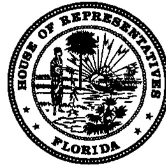
Committee on Health Quality

Tuesday, February 20, 2007
9:00 AM – 12:00 Noon
306 HOB

COMMITTEE MEETING PACKET

Marco Rubio
Speaker

Gayle Harrell
Chair



House of Representatives

Committee on Health Quality

AGENDA

February 20, 2007
9:00 AM – 12:00 PM
(306 HOB)

I. Opening Remarks

II. Consideration of the following bills:
- **a. HB 139 by H. Gibson and others -- Suicide Prevention**
- **b. HB 281 by Kreegel -- Paramedic Certification**
- **c. HB 469 by Hays and others -- Informed Consent**

III. Presentation by the Department of Health regarding DOH Performance Measures & Standards for FY 2006-2007

IV. Discussion of transparency initiatives with the Agency for Health Care Administration and the Florida Hospital Association

V. Workshop relating to Patient Safety Corporation duties

VI. Workshop relating to Idea #84, E-Prescribing

VII. Public Input on Constitutional Amendment 4, the Comprehensive Statewide Tobacco Education and Prevention Program

VIII. Closing Remarks & Adjournment

HB 139

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 139 Suicide Prevention
SPONSOR(S): Gibson and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 224

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Quality		Guy	Lowell
2) Healthcare Council			
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

The bill creates the Statewide Office for Suicide Prevention in the Office of Drug Control within the Executive Office of the Governor.

The bill requires the director of the Office of Drug Control to employ a coordinator for the Statewide Office of Suicide Prevention.

The bill requires the creation of a 27-member Suicide Prevention Coordinating Council within the Statewide Office of Suicide Prevention. Council membership consists of representatives from private sector organizations, agency secretaries and executive directors, and Governor's appointees. The council is required to develop a statewide plan for suicide prevention to coordinate and direct numerous suicide prevention initiatives.

The bill authorizes two FTEs, one of which is a coordinator for the office. The bill appropriates $150,000 in General Revenue to implement the provisions of the bill for fiscal year 2007-2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:
This bill does not appear to implicate any of the House Principles.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

In Florida, the tenth leading cause of death for the overall population is suicide, with 2,308 suicides in the state during 2005. Suicide is the third leading cause of death for 15-24 year olds, the second leading cause of death for 25-34 year olds, and the fifth leading cause of death for 35-44 year olds.[1] Florida is ranked 15th nationally for the number of suicides.[2]

In January 2005, the Office of Drug Control released a guidance document entitled, *Florida Suicide Prevention Strategy 2005-2010*. Among other things, the Strategy advocates for the adoption of a strategic, long-term approach to suicide prevention, which includes the formation of a statewide office for suicide prevention.

Currently, the Office of Drug Control has one staff member who acts as a suicide prevention coordinator. The coordinator distributes the Florida Suicide Prevention Strategy and assists in the implementation of goals and objectives stated within the document by facilitating communication among the numerous public and private entities whose mission is suicide prevention. This position is currently funded through grants to the Office of Drug Control.

Chapter 14, F.S., describes the organizational structure of the Executive Office of the Governor (EOG). Section 397.332, F.S., creates the Office of Drug Control inside the EOG. Chapter 20, F.S., defines several types of advisory bodies:

Name	Duration	Additional Comment
"Council" or "Advisory Council"	"[On] a continuing basis..."	Created by specific statutory enactment and intended to focus on a specific function or program area. Provides recommendations and policy alternatives.
"Committee" or "Task Force"	1 year (without specific statutory enactment); 3 years (with specific statutory enactment)	Appointed to study a particular problem and recommend a solution. Existence terminates upon completion of assignment.
"Coordinating Council"	Not explicitly stated.	An interdepartmental advisory body – one department has primary responsibility but other agencies have an interest.
"Commission"	Not explicitly stated.	Exercises quasi-legislative or quasi-judicial power, and its members must generally be confirmed by the Legislature.

Pursuant to s. 20.052, F.S., the creation of any new advisory body requires the following findings or requirements:

- It must be necessary and beneficial to the furtherance of a public purpose.

[1] Florida Vital Statistics Annual Report 2005.
[2] Suicide Data Page 2004, Report to the American Association of Suicidology.

- It must be terminated by the Legislature when it is no longer necessary and beneficial to the furtherance of a public purpose.
- The Legislature and the public must be kept informed of its activities and expenses.
- It meets a statutorily defined purpose.
- Its powers and responsibilities conform to the definitions for governmental units in s. 20.03, F.S. (outlined in the table above).
- Its members, unless expressly provided otherwise in the State Constitution, are appointed for 4-year staggered terms.
- Its members, unless expressly provided otherwise by specific statutory enactment, serve without additional compensation or honorarium, and are authorized to receive only per diem and reimbursement for travel expenses as provided in s. 112.061, F.S.

In addition, the agency head or the Governor appoints private citizen members of a committee or council. Private citizen members of a commission or board of trustees are appointed by the Governor and confirmed by the Legislature, and are subject to the dual-office-holding prohibition of s. 5(a), Art. II of the State Constitution. All meetings of any entity are public, and minutes must be kept. Public records are maintained by the agency under which the entity is created.

Effect of Proposed Changes

The bill creates the Statewide Office for Suicide Prevention ("office") in the Office of Drug Control and specifies duties for the office including:

- developing a network of community-based programs to improve suicide prevention initiatives;
- implementing a statewide plan for suicide prevention;
- increasing public awareness concerning topics relating to suicide prevention;
- coordinating education and training curricula in suicide prevention efforts for professionals who may have contact with persons at risk of committing suicide; and
- soliciting grants from federal, state, and local sources to fund operations and expenses of the office and the council.

The bill requires the office to employ a coordinator whose responsibility it is to achieve the office's goals and objectives as set forth in the bill.

The bill also creates a Suicide Prevention Coordinating Council ("council") of 27 members within the office. The council is required to develop a statewide plan for suicide prevention. Further, the council is required to prepare and submit an annual report to the Legislature and the Governor regarding suicide prevention programs, activities, and future initiatives.

Council membership is specified within the bill and includes: Office of Drug Control director appointees, who are from the private sector; state agency secretaries and executive directors; and appointees by the Governor. The bill specifies terms of office, a meeting schedule, and authorizes per diem and travel reimbursement for council members as authorized by s. 112.061, F.S.

C. SECTION DIRECTORY:

Section 1: Creates s. 14.2019, F.S., to create the Statewide Office for Suicide Prevention.

Section 2: Creates s. 14.20195, F.S., to create the Suicide Prevention Coordinating Council.

Section 3: Authorizes two FTEs and appropriates $150,000 in General Revenue to the Office of Drug Control to implement the provisions of the bill for fiscal year 2007-2008.

Section 4: Provides for an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill authorizes the office to seek grants and other methods of funding from federal, state and local sources.

2. Expenditures:

   The bill authorizes two FTEs, one of which is a coordinator for the office. The bill appropriates $150,000 in General Revenue to implement the provisions of the bill for fiscal year 2007-2008.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill will have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rule-making authority is required as a result of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

N/A.

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to suicide prevention; creating s.
3 14.2019, F.S.; creating the Statewide Office for Suicide
4 Prevention as a unit of the Office of Drug Control in the
5 Executive Office of the Governor; providing the goals and
6 objectives of the office; creating the position of
7 statewide coordinator for the statewide office, contingent
8 upon a specific appropriation; authorizing the Statewide
9 Office for Suicide Prevention to seek and accept grants or
10 funds from any source to support its operation; creating
11 s. 14.20195, F.S.; creating the Suicide Prevention
12 Coordinating Council within the Statewide Office for
13 Suicide Prevention; providing the scope of activities for
14 the coordinating council; authorizing the coordinating
15 council to assemble an ad hoc committee to advise the
16 coordinating council; providing for membership on the
17 coordinating council; providing an appropriation and
18 authorizing additional positions; providing an effective
19 date.
20
21 Be It Enacted by the Legislature of the State of Florida:
22
23 Section 1. Section 14.2019, Florida Statutes, is created
24 to read:
25 <u>14.2019 Statewide Office for Suicide Prevention.--</u>
26 <u>(1) The Statewide Office for Suicide Prevention is created</u>
27 <u>as a unit of the Office of Drug Control within the Executive</u>
28 <u>Office of the Governor.</u>

29 (2) The statewide office shall, within available
30 resources:
31 (a) Develop a network of community-based programs to
32 improve suicide prevention initiatives. The network shall
33 identify and work to eliminate barriers to providing suicide
34 prevention services to individuals who are at risk of suicide.
35 The network shall consist of stakeholders advocating suicide
36 prevention, including, but not limited to, not-for-profit
37 suicide prevention organizations, faith-based suicide prevention
38 organizations, law enforcement agencies, first responders to
39 emergency calls, suicide prevention community coalitions,
40 schools and universities, mental health agencies, substance
41 abuse treatment agencies, health care providers, and school
42 personnel.
43 (b) Implement the statewide plan prepared by the Suicide
44 Prevention Coordinating Council.
45 (c) Increase public awareness concerning topics relating
46 to suicide prevention.
47 (d) Coordinate education and training curricula in suicide
48 prevention efforts for law enforcement personnel, first
49 responders to emergency calls, health care providers, school
50 employees, and other persons who may have contact with persons
51 at risk of suicide.
52 (3) Contingent upon a specific appropriation, the director
53 of the Office of Drug Control shall employ a coordinator for the
54 Statewide Office for Suicide Prevention who shall work under the
55 direction of the director to achieve the goals and objectives
56 set forth in this section.

57 (4) The Statewide Office for Suicide Prevention may seek
58 and accept grants or funds from any federal, state, or local
59 source to support the operation and defray the authorized
60 expenses of the office and the Suicide Prevention Coordinating
61 Council.
62 (5) Agencies under the control of the Governor or the
63 Governor and Cabinet are directed, and all others are
64 encouraged, to provide information and support to the Statewide
65 Office for Suicide Prevention as requested.
66 Section 2. Section 14.20195, Florida Statutes, is created
67 to read:
68 14.20195 Suicide Prevention Coordinating Council;
69 creation; membership; duties.--There is created within the
70 Statewide Office for Suicide Prevention a Suicide Prevention
71 Coordinating Council. The council shall develop strategies for
72 preventing suicide.
73 (1) SCOPE OF ACTIVITY.--The Suicide Prevention
74 Coordinating Council is a coordinating council as defined in s.
75 20.03 and shall:
76 (a) Advise the Statewide Office for Suicide Prevention
77 regarding the development of a statewide plan for suicide
78 prevention, with the guiding principle being that suicide is a
79 preventable problem. The statewide plan must:
80 1. Align and provide direction for statewide suicide
81 prevention initiatives.
82 2. Establish partnerships with state and private agencies
83 for the purpose of promoting public awareness of suicide
84 prevention.

85 3. Address specific populations in this state who are at
86 risk for suicide.
87 4. Identify ways to improve access to help individuals in
88 acute situations.
89 5. Identify resources to support the implementation of the
90 statewide plan.
91 (b) Assemble an ad hoc advisory committee comprised of
92 members from outside the council, if necessary, in order for the
93 council to receive advice and assistance in carrying out its
94 responsibilities.
95 (c) Make findings and recommendations regarding suicide
96 prevention programs and activities. The council shall prepare an
97 annual report and present it to the Governor, the President of
98 the Senate, and the Speaker of the House of Representatives by
99 January 1, 2008, and each year thereafter. The annual report
100 must describe the status of existing and planned initiatives
101 identified in the statewide plan for suicide prevention and any
102 recommendations arising therefrom.
103 (2) MEMBERSHIP.--The Suicide Prevention Coordinating
104 Council shall consist of 28 voting members.
105 (a) Fourteen members shall be appointed by the director of
106 the Office of Drug Control and shall represent the following
107 organizations:
108 1. The Substance Abuse and Mental Health Corporation
109 described in s. 394.655.
110 2. The Florida Association of School Psychologists.
111 3. The Florida Sheriffs Association.
112 4. The Suicide Prevention Action Network USA.

113 5. The Florida Initiative of Suicide Prevention.
114 6. The Florida Suicide Prevention Coalition.
115 7. The Alzheimer's Association.
116 8. The Florida School Board Association.
117 9. Volunteer Florida.
118 10. The state chapter of AARP.
119 11. The Florida Alcohol and Drug Abuse Association.
120 12. The Florida Council for Community Mental Health.
121 13. The Florida Counseling Association.
122 14. NAMI Florida.
123 (b) The following state officials or their designees shall
124 serve on the coordinating council:
125 1. The Secretary of Elderly Affairs.
126 2. The Secretary of Health.
127 3. The Commissioner of Education.
128 4. The Secretary of Health Care Administration.
129 5. The Secretary of Juvenile Justice.
130 6. The Secretary of Corrections.
131 7. The executive director of the Department of Law
132 Enforcement.
133 8. The executive director of the Department of Veterans'
134 Affairs.
135 9. The Secretary of Children and Family Services.
136 10. The director of the Agency for Workforce Innovation.
137 (c) The Governor shall appoint four additional members to
138 the coordinating council. The appointees must have expertise
139 that is critical to the prevention of suicide or represent an
140 organization that is not already represented on the coordinating

141 council.
142 (d) For the members appointed by the director of the
143 Office of Drug Control, seven members shall be appointed to
144 initial terms of 3 years, and seven members shall be appointed
145 to initial terms of 4 years. For the members appointed by the
146 Governor, two members shall be appointed to initial terms of 4
147 years, and two members shall be appointed to initial terms of 3
148 years. Thereafter, such members shall be appointed to terms of 4
149 years. Any vacancy on the coordinating council shall be filled
150 in the same manner as the original appointment, and any member
151 who is appointed to fill a vacancy occurring because of death,
152 resignation, or ineligibility for membership shall serve only
153 for the unexpired term of the member's predecessor. A member is
154 eligible for reappointment.
155 (e) The director of the Office of Drug Control shall be a
156 nonvoting member of the coordinating council and shall act as
157 chair.
158 (f) Members of the coordinating council shall serve
159 without compensation. Any member of the coordinating council who
160 is a public employee is entitled to reimbursement for per diem
161 and travel expenses as provided in s. 112.061.
162 (3) MEETINGS.--The coordinating council shall meet at
163 least quarterly or upon the call of the chair. The council
164 meetings may be held via teleconference or other electronic
165 means.
166 Section 3. Two full-time equivalent positions are
167 authorized and the sum of $150,000 is appropriated from the
168 General Revenue Fund to the Office of Drug Control for the

169 purpose of implementing this act during the 2007-2008 fiscal
170 year.
171 Section 4. This act shall take effect July 1, 2007.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 281 Paramedic Certification
SPONSOR(S): Kreegel
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Quality		Guy	Lowell
2) Healthcare Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 281 adds physician assistants within the list of healthcare practitioners who are exempt from certain requirements for paramedic certification.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

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

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Emergency Medical Technicians and Paramedics

Part III, chapter 401, Florida Statutes, provides for the regulation of emergency medical technicians and paramedics by the Department of Health ("department"). Any person who wishes to be certified as an emergency medical technician or paramedic must apply to the department, under oath, on forms provided by the department. An applicant for certification must do the following:

- complete the most recent emergency medical technician or paramedic training course as provided for by the United States Department of Transportation and as approved by the department;
- with respect to paramedics, within 1 year after course completion, pass a state-developed certification examination;
- with respect to emergency medical technicians, within 1 year after course completion, pass the National Registry of Emergency Medical Technicians-developed certification examination;
- certify under oath that he or she is not addicted to alcohol or any controlled substance;
- certify under oath that he or she is free from any physical or mental defect or disease that might impair the applicant's ability to perform his or her duties;
- with respect to paramedic certification, hold a certificate of successful course completion of advanced cardiac life support from the American Heart Association or the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS);
- with respect to emergency medical technician certification, hold either a current American Heart Association, American Red Cross or the (CECBEMS) cardiopulmonary resuscitation course card.

