
TIED BILLS: **IDEN./SIM. BILLS:** SB 138

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Beattie AB	Crosier
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Women are more likely to develop depression and anxiety during the first year after childbirth than at any other time of their lives. "Perinatal mental health" refers to the mental health of mothers and fathers during the period immediately before and after pregnancy. Perinatal mood or anxiety disorders ("PMDs") include antenatal depression and anxiety, postpartum depression and anxiety, postpartum anxiety/panic disorder, postpartum obsessive compulsive disorder, postpartum post-traumatic stress disorder, and postpartum psychosis.

Nationally, about 1 in 9 women experience postpartum depression, but state estimates can be as high as 1 in 5 women. A 2010 CDC study shows that approximately 4% of fathers experience paternal postpartum depression in the first year after their child's birth. In 2016, over 225,000 babies were born in Florida. The Florida Department of Health (DOH) tracks infant and maternal health issues, including postpartum depression. An estimated 45,000 children in Florida were born to mothers suffering from perinatal mood or anxiety disorders in 2016 alone. PMDs and poor perinatal mental health care during pregnancy can lead to a higher instance of preterm births, babies born at low birth weights, and adverse neurodevelopmental outcomes in infants. PMDs may also contribute to a parent's compromised caregiving activities for an infant.

A birth center is any facility, institution, or place, which is not an ambulatory surgical center, a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy. Birth centers are licensed and regulated by the Agency for Health Care Administration (AHCA). A birth center must ensure that its patients have adequate prenatal care, maintain records of prenatal care for each client, and make the records available during labor and delivery.

HB 937 creates s. 383.014, F.S., which requires the DOH to:

- establish and maintain a toll-free hotline for the public and a toll-free hotline for health care providers, to disseminate information about perinatal mental health;
- create public service announcements to educate the public on perinatal mental health care; and
- encourage certain health care providers to attend continuing medical education courses on perinatal mental health car.

The bill amends s. 383.318, F.S., revising components that are included in postpartum evaluation and follow-up care provided by birth centers to include a mental health screening and provide certain information on postpartum depression.

The bill also amends s. 383.1053, F.S., to encourage hospitals that provide birthing services to provide the same postpartum evaluation and follow-up care that is required to be provided by birth centers.

This bill would have a significant, negative fiscal impact on state government. The bill would not have a fiscal impact on local governments.

The bill provides an effective date of July 1, 2018.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Perinatal Mental Health

Women are more likely to develop depression and anxiety during the first year after childbirth than at any other time of their lives.[1] "Perinatal[2] mental health" refers to the mental health of mothers and fathers during the period immediately before and after pregnancy.[3] Perinatal mood or anxiety disorders ("PMDs") span a broader spectrum of disorders, including:

- Antenatal depression and anxiety
- Postpartum depression and anxiety
- Postpartum anxiety/panic disorder
- Postpartum obsessive compulsive disorder
- Postpartum post-traumatic stress disorder
- Postpartum psychosis

Pregnancy and childbirth may also exacerbate pre-existing mental health disorders.[4] The causes of PMDs are multifaceted, but the most likely hypothesis is that mental health changes are triggered by the significant changes in a woman's hormones during the perinatal period.[5] PMDs are often generalized as postpartum depression, as this is the most common complication after childbirth.[6] While 50-80%[7] of women experience worry, sadness, and tiredness after having a baby, these "baby blues" typically resolve themselves after a few days.[8] However, postpartum depression is more intense and lasts longer than "baby blues."[9] Symptoms of postpartum depression are similar to symptoms of depression, but may also include:

- Crying more often than usual.
- Feelings of anger.
- Withdrawing from loved ones.
- Feeling numb or disconnected from the baby.
- Worrying about hurting the baby.
- Feeling guilty about not being a good mom or doubting one's ability to care for the baby.[10]

