Committee on Health Quality

Tuesday, March 13, 2007
9:30 AM – 4:00 PM
306 HOB

COMMITTEE MEETING PACKET

Marco Rubio
Speaker

Gayle Harrell
Chair

House of Representatives

Committee on Health Quality

AGENDA

March 13, 2007
9:30 AM – 4:00 PM
(306 HOB)

I. Opening Remarks

II. Presentation by the Department of Health regarding funding for Information Technology Projects

III. Presentation by the Agency for Health Care Administration regarding the GenRx Program

IV. Consideration of recommendations to the following PCB:

- PCB HCC 07-02 - - Tobacco Education and Prevention

V. Consideration of the following bills:

- HB 877 by Homan - - Physician Workforce Assessment and Development
- HB 879 by Kiar - - Nursing Specialties
- HB 1007 by Baxley - - Physician Assistants
- HB 1121 by Grimsley - - Florida Health Information Network Corporation
- HB 1123 by Grimsley - - Pub. Rec./Florida Health Information Network Corporation

VI. Workshop on the following:

- HB 357 by Nelson - - Wekiva Onsite Sewage Treatment and Disposal System Compliance Grant Program
- HB 401 by Richardson - - Testing of Inmates for HIV Infection in Certain County Detention Facilities
- HB 739 by Holder - - Treatment Programs for Impaired Practitioners
- HB 947 by Skidmore - - Cardiology Services

VII. Closing Remarks & Adjournment

HB 877

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 877 Physician Workforce Assessment and Development
SPONSOR(S): Homan
TIED BILLS: **IDEN./SIM. BILLS:**

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

SUMMARY ANALYSIS

HB 877 creates the Office of Physician Workforce Assessment and Development within the Department of Health. The office is directed to use existing programs in the department to assess Florida's current and future physician workforce needs and develop strategies to addresses those needs.

According to House staff, implementation of the bill would require 1 FTE and cost $61,532 the first year and $72,889 annually thereafter.

The effective date of this bill is July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – this bill creates a new office within the department to assess Florida's current and future physician workforce needs.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Physician Workforce Data Collection
The statewide collection of physician data and its analysis is fragmented in Florida and under the purview of different agencies. Currently, there is no centralized physician workforce database that is available to provide objective statewide information on physician practice and manpower needs. Under s. 408.05, F.S., the State Center for Health Statistics within the Agency for Health Care Administration ("AHCA") must collect data on health resources, including physicians, dentists, nurses, and other health care professionals. The Division of Health Access and Tobacco within the Department of Health ("department") administers several programs that relate to physician access. The Florida Medicaid program in AHCA has claims data for physicians participating in the Medicaid program.

During Fiscal Year 2006-07, the department began collection of physician workforce data through a voluntary response survey. The survey was included in the licensure renewal application package for allopathic physicians. As of February 22, 2007, the department has received 22,547 completed surveys. Osteopathic physicians will receive the survey in their licensure renewal application packages this fall.

Medical Education and Residency Programs
Florida ranks 37th nationally in the number of medical school students (both allopathic and osteopathic) per 100,000 state population.[1] Florida has a low number of medical residency positions per 100,000 state population and ranks 41st in the nation.[2] Twenty-six percent of Florida's doctors are over the age of 65.[3]

The Center for Health Workforce Studies and the Council on Graduate Medical Education (COGME) recommend that existing medical schools increase their enrollment by 15 percent by 2015 to contend with the current and projected physician shortage. It is estimated that in order to reach the national ratio of allopathic and medical school students per state population, Florida would need to increase its capacity by 2,700 students.[4]

Research has shown that the location of a physician's practice correlates more closely to the geographic location of the residency, rather than to the medical school from which the physician graduated.[5] A recent nationwide analysis by the National Conference of State Legislatures (NCSL) found that 47 percent of individuals that complete an allopathic medical residency program stay in the same state that they completed their graduate medical education training.[6] CEPRI has projected that 60.5 percent of allopathic medical residency students remain and practice in the state of residency training.

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[1] Council for Education Policy, Research and Improvement (CEPRI). Medical Education Needs Analysis. November 2004.
[2] Florida Department of Health. Annual Report on Graduate Medical Education in Florida. January 2007.
[3] *Id.*
[4] Council for Education Policy, Research and Improvement (CEPRI). Medical Education Needs Analysis. November 2004.
[5] *Id.*
[6] *Id.*

Effect of Proposed Changes

The bill creates the Office of Physician Workforce Assessment and Development ("office") within the department. The office is directed to use existing programs in the department to assess Florida's current and future physician workforce needs and develop strategies to addresses those needs.

In particular, the bill directs the department to maintain a database of physician workforce data and directs the office to:

- Collect and analyze data on physician workforce, medical students, and residents;
- Develop a model of the current and future physician workforce, including demographic factors;
- Develop strategies to address retention of Florida medical school graduates for practice in the state;
- Develop best-practice programs for recruitment of K-12, college, and university students into medical school programs;
- Pursue strategies that target state and federal funding for graduate medical education positions and residency positions towards identified workforce needs areas;
- Target physician recruitment and retention towards identified workforce needs areas; and
- Coordinate stakeholders' efforts to address physician workforce needs.

C. SECTION DIRECTORY:

Section 1. Creates s. 381.4018 to establish the Office of Physician Workforce Assessment within the Department of Health and specifies duties of the office.

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

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

According to House staff, to implement the provisions in the bill, 1 FTE will be required. The cost for 1 FTE is $61,532 the first year and $72,889 annually thereafter.

Estimated Expenditures	**1st Year**	**2nd Year**	**3rd Year**
Salary			
1 FTE	$44,348	$59,131	$59,131
Expense Package			
Standard	9,915	6,489	6,489
Limited Travel	5,568	5,568	5,568
Operating Capital Outlay			
Standard Computer Workstation	1,300	1,300	1,300
Human Resources Services (107040)	401	401	401
Total Expenditures	$61,532	$72,889	$72,889

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

According to House staff, depending on the analysis of the physician workforce data, in the future, there may be a request for additional funding to provide Graduate Medical Education (GME) enhancements.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to affect municipal or county government.

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:

The bill does not include provisions for FTE to staff the newly-created office, nor does it include an appropriation to fund the office's activities. It would appear that the bill needs an amendment to address its contingency upon a specific appropriation in the General Appropriations Act for fiscal year 2007-2008.

D. STATEMENT OF THE SPONSOR

"A similar bill by Rep Altman and Homan (HB 1093) was passed out of the House last session but the appropriation got a line-item veto by Gov Bush. The Department of Health began collecting the data anyway with the 2006 physician license renewals and now we have data from 50% of the physicians, but no resources to analyze it. The other 50% of the physicians are coming up for renewal at the end of 2007, and once collected we want to have someone coordinate the data transfer to and analysis by the physician workforce stakeholders.(including, but not limited to: DOH, DOE, AHCA, CMS, medical schools, residency programs, hospitals, specialty societies, and insurance companies)

The Office of Physician Workforce Assessment and Development is set up to be a data collection and clearing house to get information of the physician workforce to the stakeholders to use in making strategic plans to assure accessibility to health care to all Floridians in the near and distant future."

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to physician workforce assessment and
3 development; creating s. 381.4018, F.S.; providing
4 legislative intent; creating the Office of Physician
5 Workforce Assessment and Development within the Department
6 of Health; proving a purpose; providing functions of the
7 office; providing an effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Section 381.4018, Florida Statutes, is created
12 to read:
13 381.4018 Office of Physician Workforce Assessment and
14 Development.--
15 (1) LEGISLATIVE INTENT.--The Legislature recognizes that
16 physician workforce planning is an essential component in
17 ensuring that there is an adequate and appropriate supply of
18 well-trained physicians to meet the state's future healthcare
19 service needs as both the general population and elderly
20 population of the state increase. The Legislature finds that
21 issues to consider relative to the assessment of physician
22 workforce need may include physician practice status; specialty
23 mix; geographic distribution; demographic information,
24 including, but not limited to, age, gender, race, and cultural
25 considerations; and meeting the needs of current or projected
26 medically underserved areas in the state. Long-term strategic
27 planning is essential, as the period of time from the time of
28 entering medical school to completion of graduate medical

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

29 education may range from 7 to 10 years, or longer. The
30 Legislature recognizes that strategies to provide for a well-
31 trained supply of physicians must include ensuring the
32 availability of quality medical schools and graduate medical
33 education capacity in the state as well as utilizing new or
34 existing state or federal programs that might provide incentives
35 for physicians to practice in needed specialties and in
36 underserved areas in a manner that addresses projected physician
37 manpower needs.
38 (2) CREATION; PURPOSE.--The Office of Physician Workforce
39 Assessment and Development is created in the Department of
40 Health and shall serve as a coordinating and strategic planning
41 body to actively assess the state's current and future physician
42 workforce needs and shall work with multiple stakeholders to
43 develop strategies and alternatives to address the state's
44 current and projected physician workforce needs.
45 (3) GENERAL FUNCTIONS.--The Office of Physician Workforce
46 Assessment and Development shall maximize the utilization of
47 existing programs under the jurisdiction of the department and
48 other state agencies; coordinate among governmental and
49 nongovernmental stakeholders and resources to determine a state
50 strategic plan; and assess implementation of such strategic plan
51 to:
52 (a) Monitor, evaluate, and report on the supply and
53 distribution of physicians licensed under chapters 458 and 459.
54 The department shall maintain a database to serve as the
55 official statewide source of valid, objective, and reliable data
56 on the physician workforce.

57 (b) Develop a model and quantify, on an ongoing basis, the
58 adequacy of the state's current and future physician workforce,
59 as reliable physician workforce data becomes available. Such
60 model shall consider the following factors: demographics,
61 physician practice status, place of education and training,
62 generational changes, population growth, economic indicators,
63 and issues relating to the channeling of students into medical
64 education.
65 (c) Develop and recommend strategies to determine whether
66 availability of qualified state medical school applicants who
67 might become competent practicing physicians in the state will
68 be sufficient to meet medical school capacity of the state's
69 medical schools. If appropriate, the Office of Physician
70 Workforce Assessment and Development, working with
71 representatives of appropriate governmental and nongovernmental
72 entities, shall develop strategies and recommendations and
73 identify best-practice programs that introduce health care as a
74 profession and strengthen skills needed for medical school
75 admission for elementary, middle, and high school students, and
76 improve premedical education at the K-12 and college level to
77 increase the state's potential pool of medical students.
78 (d) Assess strategies to ensure that graduates from the
79 state's public and private allopathic and osteopathic medical
80 schools are adequate to meet physician workforce needs, based on
81 the analysis of the physician workforce data, and strategies to
82 ensure that the state's medical schools are adequately funded to
83 provide a high quality medical education to students in a manner

84 that recognizes the uniqueness of each of the state's new and
85 existing medical schools.
86 (e) Pursue strategies and policies to create, expand, and
87 maintain graduate medical education positions in the state,
88 based on the analysis of the physician workforce data. Such
89 strategies and policies shall consider the impact of federal
90 funding limitations on the expansion and creation of graduate
91 medical education positions and shall develop options to address
92 such federal funding limitations. Options to provide direct
93 state funding for graduate medical education positions shall be
94 considered in a manner that addresses requirements and needs
95 relative to accreditation of graduate medical education
96 programs. Funding for residency positions should be targeted to
97 address needed physician specialty areas, rural and physician
98 shortage areas, areas of ongoing critical need, and otherwise
99 address the physician workforce needs of the state, based on the
100 analysis of ongoing physician workforce data.
101 (f) Develop strategies to maximize federal and state
102 programs that provide for the use of incentives to attract
103 physicians to the state or retain physicians in the state in
104 order to meet the state's physician workforce needs. Such
105 strategies should explore and maximize federal-state
106 partnerships available to provide for incentives for physicians
107 to practice in federally designated shortage areas. Strategies
108 shall also consider the use of state programs, such as the
109 Florida Health Service Corps established pursuant to s. 381.0302
110 and the Medical Education Reimbursement and Loan Repayment
111 Program pursuant to s. 1009.65, that provide for education loan

112 repayment or loan forgiveness to provide physicians monetary
113 incentives to relocate to underserved areas of the state.
114 (g) Coordinate and enhance activities relative to
115 physician workforce needs, undergraduate medical education, and
116 graduate medical education provided by the Office of Medical
117 Quality Assurance, the Community Hospital Education Program and
118 Graduate Medical Education Committee established pursuant to s.
119 381.0403, the area health education center network established
120 pursuant to s. 381.0402, and other offices and programs within
121 the Department of Health as deemed by the secretary.
122 (h) Work in conjunction with and act as a coordinating
123 body for governmental and nongovernmental stakeholders to
124 address matters relating to the state's physician workforce
125 assessment and development for the purpose of ensuring an
126 adequate supply of well-trained physicians to meet the state's
127 future needs. Such governmental stakeholders shall include, but
128 may not be limited to, the secretaries or designees of the
129 Department of Health, Department of Education, and Agency for
130 Healthcare Administration, the Chancellor or designee of the
131 Board of Governors, and, at the discretion of the department,
132 other representatives of state and local agencies involved in
133 the assessment, education, training, or provision of the state's
134 current or future physician workforce. Other stakeholders shall
135 include, but may not be limited to, organizations representing
136 the state's public and private allopathic and osteopathic
137 medical schools; organizations representing hospitals and other
138 healthcare-providing institutions, particularly those that
139 currently provide or have an interest in providing accredited

140 medical education and graduate medical education to medical
141 students and medical residents in the state; organizations
142 representing allopathic and osteopathic practicing physicians;
143 and, at the discretion of the department, representatives of
144 other organizations or entities involved in the assessment,
145 education, training, or provision of the state's current or
146 future physician workforce.
147 (i) Serve as a state liaison with other states and federal
148 agencies and programs to enhance resources available to the
149 state's physician workforce and medical education continuum.
150 (j) Act as a clearinghouse for collecting and
151 disseminating information of physician workforce and medical
152 education continuum issues in the state.
153 Section 2. This act shall take effect July 1, 2007.

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

Bill No. 877

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	___	

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1 Council/Committee hearing bill: Committee on Health Quality

2 Representative(s) Homan offered the following:

3

4 **Amendment**

5 Remove line(s) 116 and insert:

6 graduate medical education provided by the Division of Medical

HB 879

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 879 Nursing Specialties
SPONSOR(S): Kiar
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 248

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

SUMMARY ANALYSIS

HB 879 creates the certification of "Clinical Nurse Specialist" within Florida Nurse Practice Act. The bill requires certification of Clinical Nurse Specialists through the Board of Nursing and includes title protection for Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives.

According to the Department of Health, the fiscal impact to the state will be $37,752 in Fiscal Year 2007-08 and approximately $65,000 annually thereafter.

The effective date of this bill is July 1, 2007.

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

Licensure of nurses
Part I of Chapter 464, F.S., governs the licensure and regulation of nurses in Florida. Nurses are licensed by the Department of Health and are regulated by the Board of Nursing. Licensure requirements to practice professional nursing include completion of education requirements, demonstration of passage of a department-approved examination, a clean criminal background screening, and payment of applicable fees[1]. Renewal is biennial and contingent upon completion of certain continuing medical education requirements.

Currently, Florida law only recognizes one specialized nursing license--the advanced registered nurse practitioner ("ARNP"). A nurse who holds a license to practice professional nursing may be certified as an ARNP under s. 464.012, F.S., if the nurse meets one or more of the following requirements:

- Completion of a post basic education program of at least one academic year that prepares nurses for advanced or specialized practice;
- Certification by a specialty board, such as a registered nurse anesthetist or nurse midwife; or
- Possession of a master's degree in a nursing clinical specialty area.