Emergency medical technicians and paramedics must renew their certification on a biennial basis. Renewal candidates are subject to continuing education requirements and demonstration of current certifications. Renewal candidates must take 30 hours of refresher training in their respective area and an additional 2 hours of HIV AIDS training as well.[1]

There are approximately 18,456 paramedics and 30,010 emergency medical technicians (EMTs) in Florida.[2] Each paramedic and emergency medical technician employed within an emergency medical services system must operate under the direct supervision of a physician medical director, or indirectly by standing orders or protocols. Each emergency medical system agency employs or contracts with a physician medical director to provide this medical oversight and quality assurance. The larger emergency medical system providers in Florida have over 1,000 emergency medical technicians and paramedics on staff, all of them working under one medical director.

[1] Certification renewal requirements for paramedics and emergency medical technicians may be found in 64E-2.009 and 64E-2.008, Florida Administrative Code, respectively.

[2] Florida Department of Health, Division of Medical Quality Assurance Annual Report 2005-2006.

Medical directors must supervise and assume direct responsibility for the medical performance of the emergency medical technicians and paramedics, and must perform duties including advising, consulting, training, counseling, and overseeing of services. This includes appropriate quality assurance but does not include administrative or managerial functions. Each medical director is required to establish a quality assurance committee to provide reviews of all emergency medical technicians and paramedics operating under the director's supervision.

Physician Assistants

Sections 458.347(7), and 459.022(7), F.S., govern the licensure of physician assistants in Florida. Physician assistants are licensed by the department and are regulated by the Florida Board of Medicine or the Florida Board of Osteopathic Medicine. Among other requirements, an applicant for licensure as a physician assistant must demonstrate passage of the National Commission on Certification of Physician Assistants examination and submit certification of completion of a physician assistant training program. Fees for licensure and renewal are set in statute. Applicants for renewal must complete 100 hours of continuing medical education every two years or hold a current certification issued by the National Commission on Certification of Physician Assistants.

There are currently 3,675 active, licensed physician assistants practicing in the state of Florida.[3]

Paramedic Certification for Physicians, Dentists, and Nurses

Section 401.27(7), F. S., authorizes a physician, dentist, or registered nurse to be certified as a paramedic if the practitioner is certified as an emergency medical technician and successfully completes the emergency medical technician course, the paramedic examination, and an advanced cardiac life support course. However, a physician, dentist, or registered nurse is not required to complete the paramedic training course.

Once certified as a paramedic, physicians, dentists, and registered nurses are still subject to all criteria for licensure and renewal of licensure in their respective practice acts.

Effect of Proposed Changes

The bill extends the paramedic training course exemption for practitioners contained in s. 401.27(7), F.S., to physician assistants. Physician assistants would be subject to the same process for certification as other practitioners listed in s. 401.27(7), F.S. In addition, physician assistants are licensed by the department and thus would be subject to all criteria for licensure or renewal of licensure as a physician assistant while certified as a paramedic.

According to department staff, certification of physician assistants as paramedics will not increase the workload for department staff and consequently will not result in a significant fiscal impact on the department.

C. SECTION DIRECTORY:

Section 1: Amends s. 401.27, F.S., to allow physician assistants to be certified as paramedics.

Section 2: Provides for an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[3] The Florida Department of Health, Division of Medical Quality Assurance Annual Report 2005-2006.

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill will have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rule-making authority is required as a result of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

N/A.

D. STATEMENT OF THE SPONSOR

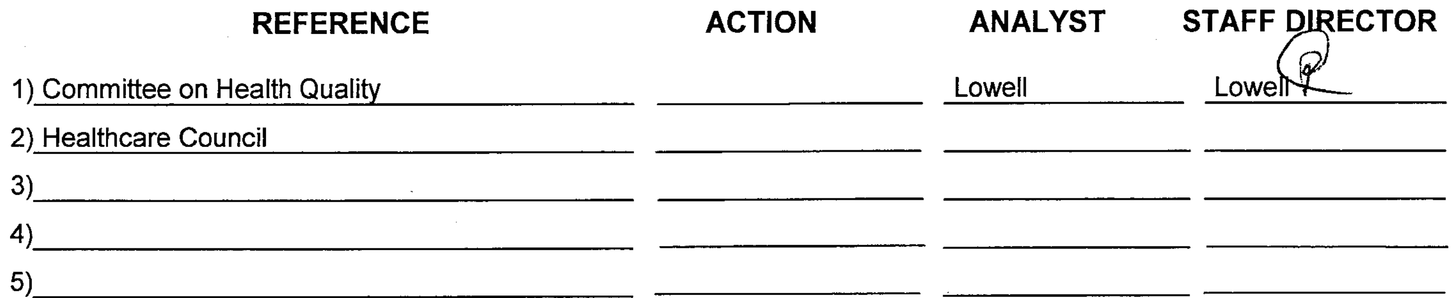
No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to paramedic certification; amending s.
3 401.27, F.S.; authorizing physician assistants who meet
4 specified criteria to be certified as paramedics;
5 providing an effective date.
6
7 Be It Enacted by the Legislature of the State of Florida:
8
9 Section 1. Subsection (7) of section 401.27, Florida
10 Statutes, is amended to read:
11 401.27 Personnel; standards and certification.--
12 (7) A physician, physician assistant, dentist, or
13 registered nurse may be certified as a paramedic if the
14 physician, physician assistant, dentist, or registered nurse is
15 certified in this state as an emergency medical technician, has
16 passed the required emergency medical technician curriculum, has
17 successfully completed an advanced cardiac life support course,
18 has passed the examination for certification as a paramedic, and
19 has met other certification requirements specified by rule of
20 the department. A physician, physician assistant, dentist, or
21 registered nurse so certified must be recertified under this
22 section.
23 Section 2. This act shall take effect July 1, 2007.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 469 Informed Consent
SPONSOR(S): Hays and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1508



REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Quality		Lowell	Lowell
2) Healthcare Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

This bill adds advanced registered nurse practitioners and physician assistants to the list of health care practitioners who are immune from a civil recovery under s. 401.445, F.S., emergency examination and treatment of incapacitated persons, and s. 766.103, F.S., the Florida Medical Consent Law.

This bill may implicate Article I, section 21 of the Florida Constitution, the right of access to the courts, by barring a civil recovery against advanced registered nurse practitioners and physician assistants under specific circumstances.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

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

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Advanced Registered Nurse Practitioners

Nurses are licensed and regulated by the Board of Nursing pursuant to part I of chapter 464, F.S. There are approximately 10,305 Advanced Registered Nurse Practitioners (ARNPs) in Florida[1]. ARNPs practice under a protocol with a supervising physician and are not required to be under direct supervision.

ARNPs perform medical acts of diagnosis, treatment, and operation pursuant to a protocol between the ARNP and a Florida-licensed medical doctor, osteopathic physician, or dentist. The degree and method of supervision is determined by the ARNP and the supervisor, must be appropriate for prudent health care providers under similar circumstances, and must be specifically identified in a written protocol.

Paramedics and Emergency Medical Technicians

Paramedics and emergency medical technicians are regulated under chapter 401, F.S., Medical Transportation and Services. There are approximately 18,456 paramedics and 30,010 emergency medical technicians (EMTs) in Florida[2]. Each paramedic and EMT employed within an Emergency Medical Services (EMS) system must operate under the direct supervision of a physician medical director, or indirectly by standing orders or protocols. Each EMS agency employs or contracts with a physician medical director to provide this medical oversight and quality assurance. The larger EMS providers in Florida have over 1,000 EMTs and paramedics on staff, all of them working under one medical director.

Medical directors must supervise and assume direct responsibility for the medical performance of the EMTs and paramedics, and must perform duties including advising, consulting, training, counseling, and overseeing of services. This includes appropriate quality assurance but does not include administrative or managerial functions. Each medical director is required to establish a quality assurance committee to provide reviews of all EMTs and paramedics operating under the director's supervision.

Physician Assistants

Sections 458.347(7), and 459.022(7), F.S., govern the licensure of physician assistants in Florida. Physician assistants are licensed by the department and regulated by either the Florida Board of Medicine or the Florida Board of Osteopathic Medicine. Among other requirements, an applicant for licensure as a physician assistant must demonstrate passage of the National Commission on Certification of Physician Assistants examination and submit certification of completion of a physician assistant training program. Applicants for renewal must complete 100 hours of continuing medical education every two years or hold a current certification issued by the National Commission on Certification of Physician Assistants.

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[1] The Florida Department of Health, Division of Medical Quality Assurance Annual Report 2005-2006.

[2] *Id.*

There are currently 3,675 active, licensed physician assistants practicing in the state of Florida.[3]

Informed Consent

In general, a health care practitioner may not treat a patient without his or her informed consent. In Florida, this general principle is codified in what is known as the "Florida Medical Consent Law."[4] This law prohibits a civil recovery for treating, examining, or operating upon a patient without his or her informed consent against a physician, chiropractic physician, podiatric physician, or dentist ("health care practitioners") under two circumstances.

In the first circumstance, the civil recovery is barred when:

- The action of the health care practitioner, in obtaining the consent of the patient or a person authorized to give consent for the patient, was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community; and
- A reasonable individual, from the information provided by the health care practitioner under the circumstances would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other health care practitioners in the same or similar community who perform similar treatments of procedures.

In the alternative, a civil recovery is also barred when the patient would reasonably, under the circumstances, have undergone such treatment or procedure had he or she been advised by the health care practitioner in the manner noted above.

Written consent to medical treatment given by a patient or another authorized person is presumptively valid.

Florida Patient's Bill of Rights and Responsibilities

Florida law delineates information that must be provided to the patient within the Patient's Bill of Rights and Responsibilities[5]. These rights include the right of a patient:

- To know the name, function, and qualifications of each health care provider who is providing medical services to the patient;
- To be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information; and
- To refuse any treatment based on information required by this paragraph, except as otherwise provided by law.

Emergency Examination and Treatment of Incapacitated Persons

Florida law also bars a civil recovery for an emergency examination or treatment without the patient's informed consent by an emergency medical technician, paramedic, physician, or any person acting under the direct medical supervision of a physician[6]. This immunity is available where the patient:

- At the time of examination or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent under s. 766.103, F.S.;

[3] *Id.*
[4] s. 766.103, F.S.
[5] s. 381.026, F.S.
[6] s. 401.445, F.S.

- At the time of examination or treatment is experiencing an emergency medical condition; and
- Would reasonably, under the circumstances, undergo the examination, treatment, or procedure if he or she were advised by the emergency medical technician, paramedic, or physician under s. 766.103, F.S.

An examination or treatment must be limited to a reasonable examination of the patient to determine his or her medical condition and treatment reasonably necessary to alleviate the emergency medical condition or to stabilize the patient. If the patient reasonably appears to be incapacitated and refuses consent, the patient may be examined or treated if he or she needs emergency attention; however, unreasonable force may not be used.

Effect of Proposed Changes

The bill adds advanced registered nurse practitioners and physician assistants to the list of health care practitioners who are immune from a civil recovery under the Florida Medical Consent Law as well as s. 401.445, F.S., emergency examination and treatment of incapacitated persons.

C. SECTION DIRECTORY:

Section 1. Amends s. 401.445, F.S., relating to immunity for medical personnel for emergency examination and treatment without consent of the patient.

Section 2. Amends s. 766.103, F.S., relating to immunity for medical personnel under the medical consent law.

Section 3. Provides an effective date of July 1, 2007.

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:

This bill may protect a larger number of health care practitioners from civil lawsuits, and thus large monetary judgments, where informed consent is at issue.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill will have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

2. Other:

   This bill may implicate Article I, section 21 of the Florida Constitution, which states that the courts "shall be open to every person for redress of any injury, and justice shall be administered without sale, denial, or delay." The test for ensuring the right of access to the courts was declared in *Kluger v. White*, 281 So.2d 1 (Fla. 1973), in which the Florida Supreme Court held that the Legislature is without power to abolish or otherwise restrict a statutory law right that predated the adoption of the constitution or a common law right without providing a reasonable alternative remedy, unless there is a showing of an overpowering public necessity to limit or abolish such right and no alternative remedy of meeting such public necessity exists.

   The Florida Supreme Court refined the *Kluger* test in *Smith v. Department of Ins.*, 507 So.2d 1080 (Fla. 1986). There, comprehensive tort reform legislation capping non-economic damages at $450,000 was challenged on the basis that it denied claimants access to the courts. In that case, the Court noted the *Kluger* test requires either (1) providing a reasonable alternative remedy or commensurate benefit, or (2) a legislative showing of overpowering public necessity for the abolishment of the right *and* no alternative method of meeting such public necessity. The Court noted that the right to sue and recover non-economic damages of any amount existed at the time the Florida Constitution was adopted. Consequently, the Court found the cap on non-economic damages unconstitutional as the Legislature did not provide an alternative remedy or commensurate benefit and the parties did not assert the existence of an overpowering public necessity.