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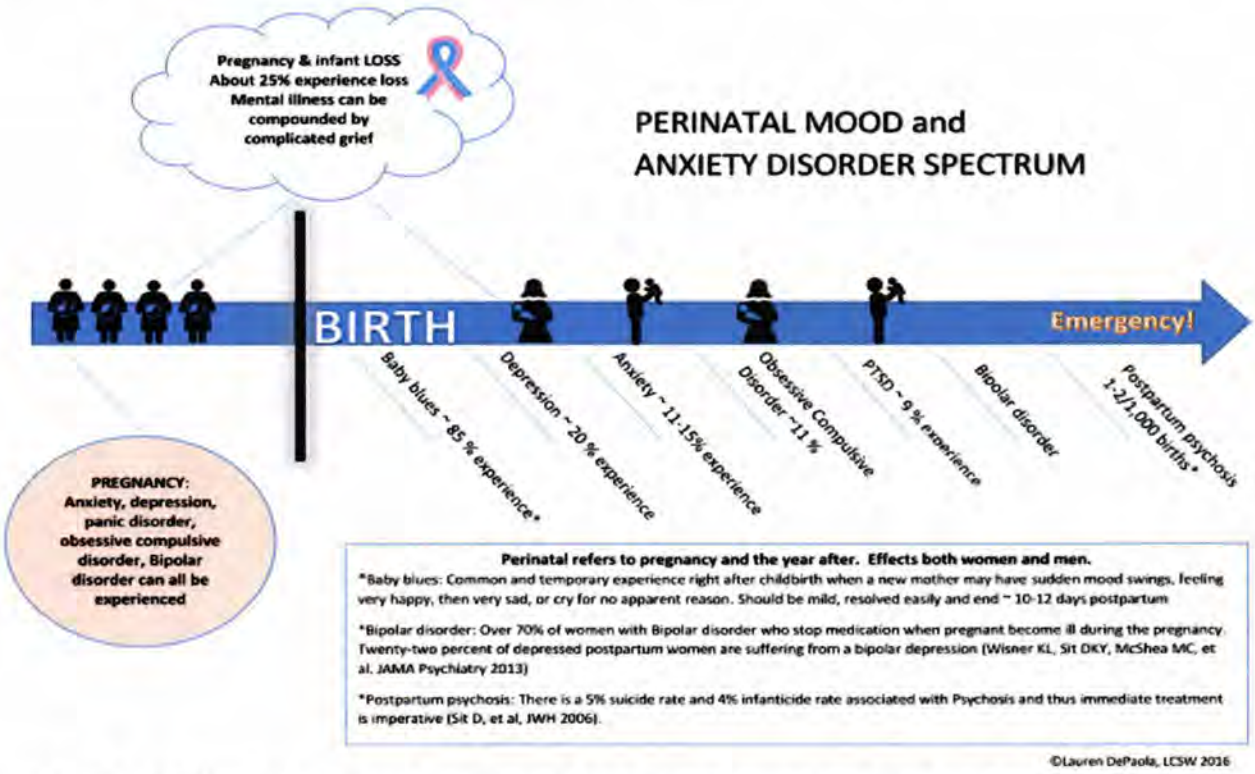
[1] Mental Health America, *Position Statement 49: Perinatal Mental Health*, available at http://www.mentalhealthamerica.net/issues/position-statement-49-perinatal-mental-health (last visited January 21, 2018).
[2] Merriam Webster, *Definition of "perinatal;"* "occurring in, concerned with, or being in the period around the time of birth," available at https://www.merriam-webster.com/dictionary/perinatal%20mental%20health (last visited January 21, 2018).
[3] This includes parents who lose an infant during the perinatal period: Lauren DePaolo, *Florida's largest reproductive health issue: Perinatal Mental Illness*, Florida Children & Youth Cabinet presentation, May 4th, 2016, available at https://www.flgov.com/cyc-2016-meeting-materials/ (last visited January 21, 2018).
[4] *Id.*
[5] *Id.*
[6] *Id. See also* Alachua County Perinatal Mental Health Coalition, *Alachua County Maternal Mental Health Needs Assessment*, May 2017, at 1, available at https://docs.wixstatic.com/ugd/8de022_cdf337ae9de947d5bdf60033899bc506.pdf (last visited January 21, 2018).
[7] Marian Earls, *Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice*, from the American Academy of Pediatrics, at 1033, available at http://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf (last visited January 21, 2018).
[8] Centers for Disease Control and Prevention, *Depression Among Women*, available at https://www.cdc.gov/reproductivehealth/depression/index.htm (last visited January 21, 2018).
[9] *Id.*
[10] *Id.*

The exact prevalence of PMDs is unknown because many cases go unreported, and PMDs often have overlapping symptoms, which complicates diagnosis.[11] Reports from the Centers for Disease Control and Prevention ("CDC") show that nationally, about 1 in 9 women experience postpartum depression, but state estimates can be as high as 1 in 5 women.[12] The rates of depression for low-income mothers and pregnant and parenting teenagers are even higher, at 40-60%.[13] It is estimated that every year, over 400,000 infants are born to mothers who are depressed, which makes perinatal depression the most underdiagnosed obstetric complication in America.[14]



Source: Alachua County Perinatal Mental Health Coalition, *Alachua County Maternal Mental Health Needs Assessment*, May 2017, at 10.

Additionally, a 2010 CDC study shows that approximately 4% of fathers experience paternal postpartum depression in the first year after their child's birth.[15] Other studies suggest that the rates for fathers are similar to those for mothers.[16] Research suggests that depression in one partner is significantly correlated with depression in the other partner.[17] Maternal postpartum depression is the primary risk factor for paternal postpartum depression.[18] One study found that 24-50% of men with paternal postpartum depression also had partners with it.[19] This means that infants may be in family situations where multiple caregivers are depressed.[20] Compounded effects from parental PMDs can lead to more severe disruptions in infant development.[21]