Section 464.012(2), F.S., defines three categories of ARNPs: certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners. All ARNPs, regardless of practice category, may only practice within the framework of an established protocol and under the supervision of an allopathic or osteopathic physician or a dentist. All ARNPs may carry out treatments as specified in statute. Although there are three categories of ARNPs, only the title of ARNP is protected under Florida law[2].

There are currently 10,305 active, licensed ARNPs in Florida[3].

According to the department, Clinical Nurse Specialists (CNSs) are licensed in 23 states. They are licensed registered nurses who have graduate preparation (Master's or Doctorate) in nursing as a Clinical Nurse Specialist. According to the National Association of Clinical Nurse Specialists, they are trained to be expert clinicians in a specialized area of nursing practice, such as a particular disease state or population.

Costs of regulation of health care practitioners
Section 456.025, F.S. declares that "it is the intent of the Legislature that all costs of regulating health care professions and practitioners shall be borne solely by licensees and licensure applicants." The regulatory boards, in consultation with the department, or the department if there is no board, must set renewal fees that are, among other requirements:

- Based on revenue projections prepared using generally accepted accounting procedures;
- Adequate to cover all expenses relating to that board identified in the department's long-range policy plan;
- Shall be similar to fees imposed on similar licensure types.

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[1] Section 464.009, F.S., provides an alternative to licensure by examination for nurses through licensure by endorsement.
[2] s. 464.015, F.S.
[3] Florida Department of Health, Division of Medical Quality Assurance Annual Report 2005-2006.

Section 216.0236, F.S., further requires each agency to examine the fees it charges for providing regulatory services and oversight to businesses or professions. In particular the agency must determine whether the fees charged for each regulatory program are:

- Based on revenue projections that are prepared using generally accepted governmental accounting procedures or official estimates by the Revenue Estimating Conference, if applicable;
- Adequate to cover both the direct and indirect costs of providing the regulatory service or oversight; and
- Reasonable and take into account differences between the types of professions or businesses that are regulated.

If the agency determines that the fees charged for regulatory services or oversight to businesses or professions are not adequate to cover program costs and that an appropriation from other state funds is necessary to supplement the direct or indirect costs of providing a regulatory service or regulating a program, the agency must present to the Governor and the Legislature, as part of its legislative budget request, information regarding alternatives for realigning revenues or costs to make the regulatory service or program totally self-sufficient. In the alternative, the agency may demonstrate that the service or program provides substantial benefits to the public which justify a partial subsidy from other state funds.

Effect of Proposed Changes

The bill defines the scope of practice for a CNS as the "delivery and management of expert-level nursing care to individuals or groups." Specifically, the scope of practice includes:

- Assessing the health status of individuals and families using methods appropriate to the population and area of practice;
- Diagnosing human responses to actual or potential health problems;
- Planning for health promotion, disease prevention, and therapeutic intervention in collaboration with the patient;
- Implementing therapeutic interventions based on the nurse specialist's area of expertise; and
- Coordinating health care as necessary and appropriate and evaluating with the patient the effectiveness of care.

The bill adds CNS as a category of ARNP and requires the following in order to be certified as a CNS:

- Hold a current professional nursing license;
- Have completed a master's degree in a clinical nursing specialty; and
- Hold a current certificate in a specialty area from a national clinical nurse specialist certifying body.

Last, the bill provides title protection for the following nurses: Clinic Nurse Specialists; Certified Registered Nurse Anesthetists; and Certified Nurse Midwives. The misuse of these titles is a misdemeanor of the first degree.

C. SECTION DIRECTORY:

Section 1. Amends s. 464.003, F.S., to define the scope of practice of a clinical nurse specialist and amends the definition of advanced registered nurse practitioner.

Section 2. Creates s. 464.0115, F.S., to establish certification criteria for clinical nurse specialists, fees for application and renewal, and rulemaking authority.

Section 3. Amends s. 464.012, F.S., to add clinical nurse specialists to the categories of advanced registered nurse practitioners.

Section 4. Amends s. 464.015, F.S., to provide title protection for "Clinical Nurse Specialist" and the abbreviation "C.N.S."; "Certified Registered Nurse Anesthetist" and the abbreviation "C.R.N.A."; and "Certified Nurse Midwife" and the abbreviation "C.N.M."

Section 5. Amends s. 464.016, F.S., to prohibit the use of the above-referenced titles unless the person is duly licensed or certified.

Section 6. Reenacts s. 921.0022, F.S., to incorporate changes in s. 464.016, F.S., by reference.

Section 7. Amends s. 458.348, F.S., to correct a cross-reference.

Section 8. Amends s. 459.025, F.S., to correct a cross-reference.

Section 9. Provides an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The department estimates that 2,065 nurses will apply for CNS certification in the first year and 200 in subsequent years at the proposed rate of $25 for the initial certification and $10 for biennial certification.

Estimated Revenue	1st Year	2nd Year	3rd Year	4th Year
Initial CNS Certification Fee	$ 51,625	$ 5,000	$ 5,000	$ 5,000
Certification Renewal Fee	$ 0	$ 0	$ 20,650	$ 2,000
Total Estimated Revenues	$ 51,625	$ 5,000	$ 25,650	$ 7,000

2. Expenditures:

According to the department, 1 FTE is required to implement provisions contained in the bill.

Estimated Expenditures	1st Year	2nd Year	3rd Year	4th Year
Salaries				
1 - Nurse Consultant, PG 077	$ 55,962	$ 55,962	$ 55,962	$ 55,962
Expense				
1 - Nurse Consultant, ltd travel	$ 12,057	$ 12,057	$ 12,057	$ 12,057
1 - Nurse Consultant, non-recurring	$ 3,426	$ 3,426	$ 3,426	$ 3,426
Operating Capital Outlay				
1 - Nurse Consultant	$ 1,300	$ 0	$ 0	$ 0
Contracted Services				
Initial & Renewal processing	$ 16,231	$ 1,572	$ 17,803	$ 3,144

Human Resources Services *1 - Nurse Consultant*	$ 401	$ 401	$ 401	$ 401
Total Estimated Expenditures	$ 89,377	$ 73,418	$ 89,649	$ 74,990

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

According to the department, the fees included in the bill are insufficient to cover expenses associated with the licensure and renewal of licensure for Clinical Nurse Specialists. Consequently, certification of CNSs will operate in deficit from the first year and thereafter.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to affect municipal or county government.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill contains rule-making authority for the department to implement provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to nursing specialties; amending s.
3 464.003, F.S.; defining the terms "clinical nurse
4 specialist practice" and "clinical nurse specialist";
5 creating s. 464.0115, F.S.; providing requirements for
6 certification as a clinical nurse specialist; providing
7 fees; authorizing the Board of Nursing to adopt rules;
8 amending s. 464.012, F.S.; adding clinical nurse
9 specialist to the classifications of advanced registered
10 nurse practitioners; amending s. 464.015, F.S.;
11 restricting the use of professional titles and
12 abbreviations relating to practice by clinical nurse
13 specialists, certified registered nurse anesthetists, and
14 certified nurse midwives; providing penalties; amending s.
15 464.016, F.S.; prohibiting the use of any name or title
16 stating or implying that a person is a clinical nurse
17 specialist, certified registered nurse anesthetist, or
18 certified nurse midwife unless the person is licensed or
19 certified; providing penalties; reenacting s.
20 921.0022(3)(g), F.S., relating to the offense severity
21 ranking chart of the Criminal Punishment Code, to
22 incorporate the amendment to s. 464.016, F.S., in a
23 reference thereto; amending ss. 458.348 and 459.025, F.S.;
24 conforming cross-references; providing an effective date.
25
26 Be It Enacted by the Legislature of the State of Florida:
27
28 Section 1. Section 464.003, Florida Statutes, is amended

29 to read:

30 464.003 Definitions.--As used in this part, the term:

31 (1) "Department" means the Department of Health.

32 (2) "Board" means the Board of Nursing.

33 (3)(a) "Practice of professional nursing" means the
34 performance of those acts requiring substantial specialized
35 knowledge, judgment, and nursing skill based upon applied
36 principles of psychological, biological, physical, and social
37 sciences which shall include, but not be limited to:

38 1. The observation, assessment, nursing diagnosis,
39 planning, intervention, and evaluation of care; health teaching
40 and counseling of the ill, injured, or infirm; and the promotion
41 of wellness, maintenance of health, and prevention of illness of
42 others.

43 2. The administration of medications and treatments as
44 prescribed or authorized by a duly licensed practitioner
45 authorized by the laws of this state to prescribe such
46 medications and treatments.

47 3. The supervision and teaching of other personnel in the
48 theory and performance of any of the above acts.

49 (b) "Practice of practical nursing" means the performance
50 of selected acts, including the administration of treatments and
51 medications, in the care of the ill, injured, or infirm and the
52 promotion of wellness, maintenance of health, and prevention of
53 illness of others under the direction of a registered nurse, a
54 licensed physician, a licensed osteopathic physician, a licensed
55 podiatric physician, or a licensed dentist.

56

57 The professional nurse and the practical nurse shall be
58 responsible and accountable for making decisions that are based
59 upon the individual's educational preparation and experience in
60 nursing.
61 (c) "Clinical nurse specialist practice" means the
62 delivery and management of expert-level nursing care to
63 individuals or groups, including the ability to:
64 1. Assess the health status of individuals and families
65 using methods appropriate to the population and area of
66 practice.
67 2. Diagnose human responses to actual or potential health
68 problems.
69 3. Plan for health promotion, disease prevention, and
70 therapeutic intervention in collaboration with the patient or
71 client.
72 4. Implement therapeutic interventions based on the nurse
73 specialist's area of expertise, including, but not limited to,
74 direct nursing care, counseling, teaching, and collaboration
75 with other licensed health care providers.
76 5. Coordinate health care as necessary and appropriate and
77 evaluate with the patient or client the effectiveness of care.
78 (d) ~~(c)~~ "Advanced or specialized nursing practice" means,
79 in addition to the practice of professional nursing, the
80 performance of advanced-level nursing acts approved by the board
81 which, by virtue of postbasic specialized education, training,
82 and experience, are proper to be performed by an advanced
83 registered nurse practitioner. Within the context of advanced
84 or specialized nursing practice, the advanced registered nurse

85 practitioner may perform acts of nursing diagnosis and nursing
86 treatment of alterations of the health status. The advanced
87 registered nurse practitioner may also perform acts of medical
88 diagnosis and treatment, prescription, and operation which are
89 identified and approved by a joint committee composed of three
90 members appointed by the Board of Nursing, two of whom shall be
91 advanced registered nurse practitioners; three members appointed
92 by the Board of Medicine, two of whom shall have had work
93 experience with advanced registered nurse practitioners; and the
94 secretary of the department or the secretary's designee. Each
95 committee member appointed by a board shall be appointed to a
96 term of 4 years unless a shorter term is required to establish
97 or maintain staggered terms. The Board of Nursing shall adopt
98 rules authorizing the performance of any such acts approved by
99 the joint committee. Unless otherwise specified by the joint
100 committee, such acts shall be performed under the general
101 supervision of a practitioner licensed under chapter 458,
102 chapter 459, or chapter 466 within the framework of standing
103 protocols which identify the medical acts to be performed and
104 the conditions for their performance. The department may, by
105 rule, require that a copy of the protocol be filed with the
106 department along with the notice required by s. 458.348.
107 (e) ~~(d)~~ "Nursing diagnosis" means the observation and
108 evaluation of physical or mental conditions, behaviors, signs
109 and symptoms of illness, and reactions to treatment and the
110 determination as to whether such conditions, signs, symptoms,
111 and reactions represent a deviation from normal.
112 (f) ~~(e)~~ "Nursing treatment" means the establishment and

113 implementation of a nursing regimen for the care and comfort of
114 individuals, the prevention of illness, and the education,
115 restoration, and maintenance of health.
116 (4) "Registered nurse" means any person licensed in this
117 state to practice professional nursing.
118 (5) "Licensed practical nurse" means any person licensed
119 in this state to practice practical nursing.
120 (6) "Clinical nurse specialist" means any person licensed
121 in this state to practice professional nursing and certified in
122 clinical nurse specialist practice.
123 (7) ~~(6)~~ "Advanced registered nurse practitioner" means any
124 person licensed in this state to practice professional nursing
125 and certified in advanced or specialized nursing practice,
126 including certified registered nurse anesthetists, certified
127 nurse midwives, nurse practitioners, and clinical nurse
128 specialists.
129 (8) ~~(7)~~ "Approved program" means a nursing program
130 conducted in a school, college, or university which is approved
131 by the board pursuant to s. 464.019 for the education of nurses.
132
133 Section 2. Section 464.0115, Florida Statutes, is created
134 to read:
135 464.0115 Certification of clinical nurse specialists.--
136 (1) Any nurse desiring to be certified as a clinical nurse
137 specialist must apply to the department and submit proof that he
138 or she holds a current license to practice professional nursing,
139 a master's degree in a clinical nursing specialty, and current
140 certification in a specialty area as a clinical nurse specialist

141 from a nationally recognized certifying body as determined by
142 the board.
143 (2) The board shall certify, and the department shall
144 issue a certificate to, any nurse who fulfills the
145 qualifications in this section. The board shall establish an
146 application fee not to exceed $25 and a biennial renewal fee not
147 to exceed $10.
148 (3) The board may adopt rules necessary to administer this
149 section pursuant to ss. 120.536(1) and 120.54.
150 Section 3. Subsections (2) and (3) of section 464.012,
151 Florida Statutes, are amended to read:
152 464.012 Certification of advanced registered nurse
153 practitioners; fees.--
154 (2) The board shall provide by rule the appropriate
155 requirements for advanced registered nurse practitioners in the
156 categories of certified registered nurse anesthetist, certified
157 nurse midwife, ~~and~~ nurse practitioner, and clinical nurse
158 specialist.
159 (3) An advanced registered nurse practitioner shall
160 perform those functions authorized in this section within the
161 framework of an established protocol that is filed with the
162 board upon biennial license renewal and within 30 days after
163 entering into a supervisory relationship with a physician or
164 changes to the protocol. The board shall review the protocol to
165 ensure compliance with applicable regulatory standards for
166 protocols. The board shall refer to the department licensees
167 submitting protocols that are not compliant with the regulatory
168 standards for protocols. A practitioner currently licensed under

169 chapter 458, chapter 459, or chapter 466 shall maintain
170 supervision for directing the specific course of medical
171 treatment. Within the established framework, an advanced
172 registered nurse practitioner may:
173 (a) Monitor and alter drug therapies.
174 (b) Initiate appropriate therapies for certain conditions.
175 (c) Perform additional functions as may be determined by
176 rule in accordance with s. 464.003(3)(d) ~~s. 464.003(3)(c)~~.
177 (d) Order diagnostic tests and physical and occupational
178 therapy.
179 Section 4. Section 464.015, Florida Statutes, is amended
180 to read:
181 464.015 Titles and abbreviations; restrictions; penalty.--
182 (1) Only persons who hold licenses to practice
183 professional nursing in this state or who are performing nursing
184 services pursuant to the exception set forth in s. 464.022(8)
185 shall have the right to use the title "Registered Nurse" and the
186 abbreviation "R.N."
187 (2) Only persons who hold licenses to practice as licensed
188 practical nurses in this state or who are performing practical
189 nursing services pursuant to the exception set forth in s.
190 464.022(8) shall have the right to use the title "Licensed
191 Practical Nurse" and the abbreviation "L.P.N."
192 (3) Only persons who are graduates of approved programs or
193 the equivalent may use the term "Graduate Nurse" and the
194 abbreviation "G.N.," pending the results of the first licensure
195 examination for which they are eligible.
196 (4) Only persons who are graduates of approved programs or

197 the equivalent may use the term "Graduate Practical Nurse" and
198 the abbreviation "G.P.N.," pending the results of the first
199 licensure examination for which they are eligible.
200 (5) Only persons who hold valid certificates to practice
201 as clinical nurse specialists in this state may use the title
202 "Clinical Nurse Specialist" and the abbreviation "C.N.S."
203 (6) Only persons who hold valid certificates to practice
204 as certified registered nurse anesthetists in this state may use
205 the title "Certified Registered Nurse Anesthetist" and the
206 abbreviations "C.R.N.A." or "anesthetist."
207 (7) Only persons who hold valid certificates to practice
208 as certified nurse midwives in this state may use the title
209 "Certified Nurse Midwife" and the abbreviations "C.N.M." or
210 "nurse midwife."
211 (8) ~~(5)~~ Only persons who hold valid certificates to
212 practice as advanced registered nurse practitioners in this
213 state may ~~shall have the right to~~ use the title "Advanced
214 Registered Nurse Practitioner" and the abbreviation "A.R.N.P."
215 (9) ~~(6)~~ A ~~No~~ person may not ~~shall~~ practice or advertise as,
216 or assume the title of, registered nurse, licensed practical
217 nurse, clinical nurse specialist, certified registered nurse
218 anesthetist, certified nurse midwife, or advanced registered
219 nurse practitioner or use the abbreviation "R.N.," "L.P.N.,"
220 "C.N.S.," "C.R.N.A.," "C.N.M.," or "A.R.N.P." or take any other
221 action that would lead the public to believe that person was
222 certified as such or is performing nursing services pursuant to
223 the exception set forth in s. 464.022(8), unless that person is
224 licensed or certified to practice as such.