B. RULE-MAKING AUTHORITY:

No additional rule-making authority is required as a result of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Paragraph (a)2. of subsection (3), section 766.103, F.S., appears to contain a drafting error. The end of the paragraph reads, "which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; or"; this language fails to reference advanced registered nurse practitioners or physician assistants.

D. STATEMENT OF THE SPONSOR

This bill will enhance access to medical care by more fully utilizing the skills and talents of our Physician Assistants and our Advanced Registered Nurse Practitioners.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to informed consent; amending s. 401.445,
3 F.S.; adding additional medical personnel to provisions
4 allowing immunity for certain emergency examination and
5 treatment of incapacitated persons done without consent if
6 informed consent would have reasonably been given under
7 the medical consent law; conforming provisions; amending
8 s. 766.103, F.S.; adding additional medical personnel to
9 the medical consent law; providing an effective date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Subsections (1) and (2) of section 401.445,
14 Florida Statutes, are amended to read:
15 401.445 Emergency examination and treatment of
16 incapacitated persons.--
17 (1) No recovery shall be allowed in any court in this
18 state against any emergency medical technician, paramedic, or
19 physician as defined in this chapter, any advanced registered
20 nurse practitioner certified under s. 464.012, or any physician
21 assistant licensed under s. 458.347 or s. 459.022, or any person
22 acting under the direct medical supervision of a physician, in
23 an action brought for examining or treating a patient without
24 his or her informed consent if:
25 (a) The patient at the time of examination or treatment is
26 intoxicated, under the influence of drugs, or otherwise
27 incapable of providing informed consent as provided in s.
28 766.103;

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

29 (b) The patient at the time of examination or treatment is
30 experiencing an emergency medical condition; and
31 (c) The patient would reasonably, under all the
32 surrounding circumstances, undergo such examination, treatment,
33 or procedure if he or she were advised by the emergency medical
34 technician, paramedic, ~~or~~ physician, advanced registered nurse
35 practitioner, or physician assistant in accordance with s.
36 766.103(3).
37
38 Examination and treatment provided under this subsection shall
39 be limited to reasonable examination of the patient to determine
40 the medical condition of the patient and treatment reasonably
41 necessary to alleviate the emergency medical condition or to
42 stabilize the patient.
43 (2) In examining and treating a person who is apparently
44 intoxicated, under the influence of drugs, or otherwise
45 incapable of providing informed consent, the emergency medical
46 technician, paramedic, ~~or~~ physician, advanced registered nurse
47 practitioner, or physician assistant, or any person acting under
48 the direct medical supervision of a physician, shall proceed
49 wherever possible with the consent of the person. If the person
50 reasonably appears to be incapacitated and refuses his or her
51 consent, the person may be examined, treated, or taken to a
52 hospital or other appropriate treatment resource if he or she is
53 in need of emergency attention, without his or her consent, but
54 unreasonable force shall not be used.
55 Section 2. Subsection (3) of section 766.103, Florida
56 Statutes, is amended to read:

57 766.103 Florida Medical Consent Law.--
58 (3) No recovery shall be allowed in any court in this
59 state against any physician licensed under chapter 458,
60 osteopathic physician licensed under chapter 459, chiropractic
61 physician licensed under chapter 460, podiatric physician
62 licensed under chapter 461, ~~or~~ dentist licensed under chapter
63 466, advanced registered nurse practitioner certified under s.
64 464.012, or physician assistant licensed under s. 458.347 or s.
65 459.022 in an action brought for treating, examining, or
66 operating on a patient without his or her informed consent when:
67 (a)1. The action of the physician, osteopathic physician,
68 chiropractic physician, podiatric physician, ~~or~~ dentist,
69 advanced registered nurse practitioner, or physician assistant
70 in obtaining the consent of the patient or another person
71 authorized to give consent for the patient was in accordance
72 with an accepted standard of medical practice among members of
73 the medical profession with similar training and experience in
74 the same or similar medical community; and
75 2. A reasonable individual, from the information provided
76 by the physician, osteopathic physician, chiropractic physician,
77 podiatric physician, ~~or~~ dentist, advanced registered nurse
78 practitioner, or physician assistant, under the circumstances,
79 would have a general understanding of the procedure, the
80 medically acceptable alternative procedures or treatments, and
81 the substantial risks and hazards inherent in the proposed
82 treatment or procedures, which are recognized among other
83 physicians, osteopathic physicians, chiropractic physicians,

84 podiatric physicians, or dentists in the same or similar
85 community who perform similar treatments or procedures; or
86 (b) The patient would reasonably, under all the
87 surrounding circumstances, have undergone such treatment or
88 procedure had he or she been advised by the physician,
89 osteopathic physician, chiropractic physician, podiatric
90 physician, ~~or~~ dentist, advanced registered nurse practitioner,
91 or physician assistant in accordance with the provisions of
92 paragraph (a).
93 Section 3. This act shall take effect July 1, 2007.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **0469**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ____

---

1 Council/Committee hearing bill: Committee on Health Quality

2 Representative Hays offered the following:

3

4 **Amendment**

5 Remove line 84 and insert:

6 podiatric physicians, ~~or~~ dentists, advanced registered nurse

7 practitioners, or physician assistants in the same or similar

Department of Health
Performance Measurement

February 20, 2007

Meade Grigg
Florida Department of Health

Overview

The Department of Health maintains an extensive system of performance measures. Measures for Performance Based Program Planning (PB2) are just a sub-set of measures used. These include:

Outcome Measures: Population health status measures such as infant mortality rates or infectious disease incidence rates;

Process Measures: Include performance measures of a work process such as the percent of TB patients completing therapy, timeliness of services provided, and efficiency measures;

Output and Workload Measures: Includes measures of number of clients served and number of services provided.

Performance Based Program Budgeting Performance Measures

- Executive agencies in Florida currently operate under performance-based program budgets (PB^2).
- Under PB^2 the agencies, in conjunction with EOG and the Legislature, set a series of performance targets on an annual basis.
- Agencies then report on actual prior year performance compared to the targets through the Legislative Budget Request process.

Development of Measures

- Collaborative exercise among between DOH Legislative staff of House and Senate, the Governor's Office, and OPPAGA (1998);
- Began with an array of outcome, process, and output measures for all agency programs;
- Was refined through workgroup meetings to a subset of key measures with policy implications.

Measures Organized by Focus Area/ Budget Entity

- Infectious Disease Control;
- Family Health/Primary Care;
- Environmental Health;
- Children's Medical Services;
- Regulation of Health Care Practitioners;
- Public Health Support (Labs, Pharmacy, etc.).

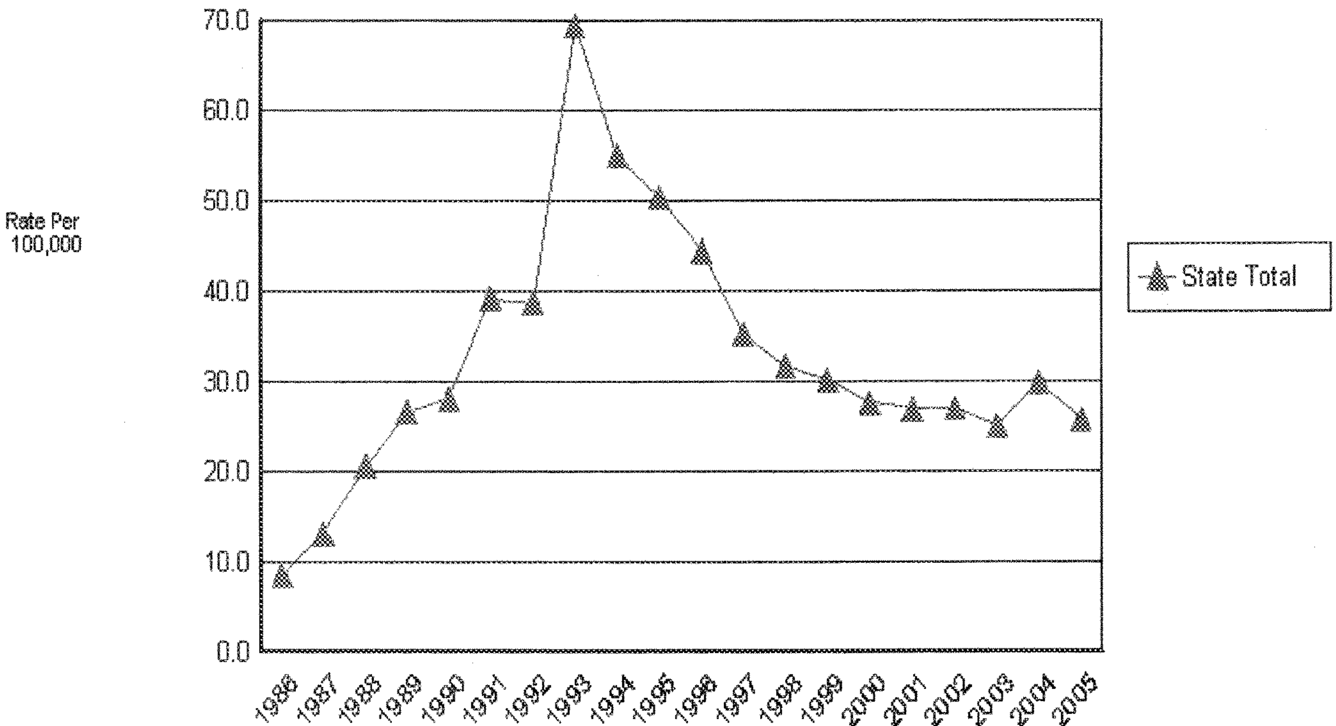
Performance Measure Uses

- Shows where Florida stands compared to national data and to similar states (Texas, California, New York);
- Shows trends -- are we gaining or losing?
- Provides insight into whether current intervention strategies are working.
- Worsening performance "red flags" an issue for agency and policymaker attention.

Example – AIDS Cases per 100,000

Provides insight into:

- Prevalence of AIDS;
- Quality of care for HIV-infected persons;
- Effectiveness of prevention efforts;
- Quality of surveillance;
- Changes in high risk groups.



FloridaCHARTS.com is provided by the Florida Department of Health, Office of Planning, Evaluation and Data Analysis, (850) 245-4009

Data Source: Florida Department of Health, Bureau of HIV/AIDS.

Rates calculated using July 1 population estimates from the Florida Legislature, Office of Economic and Demographic Research.

AIDS Rate Increases?
Utilize Health Problem Analysis

- More effective surveillance?
- Increase in high risk behaviors?
- Ineffective medical treatment?
- Analyze contributing factor performance data to identify problem areas – part of the performance assessment process.

AIDS Case Rate Performance

- Exceeded targets two of the last three years.
- Missed 2004-05 target due to improvements in surveillance (but how do we know?)
- Increased emphasis on surveillance resulted in increased CD4 testing and increased laboratory reporting;
- HIV/AIDS deaths actually decreased;
- Increases were seen in all age, sex, race, and residence groups – a true increase would first be seen in specific subgroups.

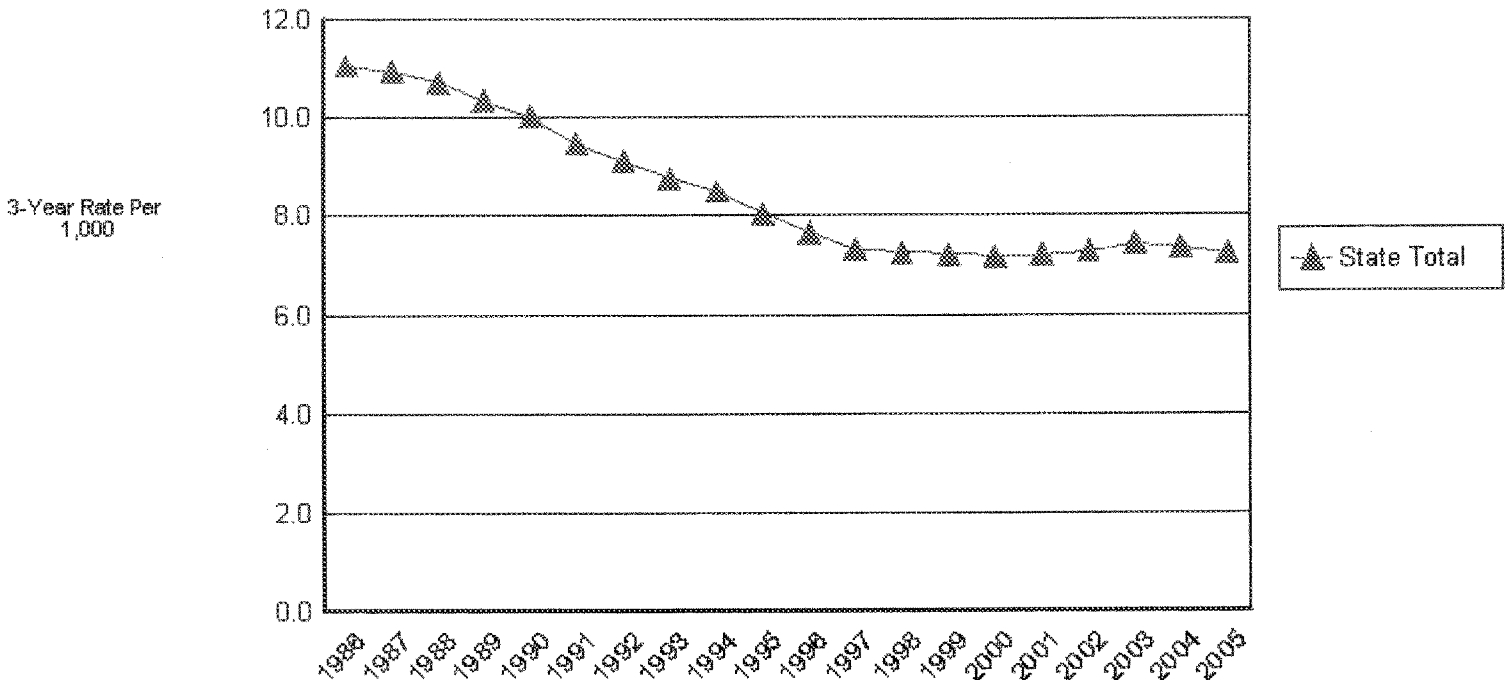
Example – Infant Mortality

Provides insight into:

- Access to care & quality of the health care system;
- Health status of reproductive age women;
- Magnitude of racial disparities;
- Newly emerging risk factors;
- Effectiveness of current intervention strategies.