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[11] *Id.*
[12] *Id.*
[13] *Supra* n. 7, at 1032.
[14] *Id.*
[15] *Supra* n. 7.
[16] Kathleen Biebel & Shums Alikhan, *Paternal Postpartum Depression*, Vol. 1, Iss. 1 U. Mass. Journal of Parent & Family Mental Health August, 2016, at 1, available at https://escholarship.umassmed.edu/cgi/viewcontent.cgi?article=1000&context=parentandfamily (last visited January 21, 2018).
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*

Effects of PMDs on Infants

PMDs and poor perinatal mental health care during pregnancy can lead to a host of issues for infants.[22] Maternal stress and anxiety have been linked to a higher instance of preterm births, babies born at low birth weights, and adverse neurodevelopmental outcomes in infants.[23]

PMDs that continue after birth may also contribute to a parent's compromised caregiving activities for an infant.[24] Reports show that infants of mothers with postpartum depression are more likely to be abused, neglected, and be diagnosed as failure to thrive.[25] Studies also report links between maternal depression and reduced likelihood of continued breastfeeding, problematic sleep practices, and fewer preventative services (and more emergency services) for infants.[26] Depressed mothers are also more likely to have thoughts of harming infants.[27] One study found that 41% of depressed mothers compared to 7% of the control group mothers admitted to thoughts of harming their infant.[28] A majority of these depressed mothers had a problem with thoughts of harming their infant, fear of being alone with the infants, and an inability to care for the infant.[29]

In contrast to a large body of literature on maternal care, there are fewer studies of the relationship between child development and paternal care.[30] Even so, research shows that infants establish secure attachments with primary caregivers that allow them to develop basic biological and behavioral regulatory patterns that are important for growth.[31] Infants who live in a setting where one or both parents is depressed are likely to show impaired social interaction and delays in development.[32] Unaffectionate parenting from either or both parents may lead to insecure attachment with infants, which can cause long-term effects.[33] Insecure attachment has been linked to later conduct disorders and behavior problems.[34]

Status of Perinatal Mental Health in Florida

Number of Infants in Florida Affected By PMDs

In 2016, over 225,000 babies were born in Florida.[35] The Florida Department of Health (DOH) uses its Pregnancy Risk Assessment Monitoring System (PRAMS) to track infant and maternal health issues, including postpartum depression.[36] The results from the 2009-2011 study are reflected below, and show that 23.4% of women with a recent live birth were experiencing postpartum depression.

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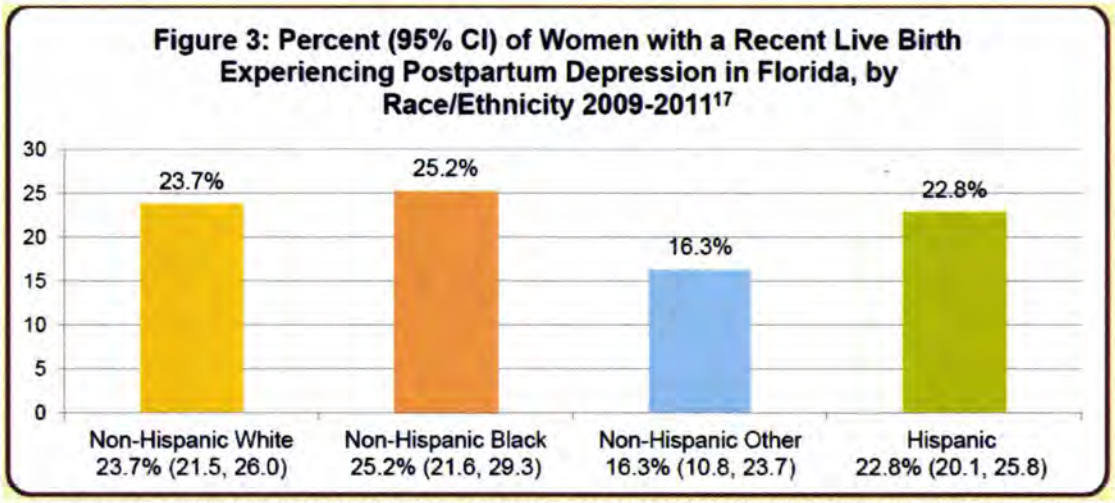
[22] Christine Schetter & Lynlee Tanner, *Anxiety, depression and stress in pregnancy: implications for mothers, children, research, and practice*, Curr Opin Psychiatry, March, 2012, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4447112/ (last visited January 21, 2018).
[23] *Id.*
[24] Tiffany Field, *Postpartum Depression Effects on Early Interactions, Parenting, and Safety Practices: A Review*, Infant Behav Dev., February, 2010, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2819576/ (last visited January 21, 2018).
[25] Holicky, A., Phillips-Bell, G. *Florida Life Course Indicator Report (Mental Health)*, Florida Department of Health (Dec. 2016), at 4, available at http://www.floridahealth.gov/programs-and-services/womens-health/florida-life-course-indicator-report/mental-health-2017.pdf (last visited January 21, 2018).
[26] *Supra* n. 24
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Supra* n. 16.
[31] *Supra* n. 22
[32] *Supra* n. 7.
[33] *Supra* n. 22.
[34] *Supra* n. 7, at 1034.
[35] Florida Department of Health, *Florida Birth Query System*, available at http://www.flhealthcharts.com/FLQUERY/Birth/BirthRpt.aspx (last visited January 21, 2018).
[36] *Supra* n. 25 at 4-5. Questions asked were:
1. Since your new baby was born, how often have you felt down, depressed or sad?
2. Since your new baby was born, how often have you felt hopeless?
3. Since your new baby was born, how often have you felt slowed down?
Women responding "always" or "often" to any of the above questions were considered to be experiencing postpartum depression.