225 (10) ~~(7)~~ A violation of this section is a misdemeanor of
226 the first degree, punishable as provided in s. 775.082 or s.
227 775.083.
228 Section 5. Section 464.016, Florida Statutes, is amended
229 to read:
230 464.016 Violations and penalties.--
231 (1) Each of the following acts constitutes a felony of the
232 third degree, punishable as provided in s. 775.082, s. 775.083,
233 or s. 775.084:
234 (a) Practicing advanced or specialized, professional, or
235 practical nursing, as defined in this part, unless holding an
236 active license or certificate to do so.
237 (b) Using or attempting to use a license or certificate
238 which has been suspended or revoked.
239 (c) Knowingly employing unlicensed persons in the practice
240 of nursing.
241 (d) Obtaining or attempting to obtain a license or
242 certificate under this part by misleading statements or knowing
243 misrepresentation.
244 (2) Each of the following acts constitutes a misdemeanor
245 of the first degree, punishable as provided in s. 775.082 or s.
246 775.083:
247 (a) Using the name or title "Nurse," "Registered Nurse,"
248 "Licensed Practical Nurse," "Clinical Nurse Specialist,"
249 "Certified Registered Nurse Anesthetist," "Certified Nurse
250 Midwife," "Advanced Registered Nurse Practitioner," or any other
251 name or title which implies that a person was licensed or
252 certified as same, unless such person is duly licensed or

253 certified.

254 (b) Knowingly concealing information relating to

255 violations of this part.

256 Section 6. For the purpose of incorporating the amendment

257 to section 464.016, Florida Statutes, in a reference thereto,

258 paragraph (g) of subsection (3) of section 921.0022, Florida

259 Statutes, is reenacted to read:

260 921.0022 Criminal Punishment Code; offense severity

261 ranking chart.--

262 (3) OFFENSE SEVERITY RANKING CHART

	Florida Statute	Felony Degree	Description
263			(g) LEVEL 7
264	316.027(1)(b)	1st	Accident involving death, failure to stop; leaving scene.
265	316.193(3)(c)2.	3rd	DUI resulting in serious bodily injury.
266	316.1935(3)(b)	1st	Causing serious bodily injury or death to another person; driving at

			high speed or with wanton disregard for safety while fleeing or attempting to elude law enforcement officer who is in a patrol vehicle with siren and lights activated.
267	327.35(3)(c)2.	3rd	Vessel BUI resulting in serious bodily injury.
268	402.319(2)	2nd	Misrepresentation and negligence or intentional act resulting in great bodily harm, permanent disfiguration, permanent disability, or death.
269	409.920(2)	3rd	Medicaid provider

			fraud.
270	456.065(2)	3rd	Practicing a health care profession without a license.
271	456.065(2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.
272	458.327(1)	3rd	Practicing medicine without a license.
273	459.013(1)	3rd	Practicing osteopathic medicine without a license.
274	460.411(1)	3rd	Practicing chiropractic medicine without a license.
275	461.012(1)	3rd	Practicing podiatric medicine without a

			license.
276	462.17	3rd	Practicing naturopathy without a license.
277	463.015(1)	3rd	Practicing optometry without a license.
278	464.016(1)	3rd	Practicing nursing without a license.
279	465.015(2)	3rd	Practicing pharmacy without a license.
280	466.026(1)	3rd	Practicing dentistry or dental hygiene without a license.
281	467.201	3rd	Practicing midwifery without a license.
282	468.366	3rd	Delivering respiratory care services without a license.
283			

	483.828(1)	3rd	Practicing as clinical laboratory personnel without a license.
284	483.901(9)	3rd	Practicing medical physics without a license.
285	484.013(1)(c)	3rd	Preparing or dispensing optical devices without a prescription.
286	484.053	3rd	Dispensing hearing aids without a license.
287	494.0018(2)	1st	Conviction of any violation of ss. 494.001-494.0077 in which the total money and property unlawfully obtained exceeded $50,000 and there were five or more victims.
288			

	560.123(8)(b)1.	3rd	Failure to report currency or payment instruments exceeding $300 but less than $20,000 by money transmitter.
289	560.125(5)(a)	3rd	Money transmitter business by unauthorized person, currency or payment instruments exceeding $300 but less than $20,000.
290	655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding $300 but less than $20,000 by financial institution.
291	775.21(10)(a)	3rd	Sexual predator; failure to register; failure to renew driver's license or

			identification card; other registration violations.
292	775.21(10)(b)	3rd	Sexual predator working where children regularly congregate.
293	775.21(10)(g)	3rd	Failure to report or providing false information about a sexual predator; harbor or conceal a sexual predator.
294	782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.
295	782.07(1)	2nd	Killing of a human being by the act, procurement, or

			culpable negligence of another (manslaughter).
296	782.071	2nd	Killing of human being or viable fetus by the operation of a motor vehicle in a reckless manner (vehicular homicide).
297	782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
298	784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.
299	784.045(1)(a)2.	2nd	Aggravated battery;

			using deadly weapon.
300	784.045(1)(b)	2nd	Aggravated battery; perpetrator aware victim pregnant.
301	784.048(4)	3rd	Aggravated stalking; violation of injunction or court order.
302	784.048(7)	3rd	Aggravated stalking; violation of court order.
303	784.07(2)(d)	1st	Aggravated battery on law enforcement officer.
304	784.074(1)(a)	1st	Aggravated battery on sexually violent predators facility staff.
305	784.08(2)(a)	1st	Aggravated battery on a person 65 years of age or older.
306			

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	784.081(1)	1st	Aggravated battery on specified official or employee.
307	784.082(1)	1st	Aggravated battery by detained person on visitor or other detainee.
308	784.083(1)	1st	Aggravated battery on code inspector.
309	790.07(4)	1st	Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).
310	790.16(1)	1st	Discharge of a machine gun under specified circumstances.
311	790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.
312			

	790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony.
313	790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.
314	790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
315	796.03	2nd	Procuring any person under 16 years for prostitution.
316	800.04(5)(c)1.	2nd	Lewd or lascivious

			molestation; victim less than 12 years of age; offender less than 18 years.
317	800.04(5)(c)2.	2nd	Lewd or lascivious molestation; victim 12 years of age or older but less than 16 years; offender 18 years or older.
318	806.01(2)	2nd	Maliciously damage structure by fire or explosive.
319	810.02(3)(a)	2nd	Burglary of occupied dwelling; unarmed; no assault or battery.
320	810.02(3)(b)	2nd	Burglary of unoccupied dwelling; unarmed; no assault or battery.
321	810.02(3)(d)	2nd	Burglary of occupied

			conveyance; unarmed; no assault or battery.
322	812.014(2)(a)1.	1st	Property stolen, valued at $100,000 or more or a semitrailer deployed by a law enforcement officer; property stolen while causing other property damage; 1st degree grand theft.
323	812.014(2)(b)2.	2nd	Property stolen, cargo valued at less than $50,000, grand theft in 2nd degree.
324	812.014(2)(b)3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
325	812.0145(2)(a)	1st	Theft from person 65 years of age or

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			older; $50,000 or more.
326	812.019(2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.
327	812.131(2)(a)	2nd	Robbery by sudden snatching.
328	812.133(2)(b)	1st	Carjacking; no firearm, deadly weapon, or other weapon.
329	817.234(8)(a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
330	817.234(9)	2nd	Organizing, planning, or

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			participating in an intentional motor vehicle collision.
331	817.234(11)(c)	1st	Insurance fraud; property value $100,000 or more.
332	817.2341(2)(b) & (3)(b)	1st	Making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity which are a significant cause of the insolvency of that entity.
333	825.102(3)(b)	2nd	Neglecting an elderly person or disabled adult causing great bodily harm, disability, or disfigurement.
334			

	825.103(2)(b)	2nd	Exploiting an elderly person or disabled adult and property is valued at $20,000 or more, but less than $100,000.
335	827.03(3)(b)	2nd	Neglect of a child causing great bodily harm, disability, or disfigurement.
336	827.04(3)	3rd	Impregnation of a child under 16 years of age by person 21 years of age or older.
337	837.05(2)	3rd	Giving false information about alleged capital felony to a law enforcement officer.
338	838.015	2nd	Bribery.
339			

	838.016	2nd	Unlawful compensation or reward for official behavior.
340	838.021(3)(a)	2nd	Unlawful harm to a public servant.
341	838.22	2nd	Bid tampering.
342	847.0135(3)	3rd	Solicitation of a child, via a computer service, to commit an unlawful sex act.
343	872.06	2nd	Abuse of a dead human body.
344	893.13(1)(c)1.	1st	Sell, manufacture, or deliver cocaine (or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4.) within

			1,000 feet of a child care facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.
345	893.13(1)(e)1.	1st	Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., within 1,000 feet of property used for religious services or a specified business site.
346	893.13(4)(a)	1st	Deliver to minor cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d),

			(2)(a), (2)(b), or (2)(c)4. drugs).
347	893.135(1)(a)1.	1st	Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.
348	893.135(1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.
349	893.135(1)(c)1.a.	1st	Trafficking in illegal drugs, more than 4 grams, less than 14 grams.
350	893.135(1)(d)1.	1st	Trafficking in phencyclidine, more than 28 grams, less than 200 grams.
351	893.135(1)(e)1.	1st	Trafficking in methaqualone, more than 200 grams, less than 5 kilograms.
352			

	893.135(1)(f)1.	1st	Trafficking in amphetamine, more than 14 grams, less than 28 grams.
353	893.135(1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.
354	893.135(1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.
355	893.135(1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms.
356	893.135(1)(k)2.a.	1st	Trafficking in Phenethylamines, 10 grams or more, less than 200 grams.
357			

	896.101(5)(a)	3rd	Money laundering, financial transactions exceeding $300 but less than $20,000.
358	896.104(4)(a)1.	3rd	Structuring transactions to evade reporting or registration requirements, financial transactions exceeding $300 but less than $20,000.
359	943.0435(4)(c)	2nd	Sexual offender vacating permanent residence; failure to comply with reporting requirements.
360	943.0435(8)	2nd	Sexual offender; remains in state after indicating intent to leave;

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			failure to comply with reporting requirements.
361	943.0435(9)(a)	3rd	Sexual offender; failure to comply with reporting requirements.
362	943.0435(13)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
363	943.0435(14)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
364	944.607(9)	3rd	Sexual offender; failure to comply with reporting requirements.
365			

	944.607(10)(a)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
366			
	944.607(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
367			
	944.607(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
368			

369 Section 7. Paragraph (a) of subsection (1) and subsection
370 (2) of section 458.348, Florida Statutes, are amended to read:
371 458.348 Formal supervisory relationships, standing orders,
372 and established protocols; notice; standards.--
373 (1) NOTICE.--
374 (a) When a physician enters into a formal supervisory
375 relationship or standing orders with an emergency medical
376 technician or paramedic licensed pursuant to s. 401.27, which

377 relationship or orders contemplate the performance of medical
378 acts, or when a physician enters into an established protocol
379 with an advanced registered nurse practitioner, which protocol
380 contemplates the performance of medical acts identified and
381 approved by the joint committee pursuant to s. 464.003(3)(d) ~~s.~~
382 ~~464.003(3)(c)~~ or acts set forth in s. 464.012(3) and (4), the
383 physician shall submit notice to the board. The notice shall
384 contain a statement in substantially the following form:
385
386 I, (name and professional license number of physician) ,
387 of (address of physician) have hereby entered into a formal
388 supervisory relationship, standing orders, or an established
389 protocol with (number of persons) emergency medical
390 technician(s), (number of persons) paramedic(s), or
391 (number of persons) advanced registered nurse practitioner(s).
392 (2) ESTABLISHMENT OF STANDARDS BY JOINT COMMITTEE.--The
393 joint committee created by s. 464.003(3)(d) ~~s. 464.003(3)(c)~~
394 shall determine minimum standards for the content of established
395 protocols pursuant to which an advanced registered nurse
396 practitioner may perform medical acts identified and approved by
397 the joint committee pursuant to s. 464.003(3)(d) ~~s.~~
398 ~~464.003(3)(c)~~ or acts set forth in s. 464.012(3) and (4) and
399 shall determine minimum standards for supervision of such acts
400 by the physician, unless the joint committee determines that any
401 act set forth in s. 464.012(3) or (4) is not a medical act. Such
402 standards shall be based on risk to the patient and acceptable
403 standards of medical care and shall take into account the
404 special problems of medically underserved areas. The standards

405 developed by the joint committee shall be adopted as rules by
406 the Board of Nursing and the Board of Medicine for purposes of
407 carrying out their responsibilities pursuant to part I of
408 chapter 464 and this chapter, respectively, but neither board
409 shall have disciplinary powers over the licensees of the other
410 board.
411 Section 8. Paragraph (a) of subsection (1) of section
412 459.025, Florida Statutes, is amended to read:
413 459.025 Formal supervisory relationships, standing orders,
414 and established protocols; notice; standards.--
415 (1) NOTICE.--
416 (a) When an osteopathic physician enters into a formal
417 supervisory relationship or standing orders with an emergency
418 medical technician or paramedic licensed pursuant to s. 401.27,
419 which relationship or orders contemplate the performance of
420 medical acts, or when an osteopathic physician enters into an
421 established protocol with an advanced registered nurse
422 practitioner, which protocol contemplates the performance of
423 medical acts identified and approved by the joint committee
424 pursuant to s. 464.003(3)(d) ~~s. 464.003(3)(c)~~ or acts set forth
425 in s. 464.012(3) and (4), the osteopathic physician shall submit
426 notice to the board. The notice must contain a statement in
427 substantially the following form:
428 I, (name and professional license number of osteopathic
429 physician) , of (address of osteopathic physician) have
430 hereby entered into a formal supervisory relationship, standing
431 orders, or an established protocol with (number of persons)
432 emergency medical technician(s), (number of persons)

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433 paramedic(s), or (number of persons) advanced registered
434 nurse practitioner(s).
435 Section 9. This act shall take effect July 1, 2007.