Infant Mortality Increases?

- Analyze Measures Related to Risk Factors
- Problems accessing care (trimester of entry into prenatal care, number of visits, etc.)?
- Decrease in maternal health status (obesity, prevalence of bacterial infections, age of mother, etc.)?
- Increase in risky behaviors (smoking, poor diet, unstable home, etc.)?



FloridaCHARTS.com is provided by the Florida Department of Health, Office of Planning, Evaluation and Data Analysis, (850) 245-4009

Data Source: Florida Department of Health, Office of Vital Statistics.

Data Note(s): Deaths occurring within 364 days of birth. Beginning in 2004, the state total for the denominator in this calculation may be greater than the sum of county totals due to an unknown county of residence on some records.

Infant Mortality Performance

Missed target two of three past years. Decline in infant mortality leveling off.

- Use of contributing factor performance data to adjust interventions:
- 1980s – lack of access to clinical prenatal care – became a priority;
- 1990s – need for non-clinical case management & education for at-risk pregnancies (Healthy Start);
- Now – need for pre- and inter-conceptual services to improve mother's health at time of conception.

Percent of Families Served by Children's Medical Services with a Positive Evaluation of Care

- Based on a nationally recognized instrument for measuring health care plans.
- Measures access to primary & specialty care providers;
- Evaluates continuity of care;
- Evaluates the quality of care coordination services

How Has the Evaluation Data been Used?

- Identified a decline in access to specialty care providers in certain regions;
- Identified a strong need for dental providers.
- As a result, Children's Medical Services placed a high priority on recruiting specialists in underserved areas and obtaining additional dental providers.

Performance – CMS Missed Targets the Past Three Years

- Evaluation scores have been between 93% and 94% the past three years;
- Target has been 96.6%;
- An evaluation score above 90% for a family with a chronically ill child is excellent;
- A missed target does not automatically equal poor performance.

Questions?

C. Meade Grigg

Director, Planning, Evaluation & Data Analysis

State Registrar of Vital Statistics

Department of Health

850-245-4009

Department of Health Performance Based Budgeting Measures

FAMILY HEALTH SERVICES	2005-06 Actual	2006-07 Target
Infant mortality rate per 1,000 live births	7.2	6.9
Nonwhite infant mortality rate per 1,000 nonwhite births	12.5	10.7
Percent of low birth weight births among prenatal Women, Infants and Children (WIC) program clients	8.76%	8.5
Live births to mothers age 15 - 19 per 1,000 females 15 - 19	41.9	41.5
Number of monthly participants-Women, Infants and Children (WIC) program	377,609	375,000
Number of daily child care food participants	151,342	167,118

INFECTIOUS DISEASE CONTROL SERVICES	2005-06 Actual	2006-07 Target
AIDS case rate per 100,000 population	27.1	28.0
HIV/AIDS resident total deaths per 100,000 population	9.5	9.0
Chlamydia case rate per 100,000 population	241.5	239.0
Tuberculosis case rate per 100,000 population	6.1	6.0
Immunization rate among 2 year olds	86.6	90.25%
Vaccine preventable disease rate per 100,000 population	0.54	0.42
Number of patient days (A.G. Holley tuberculosis hospital)	15,110	13,500

ENVIRONMENTAL HEALTH	2005-06 Actual	2006-07 Target
Food and waterborne disease outbreaks per 10,000 facilities regulated by the Department of Health	0.67	3.55
Overall sanitation and safety score in department regulated facilities	95.75%	94.0%
Septic tank failure rate per 1,000 within 2 years of system installation	3.77	3.5
Number of radiation facilities, devices and users regulated	74,162	75,148

COUNTY HEALTH DEPARTMENT OUTPUT MEASURES	2005-06 Actual	2006-07 Target
Number of school health services provided	17,867,203	19,146,639
Number of Healthy Start clients	248,422	235,771
Number of Family Planning clients	217,637	218,073
Immunization services	1,365,258	1,576,084
Number of sexually transmitted disease clients	100,286	97,598
Persons receiving HIV patient care from county health departments	11,850	12,821
Number of tuberculosis medical, screening, tests, test read services	289,467	324,775
Number of onsite sewage disposal systems inspected	452,336	383,837
Number of community hygiene services	117,573	96,100
Water system/storage tank inspections/plans reviewed.	242,948	278,170
Number of vital events recorded.	400,690	406,083

Department of Health Performance Based Budgeting Measures

STATEWIDE HEALTH SUPPORT SERVICES	2005-06 Actual	2006-07 Target
Percent saved on prescription drugs compared to market price	25.8%	27.7%
Percent of laboratory test samples passing routine proficiency testing	99%	100%
Number of birth, death, fetal death, marriage and divorce records processed	640,320	653,447

CHILDRENS MEDICAL SERVICES	2005-06 Actual	2006-07 Target
Percent of families served with a positive evaluation of care	93.6%	94.0%
Percent of CMS Network enrollees in compliance with the periodicity schedule for well child care	90.0%	91.0%
Percent of eligible infants/toddlers provided CMS early intervention services	95%	100%
Percent of Child Protection Team assessments provided to Family Safety/Preservation within established timeframes	91%	92%
Percent of hospitalizations for conditions preventable by good ambulatory care	13%	13%
Number of children enrolled in CMS Program Network (Medicaid and Non-Medicaid)	60,723	64,740
Number of children provided early intervention services	35,854	47,502
Number of children receiving Child Protection Team (CPT) assessments	25,709	25,123

MEDICAL QUALITY ASSURANCE	2005-06 Actual	2006-07 Target
Average number of days to issue nursing licenses	24	15
Number of licensees who are found to be practicing on a delinquent license	17	23
Amount of revenue collected from delinquent license fines	$17,400	$10,000
Number of cease and desist orders issued	195	130
Number of licenses that turn null and void	28,879	245,000
Percent of unlicensed cases referred for criminal prosecution	1.5%	1.5%
Number of unlicensed activities investigated	676	572
Number of licenses and renewals issued	439,569	1,041,000
Number of inquiries to practitioner profile website	1,511,583	2,000,000*
Percent of Priority I practitioner investigations resulting in emergency action	45.6%	30.0%
Average number of days to take emergency action on Priority I practitioner investigations	127	150
Percent of initial investigations and recommendations as to the existence of probable cause completed within 180 days of receipt	82%	90%
Number of practitioner complaints determined legally sufficient	9,661	7,500
Number of legally sufficient practitioner complaints resolved by findings of no probable cause	3,850	3,150
Number of legally sufficient practitioner complaints resolved by findings of no probable cause (letters of guidance)	1,632	1,300
Number of legally sufficient practitioner complaints resolved by findings of no probable cause (notice of noncompliance)	249	40
Number of legally sufficient practitioner complaints resolved by the issuance of citation for minor violations	1,117	775
Number of legally sufficient practitioner complaints resolved by findings of stipulations or informal hearings	1,909	1,700
Number of legally sufficient practitioner complaints resolved by findings of formal hearings	59	30
Average number of practitioner complaint investigations per FTE	351	352

Department of Health Performance Based Budgeting Measures

HEALTH CARE ACCESS AND TOBACCO	2005-06 Actual	2006-07 Target
Percent of emergency medical service providers found to be in compliance during licensure inspection	86%	86.00%
Number of medical students who do a rotation in a medically underserved area	5,292	5,598
Percent of individuals with brain and spinal cord injuries reintegrated to the community	84.3%	91.7%
Number of providers who receive continuing education	19,132	16,750
Number of emergency medical services providers licensed annually	263	262
Number of brain and spinal cord injured individuals served	2,941	2,985
Number of emergency medical technicians and paramedics certified	50,024	50,000

DISABILITY BENEFITS DETERMINATIONS	2005-06 Actual	2006-07 Target
Percent of disability determinations completed accurately as determined by the Social Security Administration	91.9%	94.3%
Number of disability determinations completed	226,496	249,608

ADMINISTRATIVE SUPPORT	2005-06 Actual	2006-07 Target
Agency administrative costs as a percent of total agency costs/ agency administrative positions as a percent of total agency positions	1.0%	0.8%*
Percent of middle and high school students who report using tobacco products in the last 30 days	16.9%	16.8%
Technology costs as a percent of total agency costs	1%	1%

Adverse Incident (Code 15) Reporting

Agency for Health Care Administration

Rebecca Knapp, Division of Health Quality Assurance

February 20, 2007

Agency Position on Reporting

- The Agency does not support moving Code 15 reporting to the Patient Safety Corporation because we believe the best interests of Floridians are served by aligning reporting with regulation.
- An important component of the Agency's ability to assure quality care is its ability to be aware of adverse incidents as soon as possible and to assure that the hospital has an effective risk management system. If we are not made aware of these incidents, we lose information necessary to our oversight responsibility. We also lose the ability to identify and change deficient practice through investigation and administrative action.

The PSC's Existing Voluntary Near Miss Reporting System

- Has low participation—at last count, only 18 providers were participating.
- This participation rate suggests that moving adverse incident reporting away from the regulatory organization is not the solution.

Requiring Root Cause Analysis and Anonymity of Reports

- We should allow the industry to speak for itself about its ability/willingness to do root cause analyses given existing definitions. Generally speaking, the more complicated the process, the lower the participation.
- Anonymous reports will not work to resolve deficient practices.

Alternative Suggestion

- AHCA would support a collaborative effort of all stakeholders, including the Patient Safety Corporation, to change the existing system within the Agency to make it useful and more effective.

Immediate Needs

- Change the definitions of adverse incidents to more specific measurable incidents—such as AHRQ guidelines.
- Revise the statute to eliminate the concept of "blame" inherent in current statutory wording, i.e., ***"an event over which health care personnel could exercise control…."***

Constitutional Amendment 4
Comprehensive Statewide Tobacco Education and Prevention Program

February 18, 2007

Testimony by the
Public Health Consortium for the Prevention of Tobacco Use (PHCPTU)
University of South Florida, Florida International University and the University of Florida

Good morning. I am pleased to have the opportunity to discuss the Public Health Consortium for the Prevention of Tobacco Use (PHCPTU) proposal to address tobacco control in Florida. I am Bob Frank and I represent Florida's three colleges of public health located at the University of South Florida, Florida International University and the University of Florida. The deans of each of these colleges of public health, Donna Petersen at USF, Michele Ciccazzo at FIU, and myself at UF have come together to propose collaborative programming to address tobacco's devastating health consequences.

The expertise among the faculty in Florida's public health colleges, if strategically deployed, can foster the state's efforts to combat tobacco use. In addition, the ability of the colleges to provide an educated public health workforce is critical to ongoing efforts to control tobacco use in Florida.

The three schools of public health in the State of Florida have expertise in all the areas identified in the recent constitutional amendment on tobacco programs as well as those identified in the Centers for Disease Control and Prevention best practice guidelines. Our three universities have come together to form the Florida Public Health Consortium to Prevent Tobacco Use. Because of the geographical distribution of the three universities, the Consortium will serve the entire state of Florida. The Consortium will develop programs, provide technical assistance, consultation, and program evaluation to state and local departments of health and to communities engaged in tobacco control efforts. In addition,

the Consortium will provide advanced training at the master's level, certificates and short courses on tobacco control.

Proposed Program

Funding of this proposal will allow each university to establish a technical assistance center with core staff to address local, state and regional tobacco issues. Each of the technical assistance centers will serve three areas:

- Tobacco control interventions and short courses on tobacco issues and other related public health issues that the State Department of Health and local health departments identify as needs. Such programs or courses could include social marketing, designing preventive interventions for specific target audiences, clinical guidelines for tobacco control, designing school-based curricula, developing effective coalitions, tobacco control enforcement strategies, project evaluation, among others.
- Design, or assistance in the design of,evaluation strategies for this effort statewide. In addition, the three centers will take responsibility for local and regional program evaluations. This effort will assure data necessary for monitoring program implementation, documenting achievement of desired outcomes, and evaluating the cost-effectiveness of the interventions as well as the overall effort. Program integrity and fiscal accountability will be maintained through a high quality evaluation strategy.
- Work with the State Department of Health and local health departments, and within the universities, to identify individuals interested in obtaining a master's degree in public health (MPH). With a specialty in tobacco prevention, individuals receiving scholarships through the Consortium will be expected to make a commitment to work in local health departments once they obtain the

MPH. The Consortium will design a model curriculum and share courses to optimize faculty expertise across the three universities.

University Resources Strengthen Services

The resources needed to create a college of public health are significant. To be accredited, a college must offer five faculty in each of the five core areas of public health and offer at least three doctoral programs. The expertise required to develop these programs is costly. Each of the three universities has made huge commitments to public health. The umbrella programs existing in each university provide considerable resources and expertise. Through the Florida Public Health Consortium to Prevent Tobacco Use and its technical assistance centers, this broad array of resources will be available to local departments of health and the State Department of Health.

The State of Florida, through investment in this Consortium, will develop valuable interventions and resources to tobacco use.

Anticipated Outcomes

- Statewide tobacco interventions in communities, regions and state-wide.
- Coordinated collaboration with the State Department of Health on major initiatives.
- Creation of expertise in the state public health workforce to address tobacco use. This program will create the most knowledgeable public health workforce in the United States. Once the program reaches maturity, 30 new individuals with MPH degrees and expertise in tobacco use will enter the workforce each year.
- Each technical assistance center will offer short courses to local health department employees and to others interested in gaining more knowledge of public health issues and will respond to technical assistance requests.
- Comprehensive program evaluation, cost effective analysis, and outcome data on tobacco initiatives throughout Florida.

Budget Request for 2007-08

Recurring funds: $1.5 million per university, $4.5 million total

The H. Lee Moffitt Cancer
Center & Research Institute

The H. Lee Moffitt Cancer Center & Research Institute, Inc.