Table 3: Percent (95% CI) of Women with a Recent Live Birth Experiencing Postpartum Depression, 2009-2011	
Nation[12*]	Florida[17]
23.0% (22.9, 23.0)	23.4% (21.8, 25.0)

*The national average is derived from states participating in the CDC's CPONDER data system between 2009 and 2011. To be included in the system, states must have greater than 65% response rate on their PRAMS survey. Florida was not included in the national estimate. The numbers reported here may not be directly comparable.

Source: Holicky, A., Phillips-Bell, G. *Florida Life Course Indicator Report (Mental Health)*, Florida Department of Health (Dec. 2016)



Source: Holicky, A., Phillips-Bell, G. *Florida Life Course Indicator Report (Mental Health)*, Florida Department of Health (Dec. 2016)

The most recent PRAMS (from 2014) asked study participants two different questions from the 2009-2011 data:

1. "Since your new baby was born, how often have you felt down, depressed, or hopeless?" (8.6% answered "always or often").
2. "Since your new baby was born, how often have you had little interest or little pleasure in doing things? (10.6% answered "always or often").[37]

Although these data sets cannot be directly compared, the 2014 results may reflect that there is improvement in the incidence of postpartum depression in Florida.[38] Using this highly-cited estimate,[39] if approximately 20% of mothers experience some form of PMD, an estimated 45,000 children in Florida were born to mothers suffering from perinatal mood or anxiety disorders in 2016 alone.

Cost of Perinatal Mood and Anxiety Disorders in Florida.

Perinatal mood and anxiety disorders create a substantial cost to parents, infants, and the state. The cost of adverse health outcomes such as preterm birth, low birth weight, and compromised attachment and development for infants of mothers suffering from PMDs are difficult to measure, but significant.[40] If a mother's depression continues during an infant's childhood, the child will be more likely to experience

[37] Bo Yu et. al., *Florida Pregnancy Risk Assessment Monitoring System (PRAMS) 2014 Surveillance Data Book*, Florida Department of Health (Nov. 2017), at 69-70, available at http://www.floridahealth.gov/statistics-and-data/survey-data/pregnancy-risk-assessment-monitoring-system/_documents/reports/prams2014.pdf (last visited January 21, 2018).
[38] *See id.*
[39] *See* Lauren DePaolo, *Florida's largest reproductive health issue: Perinatal Mental Illness*, Florida Children & Youth Cabinet presentation, May 4th, 2016; Centers for Disease Control and Prevention, *Depression Among Women*, available at https://www.flgov.com/cyc-2016-meeting-materials/ (last visited January 21, 2018).
[40] *See* n. 22.

developmental delays and thus require services through the early intervention system.[41] Research further indicates that a parent-child relationship affected by maternal depression may lead to increased risk for social and emotional problems and delays or impairments in cognitive and linguistic development.[42] Besides the cost to the child, these impairments or delays may result in an increased need for early intervention services.[43]

The emotional cost of depression may be compounded by the guilt felt by parents who are unable to form bonds with their infant or experience thoughts of harming their infant.[44] Additionally, untreated antepartum and postpartum depression can lead to ongoing depression, which has been associated with an increased likelihood of cardiovascular disease, stroke, and type-2 diabetes.[45] As women are more likely to develop depression and anxiety during the first year after childbirth than at any other time, receiving perinatal mental health treatment may be crucial to preventing continued mental health issues.[46]

Untreated maternal depression has also been associated with negative outcomes in the areas of employment and income.[47] Depressed mothers when compared to nondepressed mothers may be more likely to be unemployed and less likely to be employed full time.[48] Depressed mothers may also have difficulty getting and keeping a job, leading to lower income and possibly a greater need for public assistance.[49] For the general population, depression has been shown to predict greater work disability and lower income over time, and treatment of depression has been shown to improve work productivity and decrease absenteeism.[50] This suggests that untreated postpartum depression decreases the productivity and incomes of affected parents, imposing economic costs on parents, employers, and the public assistance system.

The estimated two-generational (mother and child) annual economic cost of not treating one mother with maternal depression is $22,647.[51] However, this estimate is from 2010, and it does not account for the costs to the state, which may expend more resources on parents and children of parents affected by PMDs.[52] It also fails to include the cost of fathers experiencing PMDs, the healthcare costs to mothers experiencing ongoing depression that began from insufficient perinatal mental healthcare, or the mental and emotional costs on parents and children of parents experiencing PMDs. Relying on this cost estimate, there is an economic loss of over $1.02 billion for the 2016 birth cohort alone.[53] The true price of insufficient perinatal mental healthcare is likely much higher than the estimate reflected in the table below.