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

Bill No. **0879**

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(s) Kiar offered the following:
3
4 **Amendment**
5 Remove line(s) 62 and insert:
6 delivery and management of advanced practice nursing care to

Amendment No. 2 (for drafter's use only)

Bill No. **0879**

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(s) Kiar offered the following:

3

4 **Amendment**

5 Remove line(s) 72-73 and insert:

6 4. Implement therapeutic interventions based on the

7 clinical nurse specialist's area of expertise, within the scope

8 of advanced nursing practice, including, but not limited to,

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 3 (for drafter's use only)

Bill No. **0879**

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 ____

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1 Council/Committee hearing bill: Committee on Health Quality

2 Representative(s) Kiar offered the following:

3

4 **Amendment**

5 Remove line(s) 127-128 and insert:

6 nurse midwives and nurse practitioners.

03/12/2007 4:30 p.m.

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HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 4 (for drafter's use only)

Bill No. **0879**

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 ______

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1 Council/Committee hearing bill: Committee on Health Quality

2 Representative(s) Kiar offered the following:

3

4 **Amendment**

5 Remove line(s) 146-147 and insert:

6 application fee not to exceed $75 and a biennial renewal fee not

7 to exceed $75.

Amendment No. 5(for drafter's use only)

Bill No. **0879**

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(s) Kiar offered the following:

3

4 **Amendment**

5 Remove line(s) 206 and insert:

6 abbreviations "C.R.N.A." or "nurse anesthetist."

Amendment No. 6 (for drafter's use only)

Bill No. **0879**

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 ______

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1 Council/Committee hearing bill: Committee on Health Quality
2 Representative(s) Kiar offered the following:
3
4 **Amendment**
5 Remove line(s) 435 and insert:
6 Section 9. This act shall take effect October 1, 2007.

HB 1007

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1007 Physician Assistants
SPONSOR(S): Baxley
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

House Bill 1007 authorizes a physician assistant to dispense medicinal drugs if the physician assistant is supervised by a physician registered to dispense medical drugs.

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

The effective date of this bill is July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – this bill will authorize physician assistants to dispense medicinal drugs directly to patients, rather than through a pharmacy.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Physician Assistants
Sections 458.347(7), and 459.022(7), F.S., govern the licensure of physician assistants ("PA") in Florida. Physician assistants are licensed by the Department of Health ("department") and are regulated by the Council on Physician Assistants and 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. Fees for licensure and renewal are set in statute and renewal occurs biennially.[1] 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.

A supervising physician may only delegate tasks and procedures to the physician assistant that are within the supervising physician's scope of practice. The supervising physician is responsible and liable for any and all acts of the PA and may only supervise up to four PAs at any time.

Sections 458.347(4) and 459.022(4), F.S. authorize a supervisory physician to delegate to a PA the authority to prescribe any medication used in the supervisory physician's practice. The department must be notified by the supervising physician of the intent to delegate prescribing authority to the PA and the PA must be licensed to prescribe by the department. Licensure for a PA to prescribe is predicated upon completion of a three hour medical education course in prescriptive practice and at least three months of clinical experience in the specialty area of the supervising physician. Further, prescriptions written by PAs must be written in a form that complies with Chapter 499, F.S., and, with the exception of a drug sample, may only be filled in a pharmacy permitted under Chapter 465, F.S. Section 458.347(4)(F)(1) directs the Council on Physician Assistants to establish a formulary of medications that a PA may not prescribe. Medications that are prohibited in the formulary include controlled substances as defined in Chapter 893, F.S., antipsychotics, spinal or epidural anesthetics, radiographic contrast materials, and any parenteral preparation except insulin and epinephrine.

There are currently 3,675 active, licensed physician assistants practicing in the state of Florida.[2]

Dispensing of Medications
Section 465.0276, F.S., provides that practitioners who are authorized by law to prescribe drugs may dispense medicinal drugs, if they register with their applicable licensing boards. Approved practitioners are subject to all of the same laws and regulations as licensed pharmacists and pharmacies, including premises inspection by the department. A practitioner who only dispenses manufacturer drug samples is not required to register under this section. Currently, allopathic and osteopathic physicians and advanced register nurse practitioners may register as dispensing practitioners.

Effect of Proposed Changes

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[1] ss. 458.347(7) and 459.022(7), F.S.
[2] Florida Department of Health, Division of Medical Quality Assurance Annual Report 2005-2006.

The bill authorizes a physician assistant to dispense medicinal drugs if the physician assistant is supervised by a physician registered to dispense medical drugs.

C. SECTION DIRECTORY:

Section 1. Amends s. 458.347, F.S., relating to physician assistants.

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

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   According to department staff, the fiscal impact is insignificant as there is minimal cost to the department for enforcement and compliance functions associated with this bill.

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 does not appear to affect municipal or county government.

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:

Physician assistants are supervised by both allopathic and osteopathic physicians. However, the bill only authorizes physician assistants practicing under allopathic physicians to dispense medicinal drugs. Further,

the bill only inserts dispensing authority in one subsection of the statute, while multiple subsections apply to the prescribing of medicinal drugs by a physician assistant.

D. STATEMENT OF THE SPONSOR

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to physician assistants; amending s.
3 458.347, F.S.; requiring that a prescription be filled in
4 a pharmacy unless it is a drug dispensed by a physician
5 assistant; providing an effective date.
6
7 Be It Enacted by the Legislature of the State of Florida:
8
9 Section 1. Paragraph (e) of subsection (4) of section
10 458.347, Florida Statutes, is amended to read:
11 458.347 Physician assistants.--
12 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.--
13 (e) A supervisory physician may delegate to a fully
14 licensed physician assistant the authority to prescribe any
15 medication used in the supervisory physician's practice unless
16 such medication is listed on the formulary created pursuant to
17 paragraph (f). A fully licensed physician assistant may only
18 prescribe such medication under the following circumstances:
19 1. A physician assistant must clearly identify to the
20 patient that he or she is a physician assistant. Furthermore,
21 the physician assistant must inform the patient that the patient
22 has the right to see the physician prior to any prescription
23 being prescribed by the physician assistant.
24 2. The supervisory physician must notify the department of
25 his or her intent to delegate, on a department-approved form,
26 before delegating such authority and notify the department of
27 any change in prescriptive privileges of the physician
28 assistant.

29 3. The physician assistant must file with the department,
30 before commencing to prescribe, evidence that he or she has
31 completed a continuing medical education course of at least 3
32 classroom hours in prescriptive practice, conducted by an
33 accredited program approved by the boards, which course covers
34 the limitations, responsibilities, and privileges involved in
35 prescribing medicinal drugs, or evidence that he or she has
36 received education comparable to the continuing education course
37 as part of an accredited physician assistant training program.
38 4. The physician assistant must file with the department,
39 before commencing to prescribe, evidence that the physician
40 assistant has a minimum of 3 months of clinical experience in
41 the specialty area of the supervising physician.
42 5. The physician assistant must file with the department a
43 signed affidavit that he or she has completed a minimum of 10
44 continuing medical education hours in the specialty practice in
45 which the physician assistant has prescriptive privileges with
46 each licensure renewal application.
47 6. The department shall issue a license and a prescriber
48 number to the physician assistant granting authority for the
49 prescribing of medicinal drugs authorized within this paragraph
50 upon completion of the foregoing requirements.
51 7. The prescription must be written in a form that
52 complies with chapter 499 and must contain, in addition to the
53 supervisory physician's name, address, and telephone number, the
54 physician assistant's prescriber number. A physician assistant
55 may dispense drugs provided that the supervising physician is a
56 dispensing physician. However, unless it is a drug ~~sample~~

57 dispensed by the physician assistant, the prescription must be
58 filled in a pharmacy permitted under chapter 465 and must be
59 dispensed in that pharmacy by a pharmacist licensed under
60 chapter 465. The appearance of the prescriber number creates a
61 presumption that the physician assistant is authorized to
62 prescribe the medicinal drug and the prescription is valid.
63 8. The physician assistant must note the prescription in
64 the appropriate medical record, and the supervisory physician
65 must review and sign each notation. For dispensing purposes
66 only, the failure of the supervisory physician to comply with
67 these requirements does not affect the validity of the
68 prescription.
69 9. This paragraph does not prohibit a supervisory
70 physician from delegating to a physician assistant the authority
71 to order medication for a hospitalized patient of the
72 supervisory physician.
73
74 This paragraph does not apply to facilities licensed pursuant to
75 chapter 395.
76 Section 2. This act shall take effect July 1, 2007.

Bill No. **1007**

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 ____

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1 Council/Committee hearing bill: Committee on Health Quality
2 Representative(s) Baxley offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Paragraph (e) of subsection (4) of section
7 458.347, Florida Statutes, is amended to read:
8 458.347 Physician assistants.--
9 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.--
10 (e) A supervisory physician may delegate to a fully
11 licensed physician assistant the authority to prescribe or
12 dispense any medication used in the supervisory physician's
13 practice unless such medication is listed on the formulary
14 created pursuant to paragraph (f). A fully licensed physician
15 assistant may only prescribe or dispense such medication under
16 the following circumstances:
17 1. A physician assistant must clearly identify to the
18 patient that he or she is a physician assistant. Furthermore,
19 the physician assistant must inform the patient that the patient
20 has the right to see the physician prior to any prescription
21 being prescribed or dispensed by the physician assistant.

22 2. The supervisory physician must notify the department of
23 his or her intent to delegate, on a department-approved form,
24 before delegating such authority and notify the department of
25 any change in prescriptive privileges of the physician
26 assistant. Authority to dispense may be delegated only by a
27 supervising physician who is registered as a dispensing
28 practitioner in compliance with s. 465.0276.
29 3. The physician assistant must file with the department,
30 before commencing to prescribe or dispense, evidence that he or
31 she has completed a continuing medical education course of at
32 least 3 classroom hours in prescriptive practice, conducted by
33 an accredited program approved by the boards, which course
34 covers the limitations, responsibilities, and privileges
35 involved in prescribing medicinal drugs, or evidence that he or
36 she has received education comparable to the continuing
37 education course as part of an accredited physician assistant
38 training program.
39 4. The physician assistant must file with the department,
40 before commencing to prescribe or dispense, evidence that the
41 physician assistant has a minimum of 3 months of clinical
42 experience in the specialty area of the supervising physician.
43 5. The physician assistant must file with the department a
44 signed affidavit that he or she has completed a minimum of 10
45 continuing medical education hours in the specialty practice in
46 which the physician assistant has prescriptive privileges with
47 each licensure renewal application.
48 6. The department shall issue a license and a prescriber
49 number to the physician assistant granting authority for the
50 prescribing of medicinal drugs authorized within this paragraph
51 upon completion of the foregoing requirements. The physician

52 assistant shall not be required to independently register
53 pursuant to s. 465.0276.
54 7. The prescription must be written in a form that
55 complies with chapter 499 and must contain, in addition to the
56 supervisory physician's name, address, and telephone number, the
57 physician assistant's prescriber number. Unless it is a drug or
58 drug sample dispensed by the physician assistant, the
59 prescription must be filled in a pharmacy permitted under
60 chapter 465 and must be dispensed in that pharmacy by a
61 pharmacist licensed under chapter 465. The appearance of the
62 prescriber number creates a presumption that the physician
63 assistant is authorized to prescribe the medicinal drug and the
64 prescription is valid.
65 8. The physician assistant must note the prescription or
66 dispensing of medication in the appropriate medical record, and
67 the supervisory physician must review and sign each notation.
68 For dispensing purposes only, the failure of the supervisory
69 physician to comply with these requirements does not affect the
70 validity of the prescription.
71 9. This paragraph does not prohibit a supervisory
72 physician from delegating to a physician assistant the authority
73 to order medication for a hospitalized patient of the
74 supervisory physician.
75
76 This paragraph does not apply to facilities licensed pursuant to
77 chapter 395.
78 Section 2. Paragraph (e) of subsection (4) of section
79 459.022, Florida Statutes, is amended to read:
80 459.022 Physician assistants.--
81 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.--

82 (e) A supervisory physician may delegate to a fully
83 licensed physician assistant the authority to prescribe or
84 dispense any medication used in the supervisory physician's
85 practice unless such medication is listed on the formulary
86 created pursuant to s. 458.347. A fully licensed physician
87 assistant may only prescribe or dispense such medication under
88 the following circumstances:
89 1. A physician assistant must clearly identify to the
90 patient that she or he is a physician assistant. Furthermore,
91 the physician assistant must inform the patient that the patient
92 has the right to see the physician prior to any prescription
93 being prescribed or dispensed by the physician assistant.
94 2. The supervisory physician must notify the department of
95 her or his intent to delegate, on a department-approved form,
96 before delegating such authority and notify the department of
97 any change in prescriptive privileges of the physician
98 assistant. Authority to dispense may be delegated only by a
99 supervisory physician who is registered as a dispensing
100 practitioner in compliance with s. 465.0276.
101 3. The physician assistant must file with the department,
102 before commencing to prescribe or dispense, evidence that she or
103 he has completed a continuing medical education course of at
104 least 3 classroom hours in prescriptive practice, conducted by
105 an accredited program approved by the boards, which course
106 covers the limitations, responsibilities, and privileges
107 involved in prescribing medicinal drugs, or evidence that she or
108 he has received education comparable to the continuing education
109 course as part of an accredited physician assistant training
110 program.
111 4. The physician assistant must file with the department,
112 before commencing to prescribe or dispense, evidence that the

113 physician assistant has a minimum of 3 months of clinical
114 experience in the specialty area of the supervising physician.
115 5. The physician assistant must file with the department a
116 signed affidavit that she or he has completed a minimum of 10
117 continuing medical education hours in the specialty practice in
118 which the physician assistant has prescriptive privileges with
119 each licensure renewal application.
120 6. The department shall issue a license and a prescriber
121 number to the physician assistant granting authority for the
122 prescribing of medicinal drugs authorized within this paragraph
123 upon completion of the foregoing requirements. The physician
124 assistant shall not be required to independently register
125 pursuant to s. 465.0276.
126 7. The prescription must be written in a form that
127 complies with chapter 499 and must contain, in addition to the
128 supervisory physician's name, address, and telephone number, the
129 physician assistant's prescriber number. Unless it is a drug or
130 drug sample dispensed by the physician assistant, the
131 prescription must be filled in a pharmacy permitted under
132 chapter 465, and must be dispensed in that pharmacy by a
133 pharmacist licensed under chapter 465. The appearance of the
134 prescriber number creates a presumption that the physician
135 assistant is authorized to prescribe the medicinal drug and the
136 prescription is valid.
137 8. The physician assistant must note the prescription or
138 dispensing of medication in the appropriate medical record, and
139 the supervisory physician must review and sign each notation.
140 For dispensing purposes only, the failure of the supervisory
141 physician to comply with these requirements does not affect the
142 validity of the prescription.

143 9. This paragraph does not prohibit a supervisory
144 physician from delegating to a physician assistant the authority
145 to order medication for a hospitalized patient of the
146 supervisory physician.
147
148 This paragraph does not apply to facilities licensed pursuant to
149 chapter 395.
150 Section 3. This act shall take effect July 1, 2007.
151
152
153 ================ T I T L E A M E N D M E N T ================
154 Remove the entire title and insert:
155 A bill to be entitled
156 An act relating to physician assistants; amending ss. 458.347,
157 459.022, F.S.; requiring that a prescription be filled in a
158 pharmacy unless it is a drug dispensed by a physician assistant;
159 providing that authority to dispense may be delegated only by
160 supervisory physicians registered as dispensing practitioners;
161 providing an effective date.

HB 1121

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1121 Florida Health Information Network Corporation
SPONSOR(S): Grimsley
TIED BILLS: HB 1123 **IDEN./SIM. BILLS:** SB 2348

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

SUMMARY ANALYSIS

House Bill 1121 creates s. 408.064, F.S., forming the Florida Health Information Network Corporation as a public/private partnership that will establish a secure, privacy-protected, and integrated statewide network for the communication of electronic health information. The not-for-profit corporation will be managed by an uncompensated board of directors that will consist of 15 members.