A Unique Partnership with the State of Florida

Tobacco Research and Intervention Program
H. Lee Moffitt Cancer Center & Research Institute

Presentation To

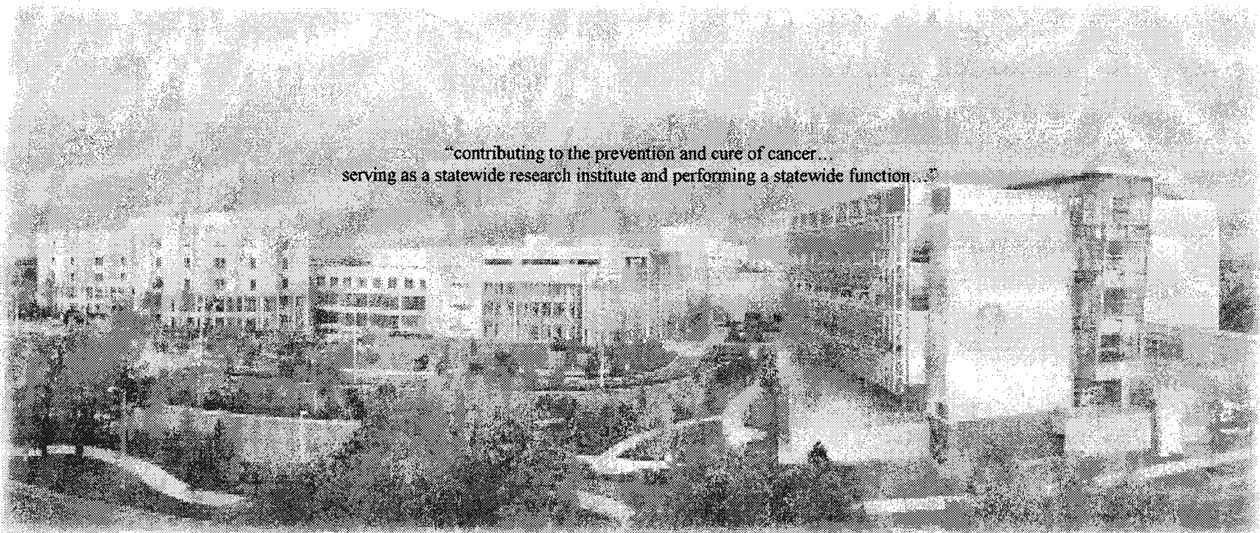
Florida House Committee on Health Quality

By

Thomas H. Brandon, Ph.D.

Director, Tobacco Research & Intervention Program,
H. Lee Moffitt Cancer Center & Research Institute
Professor of Psychology and Interdisciplinary Oncology,
University of South Florida

February 20, 2007



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February 20, 2007

Introduction

The Tobacco Research and Intervention Program is based at the H. Lee Moffitt Cancer Center & Research Institute, the only Florida-based cancer center designated by the National Cancer Institute as a Comprehensive Cancer Center. Moffitt has a legislative mandate to serve as a statewide research institute and to serve a statewide function to provide for the health and well-being of the citizens of Florida (Chapter 90-56; 93-167). The Cancer Center's sole mission is to *contribute the prevention and cure of cancer.*

The Tobacco Research and Intervention Program (TRIP) was created in 1997 to conduct a wide range of high-quality tobacco-related research. Studies include basic research into behavioral and cognitive factors that influence tobacco use; development of improved smoking cessation and relapse-prevention interventions; and development of interventions for unique subgroups of smokers, such as adolescents and pregnant/postpartum women. Research at TRIP has been funded by federal sources including the National Cancer Institute, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, as well as private foundations such as the American Cancer Society, the American Heart Association, the American Lung Association, and the Cancer Research and Prevention Foundation.

TRIP currently offers an empirically-based smoking cessation clinic to the Tampa Bay area community. Faculty and staff from TRIP provide consultation and education on tobacco-related matters throughout the state of Florida and nation.

Researchers at TRIP and the Moffitt Cancer Center have expertise in multiple aspects of tobacco use, but their unique strength is in the area of smoking cessation. Faculty members have served as: chair of California's panel that reviews tobacco grant applications; co-author of the Surgeon

General's Report on Nicotine Dependence; consultant on the Health and Human Services' Clinical Practice Guidelines for Treatment Tobacco Dependence; member of the National Institutes of Health review panel on addictions; editor of a leading scientific journal on addictions; chair of the 2005 international meeting of tobacco scientists in Prague; and developed interventions that have been adopted by the National Cancer Institute as well as health departments around the country. And while the Cancer Center has acted as a resource for these many national audiences, it our desire to bring the expertise of the TRIP team to bear on the smoking cessation efforts of the State of Florida.

The team includes six full-time doctoral-level scientists who are internationally recognized for their work and recipients of millions of dollars in competitive grants from the National Institutes of Health and foundations such as the American Cancer Society. Members serve on federal advisory panels, publish their work in top-tier journals and hold editorial positions and other respected offices in their fields. In addition, the team includes students and research staff dedicated solely to understanding the phenomenon of tobacco dependence and applying that knowledge to prevention and cessation efforts. The group also collaborates with other Moffitt Cancer Center faculty members who have complementary expertise in health communication, community outreach, statistical analysis, genetics and health economics.

Recommendation

The CDC Best Practice Guidelines for Comprehensive Tobacco Control Programs recommended for the implementation of Amendment 4 include a major role for tobacco cessation in creating a statewide tobacco education and prevention program. Cessation programs have the potential to benefit the nearly 3 million adult Floridians who currently smoke, as well as children and adolescents. Research has shown that cessation produces the most immediate health benefit and health-related cost savings.

The TRIP Program at Moffitt Cancer Center is one of the leading centers of expertise on tobacco cessation in the country. It is in the unique position of having a well-functioning, 10-year-old smoking cessation program with services that could be expanded to meet the needs of the entire state of Florida. An expansion of those services would include:

- Provide training and certification of smoking cessation counselors throughout Florida.
- Provide continuing education to health care providers on assessing and treating patients for tobacco dependence.
- Offer employers throughout Florida in-house smoking cessation services for their employees.
- Serve as a scientific resource to the Department of Health for consultation on tobacco cessation.
- Research and develop smoking cessation materials and interventions tailored to the unique needs of Florida and integrated with other state tobacco-control efforts.

<u>These services address the CDC Best Practices of (V) Statewide Programs and (VII) Cessation Programs.</u>

Project Details/Estimated Budget

(I) Provide training/certification of smoking cessation counselors throughout Florida. "Training the Trainers"

- 2- to 3-day training sessions held in Tampa and locations throughout Florida
- Aggressive outreach program
  - No charge to Florida-based employees (of health departments, hospitals, corporate human resources departments) with appropriate job titles and education.
  - Travel, per diem, meals, lodging, educational materials included.
- **Estimated annual costs: $600,000** ($2,000 per trainee; 300 trainees/year)
  - Costs include:
    - Personnel for planning, training, and scientific oversight
    - Covered costs for trainees (travel, per diem, meals, lodging, materials)
    - Promoting availability of service
    - Rental space for training sessions

(II) Provide continuing education to health care providers on assessing and treating patients for tobacco dependence.

- Health educators will travel to medical centers throughout the state to provide 1- to 2-hour continuing education programs to health care providers, based on current clinical practice guidelines and empirical research.
- No charge to providers or their organizations.
- **Estimated annual costs: $750,000** ($500 per trainee; 1500 trainees/year)
  - Costs include:
    - Personnel for planning, training, and scientific oversight
    - Travel by staff to sites throughout Florida
    - Costs of CEU credits by accrediting organizations
    - Educational materials distributed
    - Publicizing availability of this service

(III) Offer employers throughout Florida in-house smoking cessation services for their employees.

- Health educators will travel to employers throughout the state to provide 2 hours of smoking cessation counseling to groups of employees. The counseling will be based on current clinical practice guidelines and empirical evidence.
- No charge to employers or employees if at least 50 employees are seen on one day.
- For smaller groups, employer will cover staff travel expenses. (This will create incentives for employers to encourage their smokers to attend and for smaller employers to consolidate.)
- **Estimated annual costs: $500,000** ($100 per employee; 5000 employees/year)
  - Costs include:
    - Personnel for planning, training, and scientific oversight
    - Travel by staff to employers throughout Florida
    - Educational materials distributed
    - Publicizing availability of this service

(IV) Serve as a scientific resource to the Department of Health for consultation on tobacco cessation.

- Moffitt scientists are nationally-recognized experts on tobacco dependence, smoking cessation, and relapse prevention, whose expertise is drawn upon by various federal and state programs throughout the country. This line would provide dedicated time devoted to assisting the Department of Health and affiliated institutions.
- **Estimated annual costs: $35,000**
  - Cost includes:
    - 3% effort by Drs. Brandon, Drobes, Simmons, and Meade.
    - 5 trips to Tallahassee per year

(V) Research and develop smoking cessation materials and interventions tailored to the unique needs of Florida and integrated with other state tobacco-control efforts.

- Moffitt scientists have considerable expertise in developing intervention programs to meet special needs (e.g., relapse-prevention; pregnant and post-partum women; teens; Hispanic smokers). This line would provide regular R&D funding for Moffitt scientists to develop and test other innovative interventions that are particularly suited for Florida. Examples include interventions for Spanish-speaking populations; for the elderly; for medical patients; for institutionalized smokers; etc. Funds would cover costs of initial R&D work, leading to competitive NIH applications for full development and testing.
- **Estimated annual costs: $250,000** (covers approximately 2 projects/year)
  - Cost includes:
    - Scientist and research staff time.
    - Necessary equipment and supplies
    - Research-related expenses

Estimated Annual Costs For Five Projects: $2,135,000

Summary

Moffitt Cancer Center is eager to meet the challenges and opportunities that are presented by the passage of Amendment 4. Our recommendations draw upon successful models from other states. We also have attempted to avoid duplicating efforts already in place in Florida (e.g., the Smokers' Quitline). We would welcome discussing this further with your committee and staff.

Addendum 1:

Publications:

Research conducted at TRIP is published in peer-reviewed journals and other outlets. Below is a sample of recent publications by TRIP researchers since 2001.

1. Lopez, E., Simmons, V. N., Quinn, G. P, Meade, C. D., Chirikos, T. N. & Brandon, T. H. (in press). Clinical trials and tribulations: Lessons learned from recruiting pregnant ex-smokers for relapse prevention. *Nicotine and Tobacco Research.*
2. Simmons, V. N., Vidrine, J. I., & Brandon, T. H. (in press). Smoking cessation as a teachable moment for skin cancer prevention. *American Journal of Health Behavior.*
3. Lopez, E. N., Drobes, D. J., Thompson, J. K., & Brandon, T. (in press). Effects of a body image challenge on smoking motivation among college females. *Health Psychology.*
4. Steinberg, M. L., Krejci, J. A., Collett, K., Brandon, T. H., Chen, K., & Ziedonis, D. M. (in press). Self-reported task persistence is related to smoking status and quitting smoking in adolescents. *Addictive Behaviors.*
5. Brandon, T. H., Vidrine, J. I., & Litvin, E. B. (in press). Relapse and relapse prevention. *Annual Review of Clinical Psychology.*
6. Herzog, T. A. & Blagg, C. O. (in press). Are most precontemplators contemplating smoking cessation? Assessing the validity of the stages of change. *Health Psychology.*
7. Herzog, T. A. (in press). Are the stages of change for smokers qualitatively distinct? An analysis using an adolescent sample. *Psychology of Addictive Behaviors.*
8. Stasiewicz, P. R., Brandon, T. H., Bradizza, C. M. (in press). Effects of extinction context and retrieval cues on alcohol cue reactivity among alcohol dependent outpatients. *Psychology of Addictive Behaviors.*
9. Webb, M. S., Hendricks, P. S., & Brandon, T. H. (in press). Expectancy priming of smoking cessation messages enhances the placebo effect of tailored interventions. *Health Psychology.*
10. Simmons, V. N., & Brandon, T. H. (in press). Secondary smoking prevention in a university setting: A randomized comparison of an experiential theory-based intervention and a standard didactic intervention for increasing cessation motivation. *Health Psychology.*
11. Irvin, J. E., Simmons, V. N., & Brandon, T. H. (2007). Construction of smoking-relevant risk perceptions among college students: The influence of need for cognition and message content. *Journal of Applied Social Psychology*, 37, 91-114.
12. Lee, J-H, Herzog, T. A., Meade, C. D., Webb, M. S., & Brandon, T. H. (2007). Use of GEE for analyzing longitudinal binomial data: A primer using data from a tobacco intervention. *Addictive Behaviors*, 32, 187-193.
13. Callaghan, R.C. & Herzog, T.A. (2006). The relation between processes-of-change and stage-transition in smoking behavior: A two-year longitudinal test of the Transtheoretical Model. *Addictive Behaviors*, 31, 1331-1345.

14. Drobes, D.J., Elibero, A., & Evans, D.E. (2006). Attentional bias for smoking and affective stimuli: A Stroop task study. *Psychology of Addictive Behaviors*, 4, 490-495.
15. Upadhyaya, H.P., Drobes, D.J., & Wang, W. (2006). Reactivity to in vivo smoking cues in older adolescent cigarette smokers. *Nicotine & Tobacco Research*. 8, 135-140.
16. Hendricks, P. S., Ditre, J. W., Drobes, D. J., & Brandon, T. H. (2006). The early time course of smoking withdrawal effects. *Psychopharmacology*, 187, 385-395.
17. Quinn, G., Ellison, B. B., Meade, C., Roach, C. N., Lopez, E., Albrecht, T., & Brandon, T. H. (2006). Adapting smoking relapse-prevention materials for pregnant and postpartum women: Formative research. *Maternal and Child Health Journal*, 10, 235-245.
18. Brandon, T. H., & Brandon, K. O. (2005). Brother, can you spare a smoke? Sibling transmission of tobacco use. *Addiction*, 100, 439-440.
19. Colby, S.M., Drobes, D.J., & West, R. (2005). International advances in nicotine and tobacco research. *Nicotine & Tobacco Research*, 7, 667-709.
20. Drobes, D.J., Munafò, M.R., Leigh, F., & Saladin, M.E. (2005). A family smoking index to capture genetic influence in smoking: Rationale and two validation studies. *Nicotine & Tobacco Research*, 7, 41-46.
21. Hendricks, P. S., & Brandon, T. H. (2005). Smoking expectancy associates among college smokers. *Addictive Behaviors, 30, 235-245.*
22. Herzog, T.A. (2005). When popularity outstrips the evidence: Comment on West. *Addiction*, 100, 140-141.
23. Thomas, S., Drobes, D.J., & Dias, D. (2005). Alcohol cue reactivity in alcohol dependent adolescents. *Journal of Studies on Alcohol*, 66, 354-360.
24. Webb, M. S., Simmons, V. N., & Brandon, T. H. (2005). Tailored interventions for motivating smoking cessation: Using placebo-tailoring to examine the influence of personalization and expectancies. *Health Psychology*, 24, 179-188.
25. Anton, R.F., Drobes, D.J., Voronin, K., Durazo-Arvizu, R., & Moak, D. (2004). Naltrexone effects on alcohol consumption in a clinical laboratory paradigm: Temporal effects of drinking. *Psychopharmacology*, 173, 32-40.
26. Baker, T. B., Brandon, T. H., & Chassin, L. (2004). Motivational influences on cigarette smoking. *Annual Review of Psychology*, 55, 463-491.
27. Brandon, T. H., Herzog, T. A., Irvin, J. E, & Gwaltney, C. J. (2004). Cognitive and social learning models of drug dependence: Implications for the assessment of tobacco dependence in adolescents. *Addiction*, 99 (Suppl. 1), 51-77.
28. Brandon, T. H., Meade, C. D., Herzog, T. A., Chirikos, T. N., Webb, M. S., & Cantor, A. B. (2004). Efficacy and cost-effectiveness of a minimal intervention to prevent smoking relapse: Dismantling the effects of content versus contact. *Journal of Consulting & Clinical Psychology*, 72, 797-808.
29. Carrigan, M.H., Drobes, D.J., & Randall, C.L. (2004). Attentional bias and drinking to cope with social anxiety. *Psychology of Addictive Behaviors*, 18, 374-380.
30. Chirikos, T. N., Herzog, T. A., Meade, C. D., Webb, M. S., & Brandon, T. H. (2004). Cost-effectiveness analysis of a complementary health intervention: The case of smoking relapse prevention. *International Journal of Technology Assessment in Health Care*, 20, 475-480.
31. Drobes, D.J., & Klein, L.C. (2004). Research on nicotine and tobacco: A decade of progress. *Nicotine & Tobacco Research*, 6, 695-707.