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[41] Lisa Sontag-Padilla, et. al., *Maternal Depression: Implications for Systems Serving Mother and Child*, Rand Corporation, (2013), pg. 3, available at https://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR404/RAND_RR404.pdf (last visited January 21, 2018).
[42] *Id.*
[43] *Id.*
[44] *See* n. 22 and 24.
[45] *See* n. 41.
[46] *Supra* n. 1.
[47] *Supra* n. 41 at 2.
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] Jose Diaz & Richard Chase, *The Cost of Untreated Maternal Depression*, Wilder Research (October, 2010), available at https://www.wilder.org/Wilder-Research/Publications/Studies/Cost%20of%20Untreated%20Maternal%20Depression/The%20Cost%20of%20Untreated%20Maternal%20Depression,%20Brief.pdf (last visited January 21, 2018).
[52] *Id.*
[53] $22,647 x 45,000 = 1,019,115,000 (where 45,000 is the estimated be the number of babies born to mothers affected by perinatal health issues (number of births multiplied by 20% prevalence). Number of total births found at: Florida Department of Health, *Florida Birth Query System*, available at http://www.flhealthcharts.com/FLQUERY/Birth/BirthRpt.aspx (last visited January 21, 2018)).

Estimated Annual Costs

Total cost of not treating a depressed mother and her child	$22,647
Cost of not treating mothers with depression	**$7,211**
Lost income of mothers	$945
Cost due to lost productivity of mothers	$6,223
Costs associated with a child born to a depressed mother	**$15,323**
Cost of treating low birth weight (LBW) babies	$6,283
Cost of pre-term deliveries	$1,130
Loss of future income of babies due to LBW	$3,522
Loss of future income of babies due to delayed brain development	$2,465
Loss of future income of babies due to death of LBW child	$1,577
Cost to the justice system	$120
Loss in tax revenues (mother and child)	$383

Source: Jose Diaz & Richard Chase, *The Cost of Untreated Maternal Depression*, Wilder Research (October, 2010).

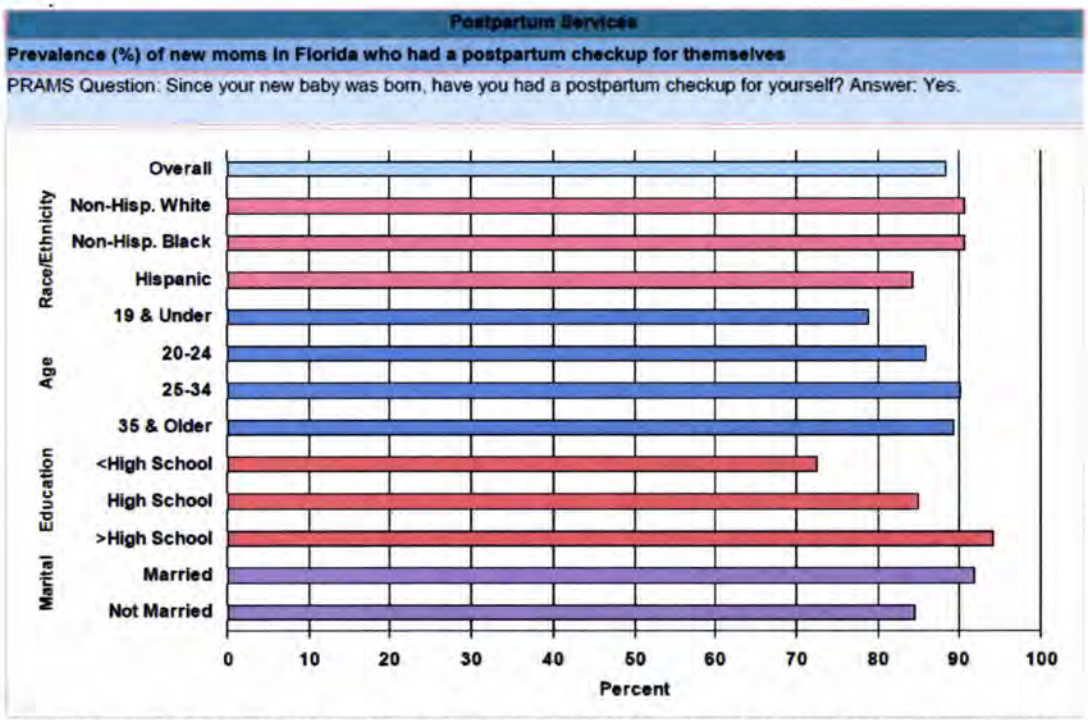
Services Currently Available

There is currently no state-wide entity coordinating support for perinatal mental health. The Florida Department of Health website provides information for new mothers, and suggests that women experiencing symptoms of postpartum depression consult their doctor, or call 911 or the National Suicide Prevention Lifeline if necessary.[54]