The agency is required to develop a plan and performance standards for the formation and operation of the network and must contract with the corporation to implement the plan for the period of July 1, 2007, through June 30, 2010.

The primary duty of the Florida Health Information Network Corporation is implementing and overseeing a statewide health information network. Among the other duties given to the corporation, the Florida Health Information Network Corporation is charged with developing and enforcing interoperability, privacy, and security standards, fostering the creation and expansion of regional health information organizations, and recruiting participants into the network.

The bill requires the Florida Health Information Network to develop a business plan to operate the network without state funding after June 30, 2010. The business plan must be submitted to the Governor and the Legislature by January 2, 2009.

The Agency for Health Care Administration must review the operation and use of the network and make recommendations for the network's continued development by June 30, 2009 to the Governor and the Legislature.

This bill will require a General Revenue appropriation of $9,443,598 in Fiscal Year 2007-08 in order to contract with the Florida Health Information Network Corporation to begin the implementation of the network. The fiscal impact to complete the development of the network will be $8,742,898 in FY 2008-09 and $7,726,898 in FY 2009-10.

The effective date of this bill is July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – this bill creates the Florida Health Information Network Corporation as a not-for-profit corporation and requires the corporation to develop a business plan to operate the network without state funding after June 30, 2010.

Empower families – full implementation of the network will likely reduce the cost, and increase the quality, of health care by promoting continuity of care among providers and potentially reducing unnecessary treatments.

Maintain public security – full implementation of the network will likely encourage widespread adoption of electronic medical records, enhancing the security and accessibility of these records during and following natural or manmade disasters.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Widespread adoption of electronic medical records holds the promise of improving patient safety and reducing the cost of health care by preventing unnecessary procedures. However, in a recent report, the National Center for Health Statistics (NCHS) within the United States Centers for Disease Control and Prevention noted that adoption of information technology within the health care sector is trailing behind other sectors in the economy of the United States[1]. The adoption of electronic medical records (EMRs) by hospitals and physicians has been particularly slow. As part of its annual National Health Care Survey, NCHS found that, from 2001 through 2003:

- The most frequent IT application used in physician offices was an electronic billing system. Nearly three-fourths (73 percent) of physicians submitted claims electronically. Electronic submission of claims was more likely among physicians in the Midwest and South, in nonmetropolitan areas, among physicians under 50 years of age, and for physicians with 10 or more managed care contracts. Physicians in medical specialties such as psychiatry, dermatology, or sports medicine (among others) were least likely to submit claims electronically.
- EMRs were used more frequently in hospital settings (31 percent in emergency departments) than in physician offices (17 percent). Among physician office practices, there were no statistically significant differences in EMR use by region, metropolitan status, specialty, physician age, type of practice, or number of managed care contracts.

Health information technology at the federal level
On April 27, 2004, President George W. Bush issued an Executive Order[2] in order to encourage the development of a nationwide interoperable health information technology infrastructure. The Executive Order directed the Secretary of Health and Human Services to establish within the Office of the Secretary the position of National Health Information Technology Coordinator ("national coordinator"). The National Coordinator is tasked with developing, maintaining, and implementing a strategic plan to guide the nationwide implementation of interoperable health information technology in both the public and private health care sectors in order to reduce medical errors, improve quality, and produce greater value for health care expenditures. The National Coordinator is expected to publish its strategic plan by Spring, 2007.

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[1] C.W. Burt and E. Hing, *Use of Computerized Clinical Support Systems in Medical Settings: United States, 2001–03*, Advance Data from Vital and Health Statistics no. 353, March 15, 2005.
[2] *Executive Order: Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator* (visited March 5, 2007) http://www.whitehouse.gov/news/releases/2004/04/20040427-4.html

In order to further the President's initiative, on September 13, 2005, Secretary Michael Leavitt, United States Department of Health and Human Services, created the American Health Information Community (AHIC). The AHIC is chartered with two primary goals:

- Recommend to the Secretary specific actions to achieve a common interoperability framework for health information technology; and
- Serve as a forum for participation for a broad range of stakeholders to provide input on achieving widespread adoption of interoperable health information technology.

The AHIC has identified four initial areas with potential for early advancement:

- Consumer Empowerment - Make available a consumer-directed and secure electronic record of health care registration information and a medication history for patients.
- Chronic Care - Allow the widespread use of secure messaging, as appropriate, as a means of communication between doctors and patients about care delivery.
- Biosurveillance - Enable the transfer of standardized and anonymized health data from the point of health care delivery to authorized public health agencies within 24 hours of its collection.
- Electronic Health Records - Create an electronic health record that includes laboratory results and interpretations, that is standardized, widely available and secure.[3]

The AHIC expects to deliver its recommendations in these four areas in calendar year 2007.

On August 22, 2006, President Bush signed an Executive Order[4] in order to "promote quality and efficient delivery of health care through the use of health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers." With regard to the use of health information technology, the Executive Order specifically directed federal agencies, as they implement, acquire, or upgrade health information technology systems used for the direct exchange of health information between agencies and with non-Federal entities, to utilize, where available, health information technology systems and products that meet recognized interoperability standards.

Among the federal agencies, the Veterans Health Administration (VHA) within the United States Department of Veterans Affairs is the most advanced in adopting health information technology. The VHA employs more than 180,000 health care practitioners in more than 1,000 facilities yet, according to a 2003 article in the International Journal of Medical Informatics[5], has computerized medical documentation and ordering at every facility. According to the article, during September 2002 alone, providers entered 90.6% of all inpatient and outpatient pharmacy orders nationwide.

Health information technology in Florida

On May 4, 2004, Governor Jeb Bush signed Executive Order Number 04-93[6], creating the Governor's Health Information Infrastructure Advisory Board ("board"). The Executive Order stated that the board must "advise and support the Agency for Health Care Administration ("Agency") as it develops and implements a strategy for the adoption and use of electronic health records and creates a plan to promote the development and implementation of a Florida health information infrastructure." The board continues in existence until all of its objectives are achieved, but no later than June 30, 2007. The Executive Order named W. Michael Heekin as Chair of the Board.

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[3] *American Health Information Community: Background* (visited March 5, 2007) http://www.os.dhhs.gov/healthit/community/background

[4] *Executive Order: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs* (visited March 5, 2007) http://www.whitehouse.gov/news/releases/2006/08/20060822-2.html

[5] S.H. Brown et al., International Journal of Medical Informatics 69 (2003).

[6] Executive Order Number 04-93 (2004), available at http://ahca.myflorida.com/dhit/pdf/executive_order.pdf

The board's interim report issued in 2005 called for, among other recommendations, the immediate development of the Florida Health Information Network (FHIN) in order to encourage the adoption of electronic health records.[7]

The agency's strategy in building the FHIN starts in the local community by encouraging local stakeholders to begin the electronic exchange of health records, otherwise generally known as Regional Health Information Organizations (RHIOs). To that end, the 2005 Legislature appropriated $1.5 million in Fiscal Year 2005-06 to AHCA for a FHIN grants program in order to encourage the development of RHIOs, subject to Legislative Budget Commission approval[8]. In 2006, the Legislature appropriated an additional $2 million in Fiscal Year 2006-07 for RHIO grants. According to the agency, these grants are awarded in three categories:

- Planning Grants - Support engaging appropriate health care stakeholders to develop a strategic plan for health information exchange in their communities;
- Implementation Grants - Support projects that demonstrate health information exchange among two or more competing provider organizations; and
- Training Grants - Support practitioner training designed to increase physician and dentist use of electronic health record systems.

In Fiscal Year 2005-06, nine grant projects were awarded during January through June 30, 2006. These include five planning grants, three implementation grants and one technical assistance grant. In Fiscal Year 2006-07, the agency awarded an additional seven grants.

According to the agency, ten RHIOs are operating throughout the state, each with varying degrees of capacity for electronically exchanging health records:

- Big Bend RHIO;
- Central Florida RHIO;
- Community Health Information Organization;
- Escambia HIN;
- Jacksonville Health Information Network;
- Palm Beach County Community Health Alliance;
- Pinellas RHIO;
- Space Coast Health Information Network;
- South Florida HII; and
- Tampa Bay RHIO.

Not-For-Profit Corporations

Chapter 617, F.S., governs the creation and operation of not-for-profit corporations in the state. Under s. 617.01401(5), F.S., a "corporation not for profit" is defined to mean a corporation no part of the income or profit of which is distributable to its members, directors, or officers. "Board of directors" is defined in s. 617.01401(2), F.S., to mean the group of persons vested with the management of the affairs of the corporation irrespective of the name by which such group is designated, including, but not limited to, managers or trustees. Section 617.0302, F.S., specifies the powers of not-for-profit corporations, which includes, among other powers, the power to acquire, enjoy, utilize, and dispose of patents, copyrights, and trademarks and any licenses and other rights or interests thereunder or therein.

Effect of Proposed Changes

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[7] Governor's Health Information Infrastructure Advisory Board, *First Interim Report to Governor Jeb Bush*, available at http://ahca.myflorida.com/dhit/pdf/interim_rept_gov.pdf

[8] *See also* s. 408.05(4)(b), F.S. (directing the Agency to "administer, manage, and monitor grants to not-for-profit organizations, regional health information organizations, public health departments, or state agencies that submit proposals for planning, implementation, or training projects to advance the development of a health information network.")

House Bill 1121 creates s. 408.064, F.S., forming the Florida Health Information Network Corporation ("corporation") as a public/private partnership that will establish a secure, privacy-protected, and integrated statewide network ("network") for the communication of electronic health information. The not-for-profit corporation is managed by an uncompensated board of directors, which will consist of the following 15 members:

- The Secretary of Agency for Health Care Administration or the secretary's designee;
- The Secretary of the Department of Health or the secretary's designee;
- The Secretary of the Department of Elderly Affairs or the secretary's designee; and
- Twelve members from the private or public sector, three of whom shall be appointed by the Governor, four of whom shall be appointed by the President of the Senate, four of whom shall be appointed by the Speaker of the House of Representatives, and one member who shall be appointed by the Chief Financial Officer.

Appointed members serve a term of four years, except that the initial appointees of the Governor are staggered.

The corporation is expressly subject to public records and public meetings laws under chapter 119, F.S. and chapter 286, F.S., respectively.

The agency is required to develop a plan and performance standards for the formation and operation of the network and must contract with the corporation to implement the plan for the period of July 1, 2007, through June 30, 2010. In implementing the network, the corporation is directed to:

- Develop and maintain the technical infrastructure necessary to perform the functions of the network;
- Implement a marketing program to promote widespread use of the network;
- Develop and implement specific programs or strategies that address the creation, development, and expansion of RHIOs and the recruitment of participants in the network;
- Develop and enforce interoperability, operational, and technical standards among regional and local health information networks;
- Develop an annual budget that includes funding from public and private entities, including user fees;
- Develop and enforce privacy and security standards for participation in the network;
- Ensure the technological standards of the network are aligned with widely adopted standards or standards accepted by a recognized organization that establishes national standards for electronic information networks; and
- Recommend reform of state law to reduce barriers to participation in the network.

The bill requires the Florida Health Information Network to develop a business plan to operate the network without state funding after June 30, 2010. The business plan must be submitted to the Governor and the Legislature by January 2, 2009.

The Agency for Health Care Administration must review the operation and use of the network and make recommendations for the network's continued development by June 30, 2009 to the Governor and the Legislature.

The corporation is required to seek funding through public and private entities to accomplish its duties. Funds appropriated for the Florida Health Information Network grants program are prohibited from being used to directly fund the operation of the corporation.

The effective date of the bill is July 1, 2007.

C. SECTION DIRECTORY:

Section 1. Creates s. 408.064, F.S., relating to the Florida Health Information Network Corporation.

Section 2. 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:

   According to the agency, the fiscal impact in FY 2007-08 will be $9,443,598; in FY 2008-09, $8,742,898; and in FY 2009-10, $7,726,898. General Revenue Funds will be required to implement the provisions of this bill. Specifically, the funds will be used for the following activities:

FHIN Proposal Goals, 2007-2008	**Budget**
FHIN Administrative Support	$2,576,898
Build Main FHIN Server (Budget is based on build-it scenario)	$4,733,200
Integrate AHCA Inpatient/Outpatient/ED databases	$600,000
Develop Web Portal	$800,000
Create FHIN Web Portal Provider Workgroup to determine priorities for website	$221,000
Communication and Training plans	$512,500
Total Budget	$9,443,598

FHIN Proposal Goals, 2008-2009	**Budget**
FHIN Administrative Support	$2,576,898
Build edge server to manage access to state agency databases (DOH), county health departments and Florida RHIOs and maintain existing servers	$3,625,000
Integrate DOH SHOTS database, additional Payor databases and RHIOs in Tallahassee, Tampa and Palm Beach	$1,600,000
Expand web portal for access by providers	$500,000
Create FHIN Data Integration State Agency Workgroup	$16,000
Communication, Training and Evaluation	$425,000
Total Budget	$8,742,898

FHIN Proposal Goals, 2009-2010	Budget
FHIN Administrative Support	$2,060,898
Maintain servers managing access to state agency databases (DOH), Payors and RHIOs, and add other health care servers	$950,000
Develop MPI and RLS for additional databases from DOH County Health Departments, four RHIOs and one federal agency	$2,150,000
Integrate DOH, RHIO and DOD databases; create interactive queries	$1,500,000
Expand web portal for access by providers, adding access interfaces	$500,000
Maintain FHIN Data Integration State Agency Workgroup and include Federal stakeholders	$16,000
Communication, Training and Evaluation	$550,000
Total Budget	$7,726,898

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The creation of a statewide network for the exchange of electronic medical records may result in substantial savings to patients, providers, and payors, particularly with respect to increased efficiency and reduction of unnecessary treatments.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to affect municipal or county government.

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:

None.

D. STATEMENT OF THE SPONSOR

"The FHIN is the single most transformative initiative possible to improve quality and efficiency in the entire health care sector - both government and private."

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the Florida Health Information Network
3 Corporation; creating s. 408.064, F.S.; providing a short
4 title; providing legislative intent; requiring the Agency
5 for Health Care Administration to develop and implement a
6 plan for the formation and operation of a health
7 information network; requiring the agency to contract to
8 implement the plan; creating the Florida Health
9 Information Network Corporation, as a not-for-profit
10 corporation; providing for a board of directors; providing
11 for appointment of board members; providing for terms;
12 providing that the corporation and any boards or
13 committees formed by the corporation are subject to public
14 records and meetings requirements; providing duties and
15 responsibilities of the corporation; requiring a report to
16 the Governor and Legislature; requiring the corporation to
17 develop a business plan and submit the plan to the
18 Governor and Legislature; providing conditions for funding
19 the network; providing an effective date.
20
21 Be It Enacted by the Legislature of the State of Florida:
22
23 Section 1. Section 408.064, Florida Statutes, is created
24 to read:
25 408.064 Florida Health Information Network Act; purpose;
26 duties.--
27 (1) This section may be cited as the "Florida Health
28 Information Network Act."