32. Drobes, D.J., Anton, R.F., Thomas, S.E., & Voronin, K. (2004). Effects of naltrexone and nalmefene on subjective response to alcohol among non-treatment seeking alcoholics and social drinkers. *Alcoholism: Clinical and Experimental Research*, 28, 1362-1370.
33. Herzog, T.A. (2004). The Transtheoretical Model. In Christensen, A.J., Martin, R., & Morrison Smith, J. (Eds.), *Encyclopedia of Health Psychology*, Kluwer Academic/Plenum Publishers, New York (pp. 319-321).
34. Juliano, L. M., & Brandon, T. H. (2004). Smokers' expectancies for nicotine replacement therapy versus cigarettes. *Nicotine & Tobacco Research*, 6, 569-574.
35. Myrick, H., Anton, R.F., Li, X., Henderson, S., Drobes, D.J., Voronin, K., & George, M.S. (2004). Differential brain activity in alcoholics and social drinkers to alcohol cues: Relationship to craving. *Neuropsychopharmacology*, 29, 393-402.
36. Phillips, K. M., & Brandon, T. H. (2004). Do psychologists adhere to the clinical practice guidelines for tobacco cessation? A survey of practitioners. *Professional Psychology: Research & Practice*, 35, 281-285.
37. Simmons, V. N., Webb, M. S., & Brandon, T. H. (2004). College student smoking: An initial test of an experiential dissonance-enhancing intervention. *Addictive Behaviors*, 29, 1129-1136.
38. Steinberg, M. L., Ziedonis, D. M., Krejci, J. A., & Brandon, T. H. (2004). A single-session motivational interviewing intervention for engaging smokers with schizophrenia in treatment for tobacco dependence. *Journal of Consulting & Clinical Psychology*, 72, 723-728.
39. Thomas, S.E., Drobes, D.J., Voronin, K , & Anton, R.F. (2004). Following alcohol consumption, nontreatment-seeking alcoholics report greater stimulation but similar sedation compared with social drinkers. *Journal of Studies on Alcohol*, 65, 330-335.
40. Upadhyaya, H.P., Drobes, D.J., & Thomas, S.E. (2004). Reactivity to smoking cues in adolescent cigarette smokers. *Addictive Behaviors*, 29, 849-856.
41. Westmaas, J. L. & Brandon, T. H. (2004). Reducing risk in smokes. *Current Opinion in Pulmonary Medicine*, 10, 284-288.
42. Brandon, T. H., Herzog, T. A. Juliano, L., Irvin, J. E., Lazev, A., & Simmons, V. N. (2003). Pretreatment task-persistence predicts smoking cessation outcome. *Journal of Abnormal Psychology*, 112, 448–456.
43. Brandon, T. H., Herzog, T. A., & Webb, M. S. (2003). It ain't over till it's over: The case for offering relapse-prevention interventions to former smokers. *The American Journal of the Medical Sciences*, 326, 197-200.
44. Cuthbert, B.N., Lang, P.J., Strauss, C., Drobes, D.J., Patrick, C.J., & Bradley, M.M. (2003). The psychophysiology of anxiety disorder: Fear memory imagery. *Psychophysiology*, 40, 407-422.
45. Drobes, D.J., Anton, R.F., Thomas, S.E., & Voronin, K. (2003). A clinical laboratory paradigm for evaluating medication effects on alcohol consumption: Naltrexone and nalmefene. *Neuropsychopharmacology*, 28, 755-764.
46. Hughes, J. R., & Brandon, T. H. (2003). A softer approach to hardening. *Nicotine & Tobacco Research,* 6, 961-962.
47. Irvin, J. E., & Brandon, T. H. (2003). Examining a quarter century of smoking cessation trials: Is the target becoming harder to treat? In, *Those who continue to smoke: Is achieving abstinence harder and do we need to change our interventions?* Smoking and

Tobacco Control Monograph 15. Bethesda, MD: Department of Health and Human Services, National Institutes of Health, National Cancer Institute (NIH Pub. No. 03-5370).

48. Irvin, J. E., Hendricks, P. S., & Brandon, T. H. (2003). The increasing recalcitrance of smokers in clinical trials II: Pharmacotherapy trials. *Nicotine & Tobacco Research*, 5, 27-35.
49. Parrott, D.J., Drobes, D.J., Saladin, M.E., Coffey, S.F., & Dansky, B.S. (2003). Perpetration of partner violence: Effects of cocaine and alcohol dependence and post-traumatic stress disorder. *Addictive Behaviors*, 28, 1587-1602.
50. Saladin, M.E., Drobes, D.J., Coffey, S.F., Dansky, B.S., Brady, K.T., & Kilpatrick, D.G. (2003). PTSD diagnosis and symptom severity as predictors of cue-elicited drug craving. *Addictive Behaviors*, 28, 1611-1629.
51. Westmaas, J. L., Brandon, T. H., & Lokitis, J. (2003). Altering risk in patients who smoke. *Respiratory Care Clinics of North America*, 9, 259-268.
52. Brandon, T. H., Irvin, J. E., & Hendricks, P. S. (2002). The increasing power of placebos in trials of antidepressants. JAMA: Journal of the American Medical Association, 288, 449-450. [letter]
53. Coffey, S.F., Saladin, M.E., Drobes, D.J., Brady, K.T., Dansky, B.S., & Kilpatrick, D.G. (2002). Trauma and substance cue reactivity in individuals with comorbid posttraumatic stress disorder and cocaine or alcohol dependence. *Drug and Alcohol Dependence*, 65, 115-127.
54. Collins, B. N., & Brandon, T. H. (2002). Effects of extinction context and retrieval cues on alcohol cue reactivity among nonalcoholic drinkers. *Journal of Consulting & Clinical Psychology*, 70, 390-397.
55. Copeland, A. L., & Brandon, T. H. (2002). Do desirability ratings moderate the validity of probability ratings on the Smoking Consequences Questionnaire—Adult (SCQ-A)? A reanalysis using regression. *Psychological Assessment*, 14, 353-359.
56. Drobes, D.J. (2002). Concurrent alcohol and tobacco dependence: Mechanisms and treatment. *Alcohol Research & Health*, 26, 136-142.
57. Drobes, D.J. (2002). Cue reactivity in alcohol and tobacco dependence. *Alcoholism: Clinical and Experimental Research*, 26, 1928-1929.
58. Herzog, T. A., Lazev, A. B., Irvin, J. E., Juliano, L. M., Greenbaum, P. E. & Brandon, T. H. (2002). Testing for group membership effects during and after treatment: The example of group therapy for smoking cessation. *Behavior Therapy*, 39, 29-43.
59. Juliano, L. M., & Brandon, T. H. (2002). Effects of nicotine dose, instructional set, and outcome expectancies on the subjective effects of smoking in the presence of a stressor. *Journal of Abnormal Psychology*, 111, 88-97.
60. Saladin, M.E., Drobes, D.J., Coffey, S.F., & Libet, J.M. (2002). The human startle reflex and alcohol cue reactivity: Effects of early versus late abstinence. *Psychology of Addictive Behaviors*, 16, 98-105.
61. Brandon, T. H. (2001). Behavioral tobacco cessation treatments: Yesterday's news or tomorrow's headlines? *Journal of Clinical Oncology*, 19, 64s-68s.
62. Brandon, T. H. (2001). Editorial: A new look for Psychology of Addictive Behaviors in 2001. Psychology of Addictive Behaviors.
63. Copeland, A. L., & Brandon, T. H. (2001). Intervening with the tobacco-dependent patient. *Journal of Clinical Outcomes Management*, 8, 43-51.

64. Copeland, A. L., & Brandon, T. H. (2001). A patient-centered approach to applying current guidelines for treating tobacco dependence. *Seminars in Medical Practice*, 4, 6-16.
65. Drobes, D.J., Miller, E.J., Hillman, C.H., Bradley, M.M., Cuthbert, B.N., & Lang, P.J. (2001). Food deprivation and emotional reactions to food cues: Implications for eating disorders. *Biological Psychology*, 57, 153-177.
66. George, M.S., Anton, R.F., Bloomer, C., Teneback, C., Drobes, D.J., Lorberbaum, J.P., Nahas, Z., & Vincent, D.J. (2001). Activation of prefrontal cortex and anterior thalamus in alcoholics on exposure to alcohol specific cues. *Archives of General Psychiatry*, 58, 345-352.
67. Mann, K., Agartz, I., Harper, C., Shoaf, S., Rawlings, R.R., Momenan, R., Hommer, D.W., Pfefferbaum, A., Sullivan, E.V., Anton, R.F., Drobes, D.J., George, M.S., Bares, R., Machulla, H., Mundle, G., Reimold, M., & Heinz, A. (2001). Neuroimaging in alcoholism: Ethanol and brain damage. *Alcoholism: Clinical and Experimental Research*, 25, 104S-109S.

Addendum 2:

Grant Funding:

Recent external funding at Moffitt Cancer Center's Tobacco Research and Intervention Program (since 2000) includes:

Therapy development for smoking cessation.

Funded by the National Institute on Drug Abuse.

- 9/96 – 6/02. Total costs = $483,857.
- This project included several basic behavioral studies investigating factors theoretically related to success at smoking cessation. Goal is to develop more effective smoking cessation treatments.

Psychosocial risk factors for postpartum cigarette smoking.

Funded by the American Lung Association.

- 7/98 – 6/00. Total costs = $40,779.
- This project investigated factors predicting smoking relapse among pregnant and postpartum women recruited primarily from public health clinics.

Smoking cessation as a "window of opportunity" for skin cancer education.

Funded by the Skin Cancer Foundation.

- 3/99-2/00. Total costs = $10,000.
- This small pilot project tested whether skin cancer prevention education could be integrated into smoking cessation counseling.

Smoking cessation for youth: Intervention development.

Funded by the American Cancer Society Institutional Grant.

- 6/99-5/00. Total Costs = $19,815
- This project surveyed high school students in Hillsborough County as the preliminary step to designed smoking cessation (as opposed to prevention) programs geared toward adolescents.

Cost-effective smoking relapse-prevention via mail.

Funded by the National Cancer Institute.

- 7/99 – 6/02. Total Costs = $739,844.
- This project was a replication and extension of our earlier work which found that a series of relapse prevention booklets was successful at reducing smoking relapse by two thirds. Former smokers were recruited from throughout Florida and provided with a form of this cost-effective minimal intervention. Funding included a supplement to train an ethnic minority doctoral student.

Contextual control of craving for alcohol.

Funded by the National Institute on Alcohol Abuse and Alcoholism (to the Research Institute on Addictions, subcontract to TRIP).

- 7/99 – 6/03. Total Costs = $692,713. TRIP Subcontract = $36,640.
- This project investigated the degree to which the environment that alcoholism treatment takes place limits the maintenance of treatment gains after treatment. The paradigm was developed by Dr. Brandon, but the study was conducted in New York, where the investigators have access to alcoholics in treatment. Similar research on tobacco is being conducted at TRIP.

Preventing smoking relapse during pregnancy and beyond.

Funded by the National Cancer Institute.

- 7/02-6/07. Total costs = $1,750,000.
- This project tests an intervention for preventing smoking relapse among pregnant and postpartum women throughout the state of Florida and the United States.

Stage versus continuum models for smoking cessation.

Funded by the National Institute on Drug Abuse.

- 5/03-4/04. Total costs = $82,000.
- This project examined the process by which smokers decide to quit smoking.

Relapse prevention for adolescent ex-smokers.

Funded by the National Cancer Institute.

- 8/03-7/05. Total costs = $328,000.
- This project developed a series of booklets designed to aid adolescents in quitting smoking and staying smoke-free.

Brief intervention for smokers: Cue reactivity & smoking.

Funded by the National Institute on Drug Abuse.

- 5/04-4/06. Total costs = $325,760.
- This project began the development of a brief computer-based, personalized intervention designed to motivate smokers to decide to quit.

Translating basic learning research into enhanced smoking cessation.

Funded by the American Cancer Society.

- 1/06-12/08. Total costs = $945,000.
- This project develops and tests a novel intensive smoking cessation intervention that incorporates two types of behavioral counseling and nicotine replacement therapy.

Drug/cue interactions in alcohol-tobacco comorbidity.

Funded by the National Institute on Alcohol Abuse and Alcoholism.

- 1/06-12/10. Total costs = $1,804,651.
- This project examines the close association between smoking and drinking, and the frequent co-occurrence of alcoholism and tobacco dependence.

Smoking relapse prevention education for pregnant and postpartum Hispanic women.

Funded by the March of Dimes.