The goals of the Florida Association of Healthy Start Coalitions (FAHSC) are to reduce infant mortality, reduce the number of low birth weight babies, and improve health and developmental outcomes by providing prenatal and postnatal education and coordination of resources through home visiting.[55] The DOH, in collaboration with the FAHSC, is working to standardize the use of the Edinburgh Postnatal Depression Scale (EPDS) as the Depression Screening used for all Healthy Start participants statewide.[56] Standardization of when the EPDS is utilized, training, and other evidence-based interventions for women found to be at risk for postpartum depression based on the EPDS are also being finalized.[57] However, not all mothers utilize Healthy Start, so even once this additional screening is implemented, it will not cover all new mothers who may have PMDs.

Most new mothers in Florida appear to be receiving checkups. The 2014 PRAMS data shows that overall, 88.5% of new moms received a postpartum checkup for themselves.[58] It is not known if screening for perinatal mental health issues took place at these checkups.

[54] Florida Department of Health, *After Pregnancy: The "Baby Blues" and Postpartum Depression*, http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/after-pregnancy.html (last visited January 22, 2018).
[55] *Supra* n. 25, at 6.
[56] *Id.*
[57] *Id.*
[58] *Supra* n. 37, at 72.



CI = Confidence Interval **Source: Bo Yu et. al., *Florida Pregnancy Risk Assessment Monitoring System (PRAMS) 2014 Surveillance Data Book*, Florida Department of Health (Nov. 2017), at 72.**

Birth Centers

A birth center is any facility, institution, or place, which is not an ambulatory surgical center, a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.[59] Birth centers are licensed and regulated by the Agency for Health Care Administration (AHCA) under ch. 383, F.S., and part II of ch. 408, F.S.

Birth centers must have a governing body responsible for the overall operation and maintenance of the birth center.[60] The governing body must develop and make available to all staff, clinicians, consultants, and licensing authorities, a manual that documents the policies, procedures, and protocols of the birth center.[61] A birth center may only accept those patients who are expected to have normal pregnancies and deliveries; and prior to being accepted for care, the patient must sign an informed consent form.[62]

AHCA is required to adopt rules establishing minimum standards for birth centers, which ensure:[63]

- Sufficient numbers and qualified types of personnel and occupational disciplines are available at all times to provide necessary and adequate patient care and safety.
- Infection control, housekeeping, sanitary conditions, disaster plan, and medical record procedures that will adequately protect patient care and provide safety are established and implemented.
- Licensed facilities are established, organized, and operated consistent with established programmatic standards.

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[59] Section 383.302(2), F.S.; Section 383.302(8), F.S. defines "low-risk pregnancy" as a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the department, and which is accompanied by adequate prenatal care.
[60] Section 383.307, F.S.
[61] *Id.*
[62] Section 383.31, F.S. The informed consent form must advise the patient of the qualifications of the clinical staff, the risks related to out-of-hospital births, the benefits of out-of-hospital births, and the possibility of referral or transfer if complications arise during pregnancy or childbirth with additional costs for services rendered (r. 59A-11.010, F.A.C.)
[63] Section 383.309, F.S.; The minimum standards for birth centers are contained in Chapter 59A-11, F.A.C.

A birth center is required to maintain the quality of care by:[64]

- Having at least one clinical staff[65] member for every two clients in labor;
- Having a clinical staff member or qualified personnel[66] available on site during the entire time a client is in the birth center. Services during labor and delivery must be provided by a physician, certified nurse midwife, or licensed midwife, assisted by at least one other staff member under protocols developed by clinical staff;
- Ensuring all qualified personnel and clinical staff are trained in infant and adult resuscitation and requiring qualified personnel or clinical staff who are able to perform neonatal resuscitation to be present during each birth;
- Maintaining complete and accurate medical records;
- Evaluating the quality of care by reviewing clinical records;
- Reviewing admissions with respect to eligibility, course of pregnancy and outcome, evaluation of services, condition of mother and newborn on discharge, or transfer to other providers; and
- Surveillance of infection risk and cases and the promotion of preventive and corrective program designed to minimize hazards.

A birth center must ensure that its patients have adequate prenatal care and must maintain records of prenatal care for each client and must make the records available during labor and delivery.[67]

Birth centers must provide postpartum care and evaluation that includes physical examination of the infant, metabolic screening tests, referral to pediatric care sources, maternal postpartum assessment, family planning, referral to secondary or tertiary care, and instruction in child care, including immunization, breastfeeding, safe sleep practices, and possible causes of Sudden Unexpected Infant Death.[68]

Birth centers must submit an annual report to AHCA that details, among other things:[69]

- The number of deliveries by birth weight;
- The number of maternity clients accepted for care and length of stay;
- The number of surgical procedures performed at the birth center by type;
- Maternal transfers, including the reason for the transfer, whether it occurred intrapartum or postpartum, and the length of the hospital stay;
- Newborn transfers, including the reason for the transfer, birth weight, days in hospital, and APGAR score at five and ten minutes;
- Newborn deaths; and
- Stillborn/Fetal deaths.