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

29 (2) It is the intent of the Legislature that the state
30 shall promote the establishment of a privacy-protected, secure,
31 and integrated statewide network for the communication of
32 electronic health information among authorized parties through a
33 coordinated public-private initiative that will develop and
34 operate the state's health information infrastructure.
35 (3) The agency is responsible for promoting the
36 development of a health information network as a public-private
37 partnership among the state's providers, payors, consumers,
38 employers, public health officials, medical researchers, and
39 other health care stakeholders. The agency shall develop a plan
40 and performance standards for the formation and operation of a
41 health information network and shall contract with the Florida
42 Health Information Network Corporation to implement the plan,
43 consistent with the performance standards for the period July 1,
44 2007, through June 30, 2010.
45 (4) There is created a not-for-profit corporation, to be
46 known as the "Florida Health Information Network Corporation,"
47 which shall be registered, incorporated, organized, and operated
48 in compliance with chapter 617.
49 (a) The affairs of the corporation shall be managed by a
50 board of directors who shall serve without compensation. The
51 board of directors shall biennially elect one of its members as
52 chairperson. The board of directors shall consist of the
53 following members:
54 1. The Secretary of Health Care Administration or the
55 secretary's designee.
56 2. The Secretary of Health or the secretary's designee.

57 3. The Secretary of Elderly Affairs or the secretary's
58 designee.
59 4. Twelve members from the private or public sector, three
60 of whom shall be appointed by the Governor, four of whom shall
61 be appointed by the President of the Senate, four of whom shall
62 be appointed by the Speaker of the House of Representatives, and
63 one member who shall be appointed by the Chief Financial
64 Officer.
65 (b) Members shall be appointed for terms of 4 years,
66 except that, for members initially appointed by the Governor,
67 one shall be appointed for a term of 1 year, one shall be
68 appointed for a term of 2 years, and one shall be appointed for
69 a term of 3 years. Any member is eligible for reappointment. A
70 vacancy on the board of directors shall be filled for the
71 remainder of the unexpired term.
72 (c) Vacancies on the board shall be filled by appointment
73 by the Governor, the President of the Senate, the Speaker of the
74 House of Representatives, or the Chief Financial Officer,
75 respectively, depending on who appointed the member whose
76 vacancy is to be filled or whose term has expired.
77 (5) The Legislature specifically declares that the
78 corporation, and the boards, advisory committees, or similar
79 groups created by the corporation, are subject to the provisions
80 of chapter 119, relating to public records, and those provisions
81 of chapter 286 relating to public meetings and records.
82 (6) The corporation shall:
83 (a) Institute a statewide health information network by:
84 1. Devising, implementing, and regularly revising a

85 strategic plan for infrastructure development.
86 2. Developing and maintaining the technical infrastructure
87 necessary to perform the functions of the network consistent
88 with the strategic plan.
89 3. Promoting an integrated approach to creating a secure
90 network for the communication of electronic health information
91 in the state.
92 4. Implementing a marketing program to promote widespread
93 use of the network.
94 5. Assisting in the development and expansion of existing
95 regional or local health information networks and the creation
96 of new networks.
97 (b) Develop and implement specific programs or strategies
98 that address the creation, development, and expansion of
99 regional or local health information networks and the
100 recruitment of participants in the network.
101 (c) Regularly assess the adoption of electronic health
102 records systems and utilization of the statewide network by
103 providers, consumers, public health officers, and other health
104 care stakeholders to identify and evaluate the strengths and
105 weaknesses of the state's health information infrastructure;
106 promote increased consumer access to consumer health records;
107 and incorporate that information into its regular strategic
108 planning process.
109 (d) Develop and enforce interoperability, operational, and
110 technical standards among regional and local health information
111 networks to ensure effective statewide efficiency and
112 interoperability across networks

113 (e) Develop an annual budget that includes funding from
114 public and private entities, including user fees.
115 (f) Implement commercially reasonable measures to protect
116 the corporation's intellectual property, including obtaining
117 patents, trademarks, and copyrights.
118 (g) Recommend reform of state law to reduce barriers to
119 participation in the network.
120 (h) Develop and maintain the technical infrastructure
121 necessary to perform the functions of the network consistent
122 with the strategic plan, including a record locator service,
123 access control systems, secure communications, audit and
124 reporting functions, and disaster recovery of core functions.
125 (i) Develop and enforce privacy and security standards for
126 participation in the network, including uniform policies and
127 procedures regarding the confidentiality of medical records,
128 authorization requirements for health information exchange
129 within the network, and technical standards for secure data
130 transmission and storage within the network.
131 (j) Ensure the technological standards of the network are
132 in alignment with widely adopted standards or standards accepted
133 by a recognized organization that establishes national standards
134 for electronic information networks.
135 (7) The agency shall review the operation and use of the
136 network and make recommendations for its continued development
137 in a report to be submitted to the Governor and the relevant
138 committees of the Senate and the House of Representatives by
139 June 30, 2009.

140 (8) The corporation must develop a business plan to
141 operate the network without state funding after June 30, 2010.
142 The business plan must be submitted to the Governor and the
143 relevant committees of the Senate and the House of
144 Representatives by January 2, 2009.
145 (9) The corporation must seek funding through public and
146 private entities to accomplish its goals and duties. Funds
147 appropriated for the Florida Health Information Network grants
148 program within the agency shall not be used to directly fund the
149 operation of the corporation.
150 Section 2. This act shall take effect July 1, 2007.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1123 Pub. Rec./Florida Health Information Network Corporation
SPONSOR(S): Grimsley
TIED BILLS: HB 1121 **IDEN./SIM. BILLS:** SB 2252, SB 2350

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

SUMMARY ANALYSIS

House Bill 1123 creates a public records exemption for certain information held by the Florida Health Information Network Corporation established in HB 1121. Information made confidential and exempt includes:

- A patient's medical or health record;
- Trade secrets as defined in the Uniform Trade Secrets Act; and
- Any information received from a person from another state or nation or the Federal Government, which is otherwise confidential or exempt pursuant to the laws of that state or nation or pursuant to federal law.

The bill provides that the patient medical records may be disclosed with a patient's written consent and in a medical emergency.

HB 1123 is linked to HB 1121. HB 1121 creates a public/private partnership that will establish a secure, privacy-protected, and integrated statewide network for the communication of electronic health information.

The bill provides for future review and repeal of the exemption on October 2, 2012, provides a statement of public necessity, and provides a contingent effective date.

The bill requires a two-thirds vote of the members present and voting for passage.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Safeguard individual liberty – this bill ensures that patient records are confidential and exempt from public disclosure.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Public Records and Public Meetings Laws
Article I, s. 24(a), Florida Constitution, sets forth the state's public policy regarding access to government records. The section guarantees every person a right to inspect or copy any public record of the legislative, executive, and judicial branches of government. Article I, s. 24(b), Florida Constitution, sets forth the state's public policy regarding access to government meetings. The section requires all meetings of the executive branch and local government to be open and noticed to the public. The Legislature may, however, provide by general law for the exemption of records and meetings from the requirements of Article I, s. 24, Florida Constitution. The general law must state with specificity the public necessity justifying the exemption and must be no broader than necessary to accomplish its purpose.

Public policy regarding access to government records and meetings is also addressed in the Florida Statutes. Section 119.07(1), F.S., guarantees every person a right to inspect, examine, and copy any state, county, or municipal record, and s. 286.011, F.S., requires that all state, county, or municipal meetings be open and noticed to the public. Furthermore, the Open Government Sunset Review Act of 1995[1] provides that a public records or public meetings exemption may be created or maintained only if it serves an identifiable public purpose, and may be no broader than is necessary to meet one of the following public purposes:

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

House Bill 1121
House Bill 1121 creates s. 408.064, F.S., forming the Florida Health Information Network Corporation as a public/private partnership that will establish a secure, privacy-protected, and integrated statewide network for the communication of electronic health information. The not-for-profit corporation will be managed by an uncompensated board of directors that will consist of 15 members.

The primary duty of the Florida Health Information Network Corporation is implementing and overseeing a statewide health information network. Among the other duties given to the corporation, the Florida Health Information Network Corporation is charged with developing and enforcing interoperability, privacy, and security standards, fostering the creation and expansion of regional health information organizations, and recruiting participants into the network.

Effect of Proposed Changes

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[1] s. 119.15, F.S.

HB 1123 creates s. 408.0641, F.S., to provide a public records exemption for certain information held by the Florida Health Information Network, Inc. The confidential and exempt[2] information includes:

- A patient's medical or health record;
- Trade secrets as defined in the Uniform Trade Secrets Act;[3] and
- Any information received from a person from another state or nation or the Federal Government, which is otherwise confidential or exempt pursuant to the laws of that state or nation or pursuant to federal law.

The bill provides that the patient medical records may be disclosed with a patient's written consent and in a medical emergency.

The bill provides for future review and repeal of the exemption on October 2, 2012, pursuant to the Open Government Sunset Review Act.[4] It also provides a statement of public necessity and provides a contingent effective date.

C. SECTION DIRECTORY:

Section 1. Creates s. 408.0641, F.S., to create a public records exemption for a patient's medical records, trade secrets, and any other information that is confidential under state or federal law held by the Florida Health Information Network Corporation.

Section 2. Provides a statement of public necessity.

Section 3. Provides a contingent effective date.

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:

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[2] There is a difference between records that are exempt from public records requirements and those that are *confidential* and exempt. If the Legislature makes a record confidential and exempt, such record cannot be released by an agency to anyone other than to the persons or entities designated in the statute. *See* Attorney General Opinion 85-62. If a record is simply made exempt from disclosure requirements, an agency is not prohibited from disclosing the record in all circumstances. *See Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA), review denied, 589 So.2d 289 (Fla. 1991).

[3] Section 688.002, F.S.

[4] Section 119.15, F.S.

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 does not appear to affect municipal or county government.

2. Other:

Vote Requirement

Article I, s. 24(c) of the Florida Constitution, requires a two-thirds vote of the members present and voting for passage of a newly created public records or public meetings exemption. The bill creates a public records exemption and thus requires a two-thirds vote for passage.

Public Necessity Statement

Article I, s. 24(c) of the Florida Constitution, requires a statement of public necessity for a newly created public records or public meetings exemption. The bill creates a public records exemption and thus includes a public necessity statement.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

"The FHIN is the single most transformative initiative possible to improve quality and efficiency in the entire health care sector - both government and private."

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to public records; creating s. 408.0641,
3 F.S.; providing an exemption from public records
4 requirements for patient medical or health records, trade
5 secrets, and certain other information that is
6 confidential or exempt contained in records of the Florida
7 Health Information Network Corporation; providing an
8 exception to the exemption; providing for review and
9 repeal; providing a statement of public necessity;
10 providing a contingent effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Section 408.0641, Florida Statutes, is created
15 to read:
16 408.0641 Florida Health Information Network Corporation;
17 public records exemption.--
18 (1) The following information held by the Florida Health
19 Information Network Corporation is confidential and exempt from
20 s. 119.07(1) and s. 24, Art. I of the State Constitution:
21 (a) A patient's medical or health record.
22 (b) Trade secrets as defined in s. 688.002.
23 (c) Any information received from a person from another
24 state or nation or the Federal Government which is otherwise
25 confidential or exempt pursuant to the laws of that state or
26 nation or pursuant to federal law.
27 (2) A patient's medical or health record may be disclosed:
28 (a) With the express written consent of the individual or

29 the individual's legally authorized representative.
30 (b) In a medical emergency, but only to the extent
31 necessary to protect the health or life of the individual.
32 (3) This section is subject to the Open Government Sunset
33 Review Act in accordance with s. 119.15 and shall stand repealed
34 on October 2, 2012, unless reviewed and saved from repeal
35 through reenactment by the Legislature.
36 Section 2. The Legislature finds that it is a public
37 necessity that a patient's medical or health record held by the
38 Florida Health Information Network Corporation, a not-for-profit
39 corporation, be made confidential and exempt from public records
40 requirements. Matters of personal health are traditionally
41 private and confidential concerns between the patient and the
42 health care provider. The private and confidential nature of
43 personal health matters pervades both the public and private
44 health care sectors. For these reasons, the individual's
45 expectation of and right to privacy in all matters regarding his
46 or her personal health necessitates this exemption. The
47 Legislature further finds that it is a public necessity to
48 protect a patient's medical record or health record because the
49 release of such record could be defamatory to the patient or
50 could cause unwarranted damage to the name or reputation of that
51 patient. The Legislature also finds that it is a public
52 necessity to protect the release of a trade secret as defined in
53 s. 688.002, Florida Statutes. A trade secret derives independent
54 economic value, actual or potential, from not being generally
55 known to, and not being readily ascertainable by proper means
56 by, other persons who can obtain economic value from its

57 disclosure or use. Without an exemption from public records
58 requirements for a trade secret as defined in s. 688.002,
59 Florida Statutes, that trade secret becomes a public record when
60 held by the Florida Health Information Network Corporation, and
61 must be divulged upon request. Divulgence of any trade secret
62 under the public records law would destroy the value of that
63 property. Release of that information would give business
64 competitors an unfair advantage and weaken the position of the
65 corporation in the marketplace. Thus, the Legislature finds that
66 it is a public necessity that a trade secret be made
67 confidential and exempt from public records requirements.
68 Finally, the Legislature finds that it is a public necessity to
69 protect information received by the Florida Health Information
70 Network Corporation, from a person from another state or nation
71 or the Federal Government which is otherwise exempt or
72 confidential pursuant to the laws of that state or nation or
73 pursuant to federal law. Without this protection, another state
74 or nation or the Federal Government might be less likely to
75 provide information to the corporation in the furtherance of its
76 duties and responsibilities.
77 Section 3. This act shall take effect July 1, 2007, if
78 House Bill 1121 or similar legislation creating the Florida
79 Health Information Network Corporation is adopted in the same
80 legislative session or an extension thereof and becomes law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCC 07-02 Tobacco Education and Prevention
SPONSOR(S): Health Care Council
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Healthcare Council			
Committee on Health Quality		Lowell	Lowell
1)			
2)			
3)			
4)			

SUMMARY ANALYSIS

This Proposed Council Bill requires the Department of Health to conduct a comprehensive, statewide tobacco education and prevention program consistent with the 1999 Best Practices for Comprehensive Tobacco Control Programs developed by the United States Centers for Disease Control and Prevention.

The PCB creates the Tobacco Education and Prevention Oversight Council in order to advise the Secretary of Health as to the direction and scope of the program.

The PCB also creates a competitive grant and contract award program. Grants and contracts will be awarded by the Secretary of Health, in consultation with the council, on the basis of merit through a competitive, peer review process.

Article X, s. 27 of the Florida Constitution requires the Legislature to annually appropriate for the program 15 percent of the total gross funds that tobacco companies paid to the State of Florida in 2005 under the Tobacco Settlement. This amount must be adjusted annually for inflation using the Consumer Price Index.

The effective date of this bill is July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – this bill creates a tobacco education and prevention program within the department, creates an advisory council, and authorizes the award of grants and contracts through a competitive, peer review process.

Empower families – this bill increases opportunities for local and statewide organizations to support and encourage prevention and cessation of tobacco use by parents and their children.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

National Best Practices for Comprehensive Tobacco Control Programs
In August of 1999, the United States Department of Health and Human Services, Centers for Disease Control and Prevention ("CDC") published *Best Practices for Comprehensive Tobacco Control Programs* ("best practices").[1] The best practices were developed from analyses of programs in California and Massachusetts, as well as from the CDC's involvement in providing technical assistance to Florida, Maine, Minnesota, Mississippi, Oregon, and Texas. The best practices are designed to help states develop comprehensive tobacco control programs and evaluate funding priorities. As noted by the CDC in the best practices, the four primary goals of a comprehensive tobacco control program are:

- Prevent the initiation of tobacco use among young people;
- Promote cessation among young people and adults;
- Eliminate nonsmokers' exposure to environmental tobacco smoke; and
- Identify and eliminate disparities related to tobacco use and its effects among different population groups.

The CDC recommends the following components within each state's tobacco control program:[2]

- Community programs to reduce tobacco use;
- Chronic disease programs to reduce the burden of tobacco-related diseases;
- School programs;
- Enforcement;
- Statewide programs;
- Counter-marketing;
- Cessation programs;
- Surveillance and evaluation; and
- Administration and management.