- 1/06-12/06. Total costs = $48,428.
- This project creates smoking-cessation and relapse-prevention materials in Spanish for pregnant women and new mothers.

Smoking relapse among lung cancer and head and neck cancer.

Funded by the National Cancer Institute.

- 4/07-3/09. Total costs = $163,000.
- This project studies smoking relapse among newly-diagnosed cancer patients, in preparation for the development of a targeted intervention.

Addendum 3:

Tobacco Research and Intervention Program: At A Glance

- Moffitt's Tobacco Research and Intervention Program (TRIP) was established in 1997. It currently comprises approximately 30 full-time and part-time staff. Doctoral-level researchers include faculty members Thomas H. Brandon, Ph.D., David J. Drobes, Ph.D., and Thaddeus A. Herzog, Ph.D., and postdoctoral fellows David Evans, Ph.D. and Vani Nath Simmons, Ph.D. In addition, affiliated faculty include biostatisticians, geneticists, alcohol researchers, and public health researchers from Moffitt, USF, and other institutions around the country.
- TRIP is the only NIH-funded research program in Florida dedicated solely to research on tobacco use.
- Research at TRIP includes basic behavioral and physiological studies on tobacco use and cessation, lab-to-clinic translational research, and full-scale clinical trials of smoking cessation and relapse-prevention interventions. Examples of recent and ongoing TRIP research includes:

  Basic research:

  - The first fully-controlled study to differentiate the roles of nicotine pharmacology and cognitive factors on the anxiolytic effects of tobacco.
  - Identifying behavioral-genetic markers of predisposition to tobacco dependence.
  - Identifying brain wave patterns associated with tobacco dependence and withdrawal.

  Translational research:

  - Applying basic learning principles identified through animal research for the enhancement of clinical interventions for tobacco and other substance abuse.

  Clinical Research:

  - Testing, via a national clinical trial, a cost-effective intervention for preventing smoking relapse among pregnant and postpartum women.
  - Studying the processes by which smokers make the decision to quit smoking, and developing interventions that enhance those processes.
  - Developing smoking cessation and relapse-prevention interventions for adolescents.
- Research at TRIP has been funded by grants from the National Cancer Institute, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the American Cancer Society, the American Lung Association, the Cancer Research and Prevention Foundation, the Skin Cancer Foundation, and the March of Dimes. In addition, generous philanthropy helps fund pilot investigations into new areas of research.
- TRIP offers the *FreshBreak*SM smoking cessation clinic. This is a research clinic that is available to smokers in the community who meet study inclusion criteria. Approximately 14

hours of group counseling are provided for a nominal fee ($5-20). TRIP faculty and doctoral students volunteer their evenings to lead these smoking cessation groups.

- The *Forever Free*™ program developed by TRIP provides a minimal, cost-effective relapse-prevention intervention for former smokers. This program has been adopted by NCI and is available on their website www.smokefree.gov.
- The peer-reviewed, archived journal, *Psychology of Addictive Behaviors*, published by the American Psychological Association, was edited at TRIP by Dr. Brandon. This is one of the most-cited substance abuse research journals worldwide.
- Dr. Drobes was the Program Chair for the 2005 international meeting of the Society for Research in Nicotine and Tobacco. Nearly 1000 tobacco scientists attended this meeting in Prague, Czech Republic.
- Research by TRIP faculty has been featured in the *New York Times*, the *Wall Street Journal*, the *Boston Globe, Investor's Business Daily*, *Psychology Today*, the *St. Petersburg Times*, the *Tampa Tribune*, and various other national and international media.
- TRIP is training the next generation of tobacco researchers. Former students of TRIP faculty hold faculty/research positions at LSU, American University, Temple University, the American Cancer Society, MD Anderson Cancer Center, Robert Wood Johnson Medical Center, Fox Chase Cancer Center, Syracuse University, and Moffitt Cancer Center.

Addendum 3:

TRIP Scientists

The following Moffitt faculty members and scientists are active collaborators on projects conducted at TRIP.

Thomas H. Brandon, Ph.D. (Director of TRIP)
College of Arts & Sciences, Department of Psychology
Clinical psychologist. Expertise in substance abuse, smoking cessation, smoking relapse.

David J. Drobes, Ph.D. (Associate Director of TRIP)
College of Medicine, Department of Interdisciplinary Oncology
Clinical Psychologist. Expertise in addictions and tobacco-alcohol interactions.

Thaddeus Herzog, Ph.D.
College of Medicine, Department of Interdisciplinary Oncology
Social Psychologist. Expertise in motivation to quit smoking, statistical analysis.

Vani Simmons, Ph.D.
College of Medicine, Department of Interdisciplinary Oncology
Clinical Psychologist. Expertise in developing interventions for college students.

Cathy D. Meade, R.N., Ph.D.
College of Medicine, Department of Interdisciplinary Oncology
Expertise in community health education, literacy, community outreach, preparation of culturally-relevant educational materials.

Thomas Chirikos, Ph.D.
College of Medicine, Department of Interdisciplinary Oncology
Health Economist. Expertise in health economics, cost-effectiveness analyses of interventions.

Ji-Hyun Lee, Ph.D.
College of Medicine, Department of Interdisciplinary Oncology
Biostatistician. Expertise in analysis of longitudinal data.

Gwendolyn Quinn, Ph.D.
College of Medicine, Department of Interdisciplinary Oncology
Expertise in qualitative analyses, social marketing, program evaluation, and prenatal care.

Marina Unrod, Ph.D.
Health Outcomes and Behavior Program, Moffitt Cancer Center
Expertise in public health dissemination of tobacco control interventions.

Florida Association of
Health Planning Agencies, Inc.
Innovators in Meeting Florida's Health Care Needs

District 1 & 2
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Proposal to Provide A State-Wide Evaluation of Florida's Tobacco Program

The Florida Association of Health Planning Agencies, Inc. (FAHPA) is comprised of the eleven local health councils, covering all 67 of Florida's counties, and working collaboratively to improve the health of Floridians.

Program evaluation will be an important aspect of Florida's Tobacco Program. The essential components of successful interventions can be identified and replicated through a well-designed, systematic program evaluation. Evaluation also identifies less effective program elements that need to be modified. Ultimately, evaluation results provide stakeholders with evidence of the impacts of tobacco prevention and control activities, and assist them in making decisions about how to improve these activities to achieve desired outcomes.

The Centers for Disease Control has developed a *Best Practices for Comprehensive Tobacco Control Programs* which identifies the need for surveillance and evaluation systems that can monitor and document program accountability to those individuals responsible for program delivery and fiscal oversight.

The FAHPA is uniquely qualified to develop and implement a state-wide evaluation of Florida's Tobacco Program based on the following:

- Full coverage of the State at a local level through a unified, coordinated network of planners and evaluators
- Staff include doctoral level health services research experience and expertise available to design a rigorous evaluation plan that will be consistent and standardized throughout the State
- Decades of collective experience and training in identifying evidence-based best practices and developing and implementing meaningful evaluation of health and social service programs
- Unbiased, objective approach and perspective on the program at both the local and state level.

The surveillance aspects of the tobacco program are, in the opinion of the FAHPA, readily available through existing data reports such as hospital discharge data and mortality data, and the continued use of survey instruments such as the Florida Youth Substance Abuse Survey, the Florida Youth Survey, the Youth Behavior Survey and the National Survey on Drug Use and Health.

Systematic evaluation utilizes surveillance data, but also includes targeted surveys to evaluate how well a program was implemented and its impact on individuals and the community. Evaluation utilizes other methods such as focus groups, community forums and interviews to gain insights into the strengths and weaknesses of a program.

Please contact Karen van Caulil, Ph.D. at kvancaulil@hcecf.org or (407) 493-6808 for more information on FAHPA's qualifications to develop and implement an effective and meaningful evaluation of the Florida Tobacco Program.

Florida Area Health Education
Center Network (AHEC)

DRAFT

Florida AHEC Network's Statewide Tobacco Initiatives for Prevention and Cessation

The Florida Area Health Education Centers' (AHEC) Network has the proven ability to reach target audiences pivotal to the reduction of tobacco use in the state. The strengths of the AHEC Network in the coordination and delivery of tobacco prevention and cessation programs include:

- The infrastructure of five university-based program offices and ten community-based centers to effectively implement programs on a statewide basis;
- A mission of creating community and academic partnerships for the health of underserved communities with tobacco prevention and cessation as a priority;
- The ability to influence the knowledge and skills of future health professionals about tobacco prevention and cessation by introducing this content into their course of study;
- An existing system in place for reaching practicing health professionals with high quality continuing education programs;
- Established partnerships with the Department of Health and local agencies in implementing tobacco prevention and education programs at the community-level;
- A proven track record of providing tobacco prevention and other health programs to school children throughout the state;
- The combination of high quality staff with health education backgrounds, the flexibility to build this capacity through internal expansions or contracting with local health professionals, and the advantage of working with faculty and health professional students who can lend expertise and manpower to health promotion initiatives;
- An established internet portal, developed and maintained by AHEC librarians, that provides links and resources on cardiovascular disease and obesity prevention, which could be expanded to include tobacco prevention and cessation information;
- A well-developed data system for tracking programs and a history of working with external evaluators.

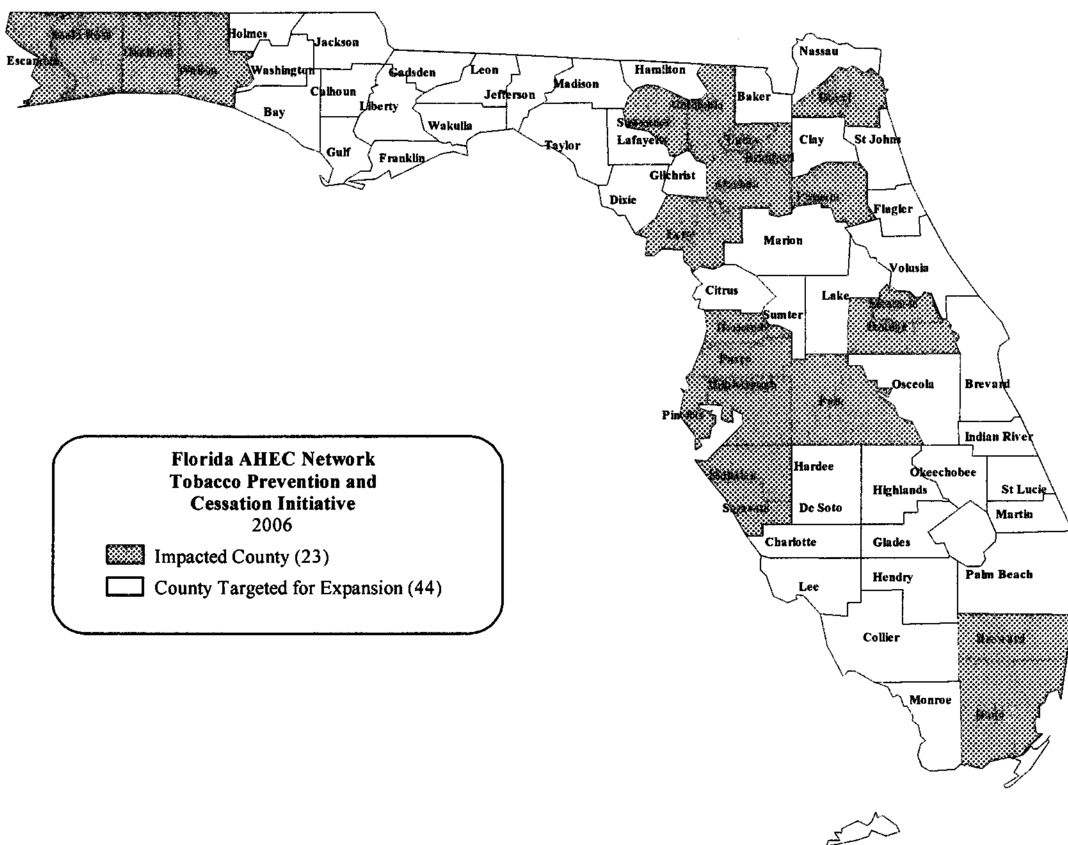
The Florida AHEC Network is proposing a multi-pronged approach for reducing tobacco use in Florida which capitalizes on the strengths of the Network. The proposed statewide initiatives are consistent with the Centers for Disease Control's recommendations in the1999 *Best Practices for Comprehensive Tobacco Control Programs.* The first AHEC strategy is to increase the number of future health professionals trained in tobacco prevention and education by expanding the existing Partners in Prevention of Substance Abuse Program. In addition, this strategy involves reaching school children in every county in the state with creative classroom presentations on tobacco prevention, which would be conducted by the health professions students trained as part of PIPSA to the extent possible, and by contracted community health professionals, AHEC staff members, or trained peer educators in the other counties. The second strategy is to train and support high school students as peer educators for tobacco prevention and cessation. The third AHEC strategy focuses on enhancing tobacco cessation resources in rural and underserved communities through the training of health providers and professionals in the targeted area, the provision of a trained tobacco cessation consultant to work in selected high-need sites, and the development of community support groups and resources for those contemplating or ready to quit tobacco use. The final strategy builds on the existing AHEC Portal to provide an electronic statewide smoking prevention and cessation

library that provides high quality, evidence-based information for different target audiences, including practicing and future health professionals, high school and middle school students, parents, and teachers. The AHEC strategies are detailed further in the summaries to follow.

Educating Future Health Professionals on Tobacco Prevention and Cessation

Currently, the Florida AHEC Network has an active program to train future health professionals about tobacco prevention and cessation, which has maintained its original name, Partners in Prevention of Substance Abuse (PIPSA). This nationally-recognized program trains community college, college and university healthcare students about tobacco prevention and cessation—in interdisciplinary groups where possible. Curriculum materials focus on the science of addiction, the real story on behavior change, and motivational techniques for effective professional support of future patients in cessation. To reinforce what they've learned in the didactic setting and to provide an invaluable community service, the college students are then organized into teams and sent to middle-schools throughout the region with prepared presentations and teaching aids to deliver message and motivation for health promotion and tobacco use prevention. As of January 2007, the estimate for PIPSA statewide impact is approximately 10,000 future healthcare practitioners and 310,000 middle school students. This year, these efforts will reach over 1,300 health professions students and approximately 40,000 school children.