Birth centers must have written consultation agreements with each consultant who has agreed to provide advice and services to the birth center.[70] A consultant must be a licensed medical doctor or licensed osteopathic physician who is either certified or eligible for certification by the American Board of Obstetrics and Gynecology, or has hospital obstetrical privileges.[71] Consultation may be provided onsite or by telephone.[72]

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[64] Rule 59A-11.005(3), F.A.C.
[65] Section 383.302(3), F.S., defines "clinical staff" as individuals employed full-time or part-time by a birth center who are licensed or certified to provide care at childbirth.
[66] Rule 59A-11.002(6), F.A.C., defines "qualified staff" as an individual who is trained and competent in the services that he or she provides and is licensed or certified when required by statute or professional standard.
[67] Section 383.312, F.S.
[68] Section 383.313(3), F.S.
[69] Rule 59A-11.019, F.A.C., and AHCA Form 3130-3004, (Feb. 2015).
[70] Section 383.315(1), F.S.
[71] Section 383.302(4), F.S.
[72] Section 383.315(2), F.S.

AHCA may impose an administrative fine not to exceed $500 per violation per day for the violation of any provision of the Birth Center Licensure Act, part II of chapter 408, or applicable rules.[73] AHCA may also impose an immediate moratorium on elective admissions to any birth center when it determines that any condition in the facility presents a threat to the public health or safety.[74]

Effect of Proposed Changes

HB 937 creates s. 383.014, F.S., which requires the Department of Health to:

- establish and maintain a toll-free hotline for the public and a toll-free hotline for health care providers, to disseminate information about perinatal mental health;
- create public service announcements to educate the public on perinatal mental health care; and
- encourage certain health care providers to attend continuing medical education courses on perinatal mental health car.

The bill amends s. 383.318, F.S., revising components that are included in postpartum evaluation and follow-up care provided by birth centers to include a mental health screening and provide certain information on postpartum depression.

The bill also amends s. 383.1053, F.S., to encourage hospitals that provide birthing services to provide the same postpartum evaluation and follow-up care that is required to be provided by birth centers.

The bill provides an effective date of July 1, 2018.

B. SECTION DIRECTORY:

Section 1: Provides a title; "Florida Families First Act."

Section 2: Creates s. 383.014, F.S., relating to perinatal mental health care; short title.

Section 3: Amends s. 383.318, F.S., relating to postpartum care for birth center clients and infants.

Section 4: Amends s. 383.1053, F.S., relating to postpartum care and education.

Section 5: Provides an effective date of July 1, 2018.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill directs DOH to establish new, separate hotlines for clients and providers. DOH estimates the fiscal impact for the first year to be $1,156,520 and $301,820 for the second year.[75]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

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[73] Section 383.33, F.S.
[74] *Id.*
[75] Department of Health, *Agency Analysis dated August 15, 2017* (on file with the House Health Innovation Subcommittee).

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Birth centers currently provide maternal postpartum assessments to its postpartum evaluation and follow-up care. The bill directs birth centers to add mental health screening to the maternal postpartum assessment. There would be an insignificant, indeterminate, negative fiscal impact for birth centers.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

According to DOH, no rule-making is required to implement this bill. [76] If necessary, DOH has sufficient rule-making authority under s. 383.011(2)(a), F.S., which authorizes DOH to promulgate rules necessary to administer the maternal and child health care program.[77]

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[76] Email from Department of Health, *FW: Family Health Line*, January 22, 2018, (on file with House Health Innovation Subcommittee staff).
[77] *Id.*

A bill to be entitled

An act relating to perinatal mental health; providing a short title; creating s. 383.014, F.S.; requiring the Department of Health to establish and maintain a toll-free hotline accessible to the general public and a toll-free hotline accessible to health care providers; requiring the department to create public service announcements to educate the public on perinatal mental health care; requiring the department to encourage certain health care providers to attend continuing medical education courses on perinatal mental health care; amending s. 383.318, F.S.; revising components that are included in the postpartum evaluation and followup care provided by birth centers to include a mental health screening and the provision of certain information on postpartum depression; amending s. 395.1053, F.S.; encouraging hospitals that provide birthing services to provide the same postpartum evaluation and followup care that is required to be provided by birth centers; providing an effective date.

WHEREAS, the Alachua County Perinatal Mental Health Coalition released its 2017 Maternal Mental Health Needs Assessment, which found that perinatal mental illness is the

leading health complication related to pregnancy and birth, and

WHEREAS, as many as 1 in 5 mothers nationally will experience Perinatal Mood and Anxiety Disorder (PMD), and

WHEREAS, as many as 1 in 10 fathers will also experience symptoms of PMD, and

WHEREAS, Florida loses approximately $900 million annually because of the failure to recognize and treat perinatal mental illnesses, and

WHEREAS, approximately 44,000 Florida babies are born to a parent experiencing a perinatal mental illness, and those babies may experience social, emotional, and cognitive detriments if their affected parents do not have access to proper care or receive treatment, NOW, THEREFORE,

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

Section 1. This act may be cited as the "Florida Families First Act."