The following is a brief description of each component.

Community programs to reduce tobacco use. The CDC notes that this component should focus on four primary goals: (1) prevention of the initiation of tobacco use among young people; (2) cessation for current users of tobacco; (3) protection from environmental tobacco smoke; and (4) elimination of disparities in tobacco use among populations. In particular, the CDC states that effective community

[1] *Best Practices for Comprehensive Tobacco Control Programs, August 1999* (visited March 9, 2007) http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/index.htm
[2] The CDC has informed staff that the *Best Practices* are being updated, which may result in the consolidation and renaming of some of the program components.

programs "involve people in their homes, work sites, schools, places of worship and entertainment, civic organizations, and other public places."

Chronic disease programs to reduce the burden of tobacco-related diseases. Examples of activities that may reduce the burden of tobacco-related diseases include: (1) community interventions that link tobacco control interventions with cardiovascular disease prevention; (2) counter-marketing to increase awareness of environmental tobacco smoke as a trigger for asthma; (3) training dental providers to counsel their patients on the role of tobacco use in the development of oral cancer; and (4) expanding cancer registries to monitor tobacco-related cancers.

School programs. The CDC notes that, since most people who are smokers start smoking before age 18, school-based programs are a "crucial part" of a state's prevention program. Specifically, education should be provided in elementary school and continued through and middle and high school.

Enforcement. The CDC best practices focus on two areas of enforcement: restriction on minors' access to tobacco and restrictions on smoking. Florida law currently addresses both of these areas.[3]

Statewide programs. The CDC states that these programs are a "major element" of the best practices. Examples of statewide programs include: (1) funding municipal organizations and networks to collect data and develop and implement culturally appropriate interventions; (2) sponsoring local, regional, and statewide training, conferences, and technical assistance on best practices; and (3) supporting innovative demonstration and research projects to prevent youth tobacco use, promote cessation, and promote smoke free communities.

Counter-marketing. According to the CDC, children are most susceptible to advertised brands and are three times more affected by advertising than adults. Consequently, a sustained counter-marketing campaign in intensity similar to tobacco advertising is needed. Counter-marketing consists of a number of approaches, including not only traditional print, radio, and television advertisements, but also press releases, media advocacy, and local events.

Cessation programs. The CDC notes that cessation programs may produce a quicker and larger short-term public health benefit than any other best practice component. Examples of cessation programs include: (1) covering treatment for tobacco use under both public and private insurance and (2) establishing population-based counseling and treatment programs, including cessation quitlines.

Surveillance and Evaluation. This component is necessary to assess program accountability and effectiveness. In particular, surveillance should monitor the decrease of the prevalence of tobacco use among young people and adults; per-capita tobacco consumption; and exposure to environmental tobacco smoke. In addition, evaluation programs should focus on individual program activities. The CDC recommends that 10 percent of the state's program budget be allocated for surveillance and evaluation.

Administration and management. The CDC recommends that 5 percent of the state's program budget be allocated to administration and management.

The Department of Health Tobacco Prevention Program

On August 25, 1997, the State of Florida entered into a settlement agreement with five tobacco companies, ending a lawsuit to recover Medicaid costs for tobacco-related illnesses. These five companies are Philip Morris, R.J. Reynolds, Brown & Williamson, Lorillard, and the United States Tobacco Company. As a result of the settlement agreement, in Fiscal Year 1997-98, Florida's tobacco prevention program began as the Youth Tobacco Pilot Program created in proviso.

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[3] *See* Part II of Chapter 386, F.S., the Clean Indoor Air Act. *Also see* s. 569.101, F.S. (prohibiting the sale of tobacco products to persons under the age of 18).

The program has evolved to placing a Tobacco Prevention Specialist in 39 county health departments. These specialists create comprehensive tobacco prevention programs in each of the 39 counties, specifically: (1) a youth initiation prevention component (SWAT); (2) a cessation component; and (3) second hand smoke reduction programs. The remaining 28 counties receive $10,000 to support the tobacco component of the Chronic Disease Program; these funds maybe used for SWAT support; cessation services; and secondhand smoke awareness. In addition, the department operates the "Florida Tobacco Quit-For-Life Line" quitline through contract with the American Cancer Society.

Amendment 4

On November 7, 2006, the people of the state of Florida adopted Amendment 4,[4] creating the Comprehensive Statewide Tobacco Education and Prevention Program. Under the amendment, the state is required to create a comprehensive, statewide program consistent with the CDC's 1999 best practices. In particular, the program must consist of the following program components:

- An advertising campaign, funded by at least one-third of the required annual appropriation;
- Evidence-based curricula and programs to educate youth about tobacco and discourage their use of it;
- Programs of local community-based partnerships;
- Enforcement of laws, regulations, and policies against the sale or other provision of tobacco to minors, and the possession of tobacco by minors; and
- Publicly-reported annual evaluations to ensure that moneys appropriated for the program are spent properly.

The amendment specifies that the Legislature must appropriate 15 percent of the total gross funds that tobacco companies paid to the State of Florida in 2005 under the Tobacco Settlement. This amount must be adjusted annually for inflation using the Consumer Price Index.

Effect of Proposed Changes

The Proposed Council Bill ("PCB") requires the Department of Health ("department") to conduct a comprehensive, statewide tobacco education and prevention program consistent with the 1999 Best Practices for Comprehensive Tobacco Control Programs developed by the United States Centers for Disease Control and Prevention.

The department is required to include the following components within the program:

- An advertising campaign;
- Cessation programs;
- Evaluations of community and statewide programs;
- Evidence-based curricula and programs;
- Programs of local-community based partnerships; and
- Training of health care providers and smoking cessation counselors.

The PCB also creates the Tobacco Education and Prevention Oversight Council ("council") in order to advise the Secretary of Health as to the direction and scope of the program. The council consists of 14 members, including:

- The Secretary of Health, or a designee;
- Two members appointed by the Commissioner of Education, of which one must be a school district superintendent;
- The CEO of the Florida Division of the American Cancer Society;
- The CEO of the Greater Southeast Affiliate of the American Heart Association;
- The CEO of the American Lung Association of Florida;
- Four members appointed by the Governor;
- Two members appointed by the Speaker of the House; and
- Two members appointed by the President of the Senate.

[4] Art. X, s. 27, Fla. Const.

In addition, the council is also provided a number of specific duties, including:

- Providing advice on program priorities and emphases;
- Participating in periodic program evaluation;
- Recommending meaningful outcome measures; and
- Recommending policies to encourage a coordinate response to tobacco use in the state.

The PCB creates a competitive grant and contract award program that will award grants and contracts under the program components listed above. Grants and contracts will be awarded by the Secretary of Health, in consultation with the council, on the basis of merit through a competitive, peer review process.

Grant and contract awards are restricted by limiting: (1) the use of food and promotional items to no more than 2.5 percent of the total amount of the contract or grant; (2) overhead or indirect costs to no more than 7.5 percent of the total amount of the contract or grant; and (3) production fees, buyer commissions, and related costs to no more than 5 percent of the total advertising contract amount.

The department is required to annually report on the program's effectiveness, including a survey of youth attitudes and behavior towards tobacco.

Last, the department's administrative expenses are limited to 5 percent of the total appropriation for the program.

C. SECTION DIRECTORY:

Section 1. Creates s. 381.84, F.S., relating to the Comprehensive Statewide Tobacco Education and Prevention Program.

Section 2. 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:

   See fiscal comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The private sector will directly benefit from the availability of grant and contract awards under the program.

D. FISCAL COMMENTS:

Article X, s. 27 of the Florida Constitution requires the Legislature to annually appropriate for the program 15 percent of the total gross funds that tobacco companies paid to the State of Florida in 2005 under the Tobacco Settlement. This amount must be adjusted annually for inflation using the Consumer Price Index. In addition, at least one third of this annual appropriation must be used for the advertising campaign component of the program.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to affect municipal or county government.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The department is provided rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to tobacco education and prevention;
3 creating s. 381.84, F.S.; requiring the Department of
4 Health to conduct a statewide tobacco education and
5 prevention program; establishing components of the
6 program; creating the Tobacco Education and Prevention
7 Advisory Council; providing membership and duties of the
8 council; requiring an annual report by the department;
9 providing an effective date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Section 381.84, Florida Statutes, is created to
14 read:
15 381.84 Comprehensive Statewide Tobacco Education and
16 Prevention Program.--
17 (1) DEFINITIONS.--As used in s. 27, Art. X of the State
18 Constitution and this act, the term:
19 (a) "CDC" means the United States Centers for Disease
20 Control and Prevention.
21 (b) "Department" means the Department of Health.
22 (c) "Tobacco" means, without limitation, tobacco itself and
23 tobacco products that include tobacco and are intended or
24 expected for human use or consumption, including, but not limited
25 to, cigarettes, cigars, pipe tobacco, and smokeless tobacco.
26 (d) "Youth" means minors and young adults.
27 (2) It is the purpose of this act to implement s. 27, Art.
28 X of the State Constitution. The Legislature finds that this
29 section of the State Constitution is intended to require the

30 department to conduct a statewide tobacco education and
31 prevention program that focuses on youth tobacco use. The
32 Legislature further finds that the primary goals of the program
33 are to reduce the prevalence of tobacco use among youth and
34 adults, reduce per-capita tobacco consumption, and reduce
35 exposure to environmental tobacco smoke.
36 (3) The department shall conduct a comprehensive, statewide
37 tobacco education and prevention program consistent with the
38 recommendations for effective program components contained in the
39 1999 Best Practices for Comprehensive Tobacco Control Programs of
40 the CDC, as amended by the CDC. The program must include the
41 following components, each of which must focus on educating
42 people, particularly youth and their parents, about the health
43 hazards of tobacco and discouraging use of tobacco:
44 (a) An advertising campaign utilizing, at a minimum,
45 internet, print, radio, and television advertising, funded with a
46 minimum of one-third of the total annual appropriation required
47 by s. 27, Art. X of the Florida Constitution;
48 (b) Cessation programs, including counseling and treatment;
49 (c) Evaluation of the effectiveness of community and
50 statewide programs;
51 (d) Evidence-based curricula and programs, including
52 school-based and after school programs, which involve youth,
53 educate youth about the health hazards of tobacco, help youth
54 develop skills to refuse tobacco, and demonstrate to youth how to
55 stop using tobacco;
56 (e) Programs of local community-based partnerships,
57 including programs for the prevention, detection, and early
58 intervention of smoking-related chronic diseases; and

59 (f) Training of health care providers and smoking cessation
60 counselors.
61 (4) The Tobacco Education and Prevention Advisory Council
62 is created within the department.
63 (a) The council shall consist of 14 members, including:
64 1. The Secretary of Health, or a designee;
65 2. Two members appointed by the Commissioner of Education,
66 of which one must be a school district superintendent;
67 3. The chief executive officer of the Florida Division of
68 the American Cancer Society, or a designee;
69 4. The chief executive officer of the Greater Southeast
70 Affiliate of the American Heart Association, or a designee;
71 5. The chief executive officer of the American Lung
72 Association of Florida, or a designee;
73 6. Four members appointed by the Governor, of which two
74 must have expertise in the field of tobacco prevention and
75 education or smoking cessation;
76 7. Two members appointed by the President of the Senate, of
77 which one must have expertise in the field of tobacco prevention
78 and education or smoking cessation; and
79 8. Two members appointed by the Speaker of the House of
80 Representatives, of which one must have expertise in the field of
81 tobacco prevention and education or smoking cessation.
82 (b) The appointments shall be for a 3-year term and shall
83 reflect the diversity of the state's population. A vacancy shall
84 be filled by appointment by the original appointing authority for
85 the unexpired portion of the term.
86 (c) An appointed member may not serve more than two
87 consecutive terms.

88 (d) The council shall annually elect from its membership
89 one member to serve as chair of the council and one member to
90 serve as vice chair.
91 (e) The council shall meet at least quarterly and upon the
92 call of the chairperson.
93 (f) Members of the council shall serve without compensation
94 but may be reimbursed for per diem and travel expenses pursuant
95 to s. 112.061.
96 (g) The department shall provide such staff, information,
97 and other assistance as is reasonably necessary to assist the
98 council in carrying out its responsibilities.
99 (5) The council shall advise the Secretary of Health as to
100 the direction and scope of the Tobacco Education and Prevention
101 Program. The responsibilities of the council include, but are not
102 limited to:
103 (a) Providing advice on program priorities and emphases;
104 (b) Providing advice on the overall program budget;
105 (c) Participating in periodic program evaluation;
106 (d) Assisting in the development of guidelines to ensure
107 fairness, neutrality, and adherence to the principles of merit
108 and quality in the conduct of the program;
109 (e) Assisting in the development of administrative
110 procedures relating to solicitation, review, and award of
111 contracts and grants, to ensure an impartial, high-quality peer
112 review system;
113 (f) Assisting in the development and supervision of peer
114 review panels;
115 (g) Reviewing reports of peer review panels and making
116 recommendations for contracts and grants;

117 (h) Recommending meaningful outcome measures through a
118 regular review of tobacco prevention and education strategies and
119 programs of other states and the Federal Government; and
120 (i) Recommending policies to encourage a coordinated
121 response to tobacco use in this state, focusing specifically on
122 creating partnerships within and between the public and private
123 sectors.
124 (6) CONTRACT AND GRANT AWARDS.--Contracts and grants for
125 the program components described in subsection (3) shall be
126 awarded by the Secretary of Health, after consultation with the
127 council, on the basis of merit, as determined by an open,
128 competitive, peer review process that ensures objectivity,
129 consistency, and high quality. A recipient of a contract or grant
130 for the program component described in paragraph (c) of
131 subsection (3) shall not be eligible for a contract or grant
132 award for any other program component described in subsection (3)
133 in the same state fiscal year.
134 (a) To ensure that all proposals for funding are
135 appropriate and are evaluated fairly on the basis of merit, the
136 Secretary of Health, in consultation with the council, shall
137 appoint a peer review panel of independent, qualified experts in
138 the field of tobacco control to review the content of each
139 proposal and establish its priority score. The priority scores
140 shall be forwarded to the council and must be considered in
141 determining which proposals shall be recommended for funding.
142 (b) The council and the peer review panel shall establish
143 and follow rigorous guidelines for ethical conduct and adhere to
144 a strict policy with regard to conflict of interest. A member of
145 the council or panel may not participate in any discussion or

146 decision with respect to a research proposal by any firm, entity,
147 or agency with which the member is associated as a member of the
148 governing body or as an employee, or with which the member has
149 entered into a contractual arrangement. Meetings of the council
150 and the peer review panels shall be subject to the provisions of
151 chapter 119, s. 286.011, and s. 24, Art. I of the State
152 Constitution.
153 (c) In each contract or grant agreement, the department
154 must limit the use of food and promotional items to no more than
155 2.5 percent of the total amount of the contract or grant and
156 limit overhead or indirect costs to no more than 7.5 percent of
157 the total amount of the contract or grant. The department, in
158 consultation with the Department of Financial Services, shall
159 publish guidelines for appropriate food and promotional items.
160 (d) In each advertising contract, the department must limit
161 the total of production fees, buyer commissions, and related
162 costs to no more than 5 percent of the total contract amount.
163 (7) By January 31 of each year, the department must provide
164 to the Legislature and the Governor a report that evaluates the
165 program's effectiveness in reducing and preventing tobacco use
166 and recommends improvements to enhance the program's
167 effectiveness. The report must contain, at a minimum, an annual
168 survey of youth attitudes and behavior toward tobacco, as well as
169 a description of the progress in reducing the prevalence of
170 tobacco use among youth and adults, reducing per-capita tobacco
171 consumption, and reducing exposure to environmental tobacco
172 smoke.
173 (8) From the total funds appropriated for the Comprehensive
174 Statewide Tobacco Education and Prevention Program in the General

175 Appropriations Act, up to 5 percent may be used by the department
176 for administrative expenses.
177 (9) The department may adopt rules necessary to implement
178 this section.
179 Section 2. This act shall take effect July 1, 2007.