Florida AHEC Network
Tobacco Cessation and Prevention Initiative Geographic Impact
2006



By expanding this program to additional state universities, private colleges, and community colleges, the number of health professional students trained in tobacco prevention and education would increase significantly. A dramatic increase would also occur in the number of middle school students who would be reached by the teams of health professions students. The middle school students and their teachers have consistently provided positive feedback about having these young health professional students, who the middle school students perceive as role models, come to their classrooms and teach them about the dangers of tobacco. The main purpose of this initiative is to build on AHEC's ten years of experience in imparting tobacco prevention and cessation education by including an increased number of future health professionals and by reaching school children in Florida's other 44 counties. The goals of the program over the next two years are highlighted in the table below:

Currently	After 1 year	After 2 years
23 counties served	45 counties served	67 counties served
40,000 school children	50,000 school children	60,000 school children
1,300 health profs. students	1,500 health profs. students	1,600 health profs. students

Because of the distance of a small number of counties from a participating university or community college, it may not be feasible to reach their middle school students with presentations by health professions students. In these situations, the curriculum will be presented to the middle school students by a contracted health professional, an AHEC staff member, or a trained peer educator to insure that all counties have access to this program.

The total annual budget for this initiative is $925,000. The majority of the funds would be distributed statewide to the AHEC Programs and their community-based centers. Each year, approximately $150,000 of the funds would be allocated to support the development of new or updated, evidence-based training materials by a cadre of faculty experts on tobacco prevention and cessation from the five universities, the production and distribution of these materials statewide, and the expansion of the program to a growing number of health professions students at the health science centers. The inclusion of faculty and students from medicine, dentistry, pharmacy, nursing, and public health helps insure that issues such as the effects of smoking and smokeless tobacco on oral health, the effective use of nicotine replacement therapies, the behavior modification approaches to cessation, and the importance of prevention education are addressed within the training materials. An emphasis is also placed on cultural competence and on age-appropriate materials and methods for community and school-based education.

At the AHEC Center level, the funds would be used to support staff time to develop new academic partnerships, to provide technical support for the training of the health professions students, and to coordinate the middle school presentations. In addition, the funding would be needed for staff, faculty and student travel, for the materials for the health professions and middle school presentations, and for paying contracted health professionals or peer educators to do the training in outlying counties. This program is work intensive based on the amount of coordination required at both the university/community college level as well as with the public and private school systems, thus requiring some development and planning time between the regional partners. The goals reflect the anticipated increases that can be achieved within the next two years.

AHEC Tobacco Peer Educators

The goal of this project is to prevent youth from using tobacco by utilizing a peer educator model. The rationale for using peer educators includes:

- The social and health behaviors pf youth are strongly influenced by their peers;
- Educating youth on the negative social and health consequences of tobacco use can reduce the number of young people that decides to use tobacco;
- A peer educator model impacts the peers' behaviors as well as the behaviors of those educated by them;
- Centers are well positioned to implement this model because of their strong ties to their school systems and community based youth service organizations;
- The tobacco prevention messages are compatible with health careers programs and the skills gained as peer educators could be used by future health care providers.

Each Center will identify and train a cadre of youth tobacco peer educators. The peers will be selected from local high schools and once trained will educate younger students in middle and/or elementary schools and at community settings. The AHEC Tobacco Peer Educators (ATPE) will come from the counties served by the Center, will be from minority and under-served backgrounds, and preferably should be interested in a health career. The ATPEs will be selected utilizing an application process developed by the Center. Each Center will hire or designate a half- time equivalent staff as the ATPE Program Coordinator, who will be responsible for implementing and managing the program.

Once selected, the ATPE will receive a one-day-training. The evidence-based curriculum for this training will be developed or identified by an established committee of health promotion experts in the Florida AHEC Network, so that there is consistency throughout the State and the program can be evaluated more effectively. The curriculum will have modules on the following topics: Introduction to AHEC/ATPE Program (Role and Characteristics of Effective Peers); Principles of Health Promotion; Tobacco (Facts, Health and Social Consequences, Tobacco and Media, Advocacy); Communication & Presentation Skills; Available Resources; Practice Section, and Evaluation/Data Collection.

Once the training is completed the Program Coordinator and the ATPE will develop two "one-hour-lesson-plans," one for elementary and one for middle school-aged students. They will also identify age-appropriate, culturally-sensitive educational materials to use for the presentations.

Each ATPE will receive $200 for participating in the training, and will sign an agreement/contract with the Center to present the program at least ten times, to an audience of ten to thirty peers for each instance, in schools and/or community settings. For each presentation the ATPE will received a $30 stipend. It is highly recommended that peer educators do their presentations in pairs, especially for their first few presentations.

The proposed program can be evaluated at different levels: pre and post tests of the peer educators before and after the training; pre and post tests of the students attending the presentations; number of peers trained; number of students educated; number of schools and community sites reached; qualitative evaluation from teachers or other adults observing the peers' presentations, and the number and type of tobacco prevention materials distributed at each presentation.

The proposed budget is $489,500 or $47,750 per Center and $12,000 for an external evaluator. The budget items include the following:

Personnel (.5 FTE program coordinator salary and benefits @ $26,000 X 10 Centers)	$ 260,000
Curriculum (development/identification/duplication)	10,000
Training (materials ($1000/Center), training stipends ($2,000/Center), room and refreshments ($750/Center)	37,500
Presentations' Materials ($3,500/Center)	35,000
Peer Stipends ($30 X15 Peers X 10 presentations X 10 Centers)	45,000
Mileage (staff and peers $5000/Center)	50,000
External Evaluation and Administrative Overhead	52,000

Enhancing Smoking Cessation Resources in Rural and Underserved Communities

This strategy focuses on enhancing tobacco cessation resources in rural and underserved communities through the training of health providers and professionals in the targeted area, the provision of a trained tobacco cessation consultant to work in selected high-need sites, and the development of community support groups and resources for those contemplating or ready to quit tobacco use. All of the ten AHEC Centers have experience in providing tobacco cessation education to health professionals based on the *Clinical Practice Guidelines for the Treatment of Tobacco Use and Dependence*, with this year's focus being on the prevention and cessation of tobacco use for pregnant and postpartum women, a project being completed in partnership with the Department of Health. Big Bend AHEC has emphasized tobacco prevention and cessation as one of their top priorities and they developed and implemented this combined model over the past four years.

The training of health professionals on the clinical practice guideline interventions will be targeted to providers in rural, minority, and underserved communities. The program will be offered in various formats including web-based programming, on-site presentations, and regional trainings. The content of the training will include:

- Identifying patients' smoking use status;
- Implementing Clinical Practice Guidelines for the Treatment of Tobacco Use and Dependence patient interventions requiring only a few minutes;
- Tailoring a health message unique to each patient's readiness to quit and personal health concerns;
- Focusing on the benefits of quitting as opposed to articulating negative health consequences;
- Learning how to correctly calculate and prescribe nicotine replacement therapy;
- Understanding that the majority of tobacco users cycle through multiple periods of relapse and remission and that on-going patient care in needed;
- Teaching professionals about the array of supports to which they should be referring their patients: community smoking cessation programs, internet based cessation supports, telephone quit lines, and culturally relevant information and materials;
- Assisting providers in developing an integrated smoking cessation program at their practice site.

Each regional AHEC will also train and enter into contracts with two or more smoking cessation consultants, with $62,500 allocated to each Center for the annual contracts. The consultant/s

will be placed at clinical practice sites, such as community health centers, county health departments or rural hospitals that are in areas of high incidence for tobacco use and smoking related diseases. The time at each site would be based on the clients' needs, space availability, and the providers' cooperation with referrals. During the time at the site, the consultant will be available to meet with patients to design a cessation plan unique to individual needs. The smoking cessation consultant is also available to provide resources and information to health professionals and paraprofessionals. Having a smoking cessation consultant on site is a powerful resource and one readily used by busy health care providers. It also provides patients with strong evidence about the seriousness of their dependence and commitment of their doctor to providing them with the help they need to quit successfully.

Each provider at the site may refer patients by using a referral form for the consultant. The consultant will make telephone contact with the patients and provide a guidelines-based assessment. The consultant then designs an individualized quit plan for those ready to quit smoking and informs the patients' primary care providers of all interventions and recommendations, enlisting their continued support of quit attempts. Individuals who are not ready to quit at that time will be asked to remain on a call list for follow-up contact in the future.

The smoking cessation consultant may develop packets of information geared for specific patient populations, such as pregnant women or cardiac patients. The materials developed for maternal infant care providers, for example, would emphasize health messages unique to new mothers and contain resources such as the "Make Yours a Fresh Start Family" patient booklets. Cardiac patients would receive information emphasizing the cardiac health benefits of quitting or strategies for quitting on one's own for middle-aged males who are not initially inclined to join the smoking cessation clinics.

In addition to individual services, the smoking cessation consultant will provide community based smoking cessation clinics. The smoking cessation clinics will meet for 8 sessions and guide the smokers through the process of quitting which occurs approximately half way through the sessions. There is a strong dose-response relationship between the intensity of tobacco cessation counseling and its effectiveness with session length, number of sessions, and total minutes of contact being critical variables.

The cessation clinics would be open to all members of the community and may be held at the provider site or any community meeting place. Flyers are sent to local physicians and potential referral sources such as HMO's, other health insurers, employers, county health departments, and other community-based clinics. All patients for whom the smoking cessation consultant receives referrals will be contacted by telephone at 3, 6, 9, and 12 month intervals. This includes all patients and community members who attend the smoking cessation clinics. Smoking status and relapse risk will be assessed at each contact. Individuals who have returned to smoking or have not yet made a defined quit attempt will be encouraged to attend the next smoking cessation clinic. Training sites are recruited by offering continuing education programs for health professionals and the on-site smoking cessation consultant, an effective resource most rural hospitals and clinics do not currently employ themselves.

A budget of $120,000 per Center and $18,000 for a statewide evaluation would provide the following:

- Approximately $62,500 for consultants per Center, which may include several part-time consultants to cover different targeted communities;

- Approximately $26,000 to each AHEC Center for a half-time Program Coordinator to develop the program in one or more targeted communities, train and oversee the consultant, and coordinate the training of health professionals;
- A total of $2,500 per Center for the training of the tobacco cessation consultants;
- Approximately $24,000 per Center to provide educational resources to the sites, to support the development of smoking cessation clinics and local support groups, and for expenses related to the providers trainings;
- Approximately $5,000 per Center to support the data collection and analysis and other administrative support of the program, such as equipment and telephone service;
- $18,000 for a statewide data collection system and an external evaluator.

When health care providers receive training on the clinical practice guidelines and have skill building opportunities, cessation interventions are more efficient and effective, leading to better patient outcomes. By improving rates of successful cessation, this project will assist individuals and communities in reducing the risks for tobacco related illnesses.

Statewide Electronic Smoking Prevention and Cessation Library

This project focuses on the development of a statewide electronic library and resource system on tobacco prevention and cessation topics which would be accessible to all the state's citizens. The library's resources will be targeted to several audiences, including practicing health professionals, future health professionals, middle school and high school students, teachers, parents and the general public. The Florida AHEC Network will create an interactive site specifically on tobacco prevention and cessation, including smokeless tobacco. It will focus on the multidisciplinary aspects involved in identifying and preventing tobacco use. The site will include links to evidence-based and best practice resources and links to expert-reviewed websites on tobacco prevention and cessation. In addition to state and national resources, users will be able to access resources and services at the county level. The initial programming, development and research to identify programs and services to be included on the site will be the most work-intensive. Staff resources will also be required to maintain the site with up-to-date information. The Florida AHEC Network will collaborate with existing state and national organizations to identify programs available in Florida communities. The Florida AHEC Network will partner with community health centers, local health departments, public libraries, school systems, senior centers and other groups to publicize and market the Smoking Prevention and Cessation Library. The funding for this program, $352,000 total, will be used for employing part-time staff to compile and continually update the information on local and regional resources and to identify the evidence based materials to be included on the portal, the development and distribution of marketing materials about the service, development of web-based and onsite training of health care professionals and the public on the use of the site, the development of a tracking system to assess the use of the site, the technical programming and maintenance of the site, and for an external evaluator.

Data and Evaluation

The Florida AHEC Network has a long history of documentation and accountability for its programs. Being recipients of both state and federal funding, the Network has strived to be good stewards of the public monies that are received. The Network has developed a nationally recognized, statewide data system called STARS, for Statewide AHEC Reporting System. This system will be modified to collect and track the information related to the proposed tobacco initiatives. In addition, the Network will establish measurable objectives for each of the

programs and develop an evaluation system with the help of an external evaluator. An annual report will be produced to highlight the activities completed and to report on the success of meeting the objectives of each program.

Budget Summary

The Florida AHEC Network is able to provide the four major statewide initiatives that have been described for a total funding amount of $3,000,000. A major strength of the Network is the ability to keep the administrative and overhead costs of the programs to a minimum based on our existing infrastructure. The AHEC Centers are independent non-profit organizations, which have the flexibility to contract with a variety of partners, as well as with part-time or short-term consultants, to meet specific needs of the initiatives. In addition, the AHEC Programs can access faculty experts and graduate-level health professions students to assist with the initiatives when applicable. While each of the initiatives will have an impact on the reduction of tobacco use in Florida, together the four initiatives offer a far-reaching approach to tobacco prevention and cessation education.

Total Budget Break-down for Florida AHEC Network's Statewide Tobacco Initiatives

Tobacco Prevention And Cessation Project	Staff Support Statewide	Curriculum Development and Training Expenses	Materials, Community Resources and Travel	Consultants or Stipends for Educators	Support Services, Data Collection and Analysis	Total per Project
Educating Future Health Professionals and Middle School Students	$260,000 (.5 FTE X 10)	$150,000 for AHEC Programs	$250,000	$200,000	$65,000	$925,000
Peer Educator Program	$260,000 (.5 FTE X 10)	$47,500	$85,000	$45,000	$52,000	$489,500
Smoking Cessation in Rural and Underserved Communities	$260,000 (.5 FTE X 10)	$25,000	$240,000	$625,000 (1.25 contracted FTEs X 10)	$68,000	$1,218,000
Statewide Electronic Smoking Prevention and Cessation Library	$247,500 ($117,500 initial set-up programmer, web-developer, librarians; $130,000 4 part-time staff)	$25,000	$30,000		$65,000	$367,500
Total	**$1,027,500**	**$247,500**	**$605,000**	**$870,000**	**$250,000**	**$3,000,000**

Draft Updated 2/19/2007