Section 2. Section 383.014, Florida Statutes, is created to read:

383.014 Perinatal mental health care.—By January 1, 2019, the Department of Health shall:

(1) Establish and maintain a perinatal mental health care toll-free hotline, accessible to the general public, which:

(a) Provides basic information on postpartum depression

and perinatal care;

(b) May recommend that a caller or patient be further evaluated by a qualified health care provider; and

(c) May refer a caller or patient to an appropriate health care provider in the caller's or patient's local area.

(2) Establish and maintain a perinatal mental health care provider toll-free hotline for health care providers, as defined in s. 408.07, which:

(a) Provides information to assist health care providers in addressing the mental health of a pregnant or postpartum patient;

(b) Maintains and offers the contact information of health care providers throughout the state who have experience in caring for pregnant or postpartum patients; and

(c) Compiles resources to encourage the efficient and coordinated care of pregnant or postpartum patients.

(3) Create public service announcements (PSAs) to educate the public on perinatal mental health care. The PSAs must include the telephone number of the perinatal mental health care hotline established in subsection (1).

(4) Encourage mental health care providers, and health care providers who conduct postpartum evaluations or treat postpartum patients, to attend continuing medical education courses on perinatal mental health care.

Section 3. Subsection (3) of section 383.318, Florida

Statutes, is amended to read:

383.318 Postpartum care for birth center clients and infants.—

(3) The birth center shall provide a postpartum evaluation and followup care that includes all of the following ~~shall be provided, which shall include~~:

(a) Physical examination of the infant.

(b) Metabolic screening tests required by s. 383.14.

(c) Referral to sources for pediatric care.

(d) Maternal postpartum assessment that incorporates mental health screening.

(e) Information on postpartum depression and the telephone number of the perinatal mental health care hotline established in s. 383.014.

(f) ~~(e)~~ Instruction in child care, including immunization, breastfeeding, safe sleep practices, and possible causes of Sudden Unexpected Infant Death.

(g) ~~(f)~~ Family planning services.

(h) ~~(g)~~ Referral to secondary or tertiary care, as indicated.

Section 4. Section 395.1053, Florida Statutes, is amended to read:

395.1053 Postpartum care and education.—A hospital that provides birthing services is encouraged to provide a postpartum evaluation and followup care that includes all of the following:

(1) Physical examination of the infant.

(2) Metabolic screening tests required by s. 383.14.

(3) Referral to sources for pediatric care.

(4) Maternal postpartum assessment that incorporates mental health screening.

(5) Information on postpartum depression and the telephone number of the perinatal mental health care hotline established in s. 383.014.

(6) Instruction in child care, including immunization, breastfeeding, ~~shall incorporate information on~~ safe sleep practices, and ~~the~~ possible causes of Sudden Unexpected Infant Death ~~into the hospital's postpartum instruction on the care of newborns~~.

(7) Family planning services.

(8) Referral to secondary or tertiary care, as indicated.

Section 5. This act shall take effect July 1, 2018.

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	_____

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Nuñez offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. This act may be cited as the "Florida Families First Act."

Section 2. Section 383.014, Florida Statutes, is created to read:

383.014 Perinatal mental health care.—By January 1, 2019, the Department of Health shall offer perinatal mental health care information through the Family Health Line toll-free hotline, accessible to the general public, which:

(1) Provides basic information on postpartum depression;

(2) May recommend that a caller be further evaluated by a qualified health care provider; and

(3) May refer a caller to an appropriate health care provider in the caller's local area.

Section 3. Section 383.318, Florida Statutes, is amended to read:

383.318 Postpartum care for birth center clients and infants.—

(3) The birth center shall provide a postpartum evaluation and followup care that includes all of the following ~~shall be provided, which shall include~~:

(a) Physical examination of the infant.

(b) Metabolic screening tests required by s. 383.14.

(c) Referral to sources for pediatric care.

(d) Maternal postpartum assessment that incorporates mental health screening.

(e) Information on postpartum depression and the telephone number of the Family Health Line operated pursuant to s. 383.01.

(f) ~~(e)~~ Instruction in child care, including immunization, breastfeeding, safe sleep practices, and possible causes of Sudden Unexpected Infant Death.

(g) ~~(f)~~ Family planning services.

(h) ~~(g)~~ Referral to secondary or tertiary care, as indicated.

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

Remove everything before the enacting clause and insert:
An act relating to perinatal mental health; providing a short title; creating s. 383.014, F.S.; requiring the Department of Health to offer perinatal mental health care information through the Family Health Line toll-free hotline accessible to the general public; amending s. 383.318, F.S.; revising components that are included in the postpartum evaluation and followup care provided by birth centers to include a mental health screening and the provision of certain information on postpartum depression; providing an effective date.