House Bill 357
Relating to the Wekiva Onsite Sewage Treatment and Disposal System Compliance Grant Program
By Rep. Nelson

- Establishes the Wekiva Onsite Sewage Treatment and Disposal System Compliance Grant Program in the Department of Health ("department").

- Limits participation in the grant program to property owners whose income is less than or equal to 200% of the federal poverty level.

- Provides grants in the form of rebates, for the construction, reconstruction, alteration, repair, or modification of any new or existing onsite sewage treatment and disposal system, in compliance with rules developed by the department, the Department of Environmental Protection, or the St. Johns Water Management District.

- Provides rule-making authority to the department for implementation of the grants program.

- Provides for the grants program to be contingent upon an appropriation in the General Appropriation Act.

- Limits the maximum grant to $10,000.

- Requires the department, based upon the results of the study funded in the 2006 General Appropriations Act, to prepare a report assessing whether onsite sewage treatment and disposal systems are a significant source of nitrogen to the underlying groundwater relative to other sources. If significant, the department must recommend a range of possible cost-effective onsite wastewater treatment system nitrogen reduction strategies. The report is due to the Governor and Legislature on February 1, 2008.

- Requires the Department of Environmental Protection to, based upon the results of the study funded in the 2006 General Appropriations Act, prepare a report recommending the best use of economic resources to reduce nitrogen outputs into the Wekiva River and associated springs. The report is due to the Governor and Legislature before the 2008 Regular Session.

Fiscal Note

According to the department, the bill will require 1 FTE to implement. The department estimates $1,820,000 will be needed annually to distribute a total of 182 grants per year. The two studies required by the bill may have an indeterminate fiscal impact. The total cost of the bill is estimated to be at least $1,892,919.

1 A bill to be entitled
2 An act relating to the Wekiva Onsite Sewage Treatment and
3 Disposal System Compliance Grant Program; creating the
4 program in the Department of Health; providing purposes;
5 authorizing certain property owners in certain areas of
6 the Wekiva basin to apply for grants for certain purposes;
7 providing grant limitations; providing for annual
8 adjustments of the amount of the grants; providing for the
9 grant as a rebate of costs incurred; requiring
10 documentation of costs; requiring the Department of Health
11 to adopt rules to administer the grant program; specifying
12 implementation as contingent upon appropriation; requiring
13 the Department of Environmental Protection to prepare and
14 submit a report to the Legislature relating to reducing
15 nitrogen inputs into the Wekiva River and associated
16 springs; requiring the Department of Health to prepare and
17 submit a report to the Governor and Legislature relating
18 to whether onsite wastewater treatment systems are a
19 significant source of nitrogen to the underlying
20 groundwater relative to other sources; providing an
21 effective date.
22
23 Be It Enacted by the Legislature of the State of Florida:
24
25 Section 1. Wekiva Onsite Sewage Treatment and Disposal
26 System Compliance Grant Program.--
27 (1) The Wekiva Onsite Sewage Treatment and Disposal System
28 Compliance Grant Program is created within the Department of

29 Health, to be administered by the Department of Health. The
30 purpose of the program is to provide grants to low-income
31 property owners in the Wekiva Study Area or the Wekiva River
32 Protection Area using onsite sewage treatment and disposal
33 systems to assist the property owner in complying with rules for
34 onsite sewage treatment and disposal systems developed by the
35 Department of Health, the Department of Environmental
36 Protection, or the St. Johns River Water Management District to
37 enforce compliance with onsite sewage treatment and disposal
38 system standards.
39 (2) Any property owner in the Wekiva Study Area or the
40 Wekiva River Protection Area having an income less than or equal
41 to 200 percent of the federal poverty guideline who is required
42 by rule of the Department of Health, the Department of
43 Environmental Protection, or the St. Johns River Water
44 Management District to construct, reconstruct, alter, repair, or
45 modify any new or existing onsite sewage treatment and disposal
46 system on such property may apply to the Department of Health
47 for a grant to assist the owner with the cost of compliance.
48 (3) The amount of the grant is limited to $10,000 per
49 property and shall be increased each calendar year by the change
50 in the annual average of the "materials and components for
51 construction" series of the producer price index, as calculated
52 and published by the United States Department of Labor, Bureau
53 of Statistics, from the previous calendar year.
54 (4) The grant shall be in the form of a rebate to the
55 property owner for costs incurred in complying with requirements
56 for onsite sewage treatment and disposal systems. The property

57 owner shall provide to the Department of Health in the
58 application for a grant documentation of costs incurred in
59 complying with requirements for such systems.
60 (5) The Department of Health shall adopt rules pursuant to
61 ss. 120.536(1) and 120.54, Florida Statutes, providing forms,
62 procedures, and requirements for applying for and disbursing
63 grants under this section and for documenting compliance costs
64 incurred.
65 (6) Implementation of this section is contingent upon an
66 appropriation in the General Appropriations Act.
67 Section 2. (1) Based upon the results of the study funded
68 by the 2006 Regular Session of the Legislature, the Department
69 of Environmental Protection shall prepare a report recommending
70 actions to be taken by the Department of Environmental
71 Protection and the St. Johns Water Management District that will
72 provide the best use of economic resources to reduce nitrogen
73 inputs into the Wekiva River and associated springs. The
74 Department of Environmental Protection shall submit the report
75 to the President of the Senate and the Speaker of the House of
76 Representative before the 2008 Regular Session of the
77 Legislature.
78 (2) Based upon the results of the study funded by the 2006
79 Regular Session of the Legislature, the Department of Health
80 shall prepare a report assessing whether onsite wastewater
81 treatment systems are a significant source of nitrogen to the
82 underlying groundwater relative to other sources and shall
83 recommend a range of possible cost-effective onsite wastewater
84 treatment system nitrogen reduction strategies if contributions

85 are significant. The Department of Health shall submit the
86 report to the Governor, the President of the Senate, and the
87 Speaker of the House of Representatives no later than February
88 1, 2008.
89 Section 3. This act shall take effect July 1, 2007.

HB 401

HB 401 – Inmate Testing for HIV Testing

- Requires the Department of Health (department) to designate a total of seven counties to participate in a county detention facility inmate HIV testing program, contingent upon approval by the county government. If the county participates, all county detention facilities within its jurisdiction must participate in the program.

- Testing is required within 30 days of an inmate's scheduled release date, except:
    - In cases where the HIV positive status is already known;
    - A test has been performed within the previous 120 days;
    - A facility received notice of release with less than 30 days that an inmate will be released due to an emergency or a court order; or
    - If the inmate is transferred to the Department of Corrections for incarceration in the state correctional system.

- If an inmate is HIV positive (known or tested), the county detention facility must, prior to release of an inmate:
    - Notify both the DOH and the local county health department serving the county in which the inmate intends to reside; and
    - Provide "special transitional assistance", which includes: education on transmission; a written discharge plan; records of all labs and diagnostic tests; medication and treatment information; and referrals and contact information for providers.

- Civil immunity is provided to any state or local employee for negligently causing death or personal injury while complying with the program.

- Informed consent is not required from inmates tested under this program.

- The bill provides an effective date of July 1, 2007.

Fiscal Impact
The Department of Health estimates that approximately 25% or 240 released, HIV-infected inmates would seek treatment through the local county health departments. At a treatment cost of approximately $25,200 per year for a HIV-positive person. Assuming 50% or 120 HIV-infected released inmates continue treatment, the total cost is $3,024,000 annually.

There is also a cost incurred by local government for the testing services for each inmate. The 2006 estimated cost is $1,448,400 to test approximately 120,000 inmates.

1 A bill to be entitled
2 An act relating to the testing of inmates for HIV
3 infection in certain county detention facilities; amending
4 s. 951.27, F.S.; requiring the Department of Health to
5 designate certain counties, if approved by the county's
6 governing body, to participate in a program to test each
7 inmate for HIV before the inmate is released if the
8 inmate's HIV status is unknown; providing certain
9 exceptions; requiring that certain county detention
10 facilities notify the Department of Health and the county
11 health department in the county where the inmate plans to
12 reside following release if the inmate is HIV positive;
13 requiring certain detention facilities to provide special
14 transitional assistance to an inmate who is HIV positive;
15 providing for immunity for complying entities; amending s.
16 381.004, F.S.; providing that informed consent is not
17 required for an HIV test of an inmate before the inmate's
18 release from a municipal or county detention facility;
19 providing an effective date.
20
21 Be It Enacted by the Legislature of the State of Florida:
22
23 Section 1. Section 951.27, Florida Statutes, is amended to
24 read:
25 951.27 Blood tests of inmates.--
26 (1) Each county and each municipal detention facility
27 shall have a written procedure developed, in consultation with
28 the facility medical provider, establishing conditions under

29 which an inmate will be tested for infectious disease, including
30 human immunodeficiency virus pursuant to s. 775.0877, which
31 procedure is consistent with guidelines of the Centers for
32 Disease Control and Prevention and recommendations of the
33 Correctional Medical Authority. It is not unlawful for the
34 person receiving the test results to divulge the test results to
35 the sheriff or chief correctional officer.
36 (2)(a) The Department of Health shall designate two
37 counties having a population of 1.2 million or more and five
38 counties having a population of fewer than 1.2 million to
39 participate in the testing program provided in this subsection,
40 if participation in the testing program is authorized by a
41 majority of the county's governing body. Each county detention
42 facility that lies within the authority of any participating
43 county shall, consistent with s. 381.004(3), perform an HIV test
44 as defined in s. 381.004(2) on each sentenced inmate who is to
45 be released from the facility unless the facility knows that the
46 inmate is HIV positive or unless, within 120 days before the
47 release date, the inmate has been tested for HIV and does not
48 request retesting. The required test must be performed not less
49 than 30 days before the release date of the inmate. A test is
50 not required under this paragraph if an inmate is released due
51 to an emergency or a court order and the detention facility
52 receives less than 30 days' notice of the release date or if the
53 inmate is transferred to the custody of the Department of
54 Corrections for incarceration in the state correctional system.
55 (b) Each county detention facility in a county that
56 participates in the testing program authorized in paragraph (a)

57 must comply with the requirements of this paragraph. If the
58 county detention facility knows that an inmate who is to be
59 released from the facility is HIV positive or has received a
60 positive HIV test result, that facility shall, before the inmate
61 is released:
62 1. Notify, consistent with s. 381.004(3), the Department
63 of Health and the county health department in the county where
64 the inmate being released plans to reside of the release date
65 and HIV status of the inmate.
66 2. Provide special transitional assistance to the inmate
67 which must include:
68 a. Education on preventing the transmission of HIV to
69 others and on the importance of receiving followup medical care
70 and treatment.
71 b. A written, individualized discharge plan that includes
72 records of all laboratory and diagnostic test results,
73 medication and treatment information, and referrals to and
74 contacts with the county health department and local primary
75 medical care services for the treatment of HIV infection which
76 are available in the area where the inmate plans to reside.
77 (3) ~~(2)~~ Except as otherwise provided in this subsection,
78 serologic blood test results obtained pursuant to subsection (1)
79 or subsection (2) are confidential and exempt from the
80 provisions of s. 119.07(1) and s. 24(a), Art. I of the State
81 Constitution. However, such results may be provided to employees
82 or officers of the sheriff or chief correctional officer who are
83 responsible for the custody and care of the affected inmate and
84 have a need to know such information, and as provided in ss.

85 381.004(3), 775.0877, and 960.003. In addition, upon request of
86 the victim or the victim's legal guardian, or the parent or
87 legal guardian of the victim if the victim is a minor, the
88 results of any HIV test performed on an inmate who has been
89 arrested for any sexual offense involving oral, anal, or vaginal
90 penetration by, or union with, the sexual organ of another,
91 shall be disclosed to the victim or the victim's legal guardian,
92 or to the parent or legal guardian of the victim if the victim
93 is a minor. In such cases, the county or municipal detention
94 facility shall furnish the test results to the Department of
95 Health, which is responsible for disclosing the results to
96 public health agencies as provided in s. 775.0877 and to the
97 victim or the victim's legal guardian, or the parent or legal
98 guardian of the victim if the victim is a minor, as provided in
99 s. 960.003(3).
100 (4) ~~(3)~~ The results of any serologic blood test on an
101 inmate are a part of that inmate's permanent medical file. Upon
102 transfer of the inmate to any other correctional facility, such
103 file is also transferred, and all relevant authorized persons
104 must be notified of positive HIV test results, as required in s.
105 775.0877.
106 (5) Notwithstanding any statute providing for a waiver of
107 sovereign immunity, the state, its agencies, or subdivisions,
108 and employees of the state, its agencies, or subdivisions, are
109 not liable to any person for negligently causing death or
110 personal injury arising out of complying with this section.
111 Section 2. Subsection (3) of section 381.004, Florida
112 Statutes, is amended to read:

113 381.004 HIV testing.--
114 (3) ~~HUMAN IMMUNODEFICIENCY VIRUS TESTING;~~ INFORMED
115 CONSENT; RESULTS; COUNSELING; CONFIDENTIALITY.--
116 (a) No person in this state shall order a test designed to
117 identify the human immunodeficiency virus, or its antigen or
118 antibody, without first obtaining the informed consent of the
119 person upon whom the test is being performed, except as
120 specified in paragraph (h). Informed consent shall be preceded
121 by an explanation of the right to confidential treatment of
122 information identifying the subject of the test and the results
123 of the test to the extent provided by law. Information shall
124 also be provided on the fact that a positive HIV test result
125 will be reported to the county health department with sufficient
126 information to identify the test subject and on the availability
127 and location of sites at which anonymous testing is performed.
128 As required in paragraph (4)(c), each county health department
129 shall maintain a list of sites at which anonymous testing is
130 performed, including the locations, phone numbers, and hours of
131 operation of the sites. Consent need not be in writing provided
132 there is documentation in the medical record that the test has
133 been explained and the consent has been obtained.
134 (b) Except as provided in paragraph (h), informed consent
135 must be obtained from a legal guardian or other person
136 authorized by law when the person:
137 1. Is not competent, is incapacitated, or is otherwise
138 unable to make an informed judgment; or
139 2. Has not reached the age of majority, except as provided
140 in s. 384.30.

141 (c) The person ordering the test or that person's designee
142 shall ensure that all reasonable efforts are made to notify the
143 test subject of his or her test result. Notification of a person
144 with a positive test result shall include information on the
145 availability of appropriate medical and support services, on the
146 importance of notifying partners who may have been exposed, and
147 on preventing transmission of HIV. Notification of a person with
148 a negative test result shall include, as appropriate,
149 information on preventing the transmission of HIV. When testing
150 occurs in a hospital emergency department, detention facility,
151 or other facility and the test subject has been released before
152 being notified of positive test results, informing the county
153 health department for that department to notify the test subject
154 fulfills this responsibility.
155 (d) A positive preliminary test result may not be revealed
156 to any person except in the following situations:
157 1. Preliminary test results may be released to licensed
158 physicians or the medical or nonmedical personnel subject to the
159 significant exposure for purposes of subparagraphs (h)10., 11.,
160 and 12.
161 2. Preliminary test results may be released to health care
162 providers and to the person tested when decisions about medical
163 care or treatment of, or recommendation to, the person tested
164 and, in the case of an intrapartum or postpartum woman, when
165 care, treatment, or recommendations regarding her newborn,
166 cannot await the results of confirmatory testing. Positive
167 preliminary HIV test results may not be characterized to the
168 patient as a diagnosis of HIV infection. Justification for the

169 use of preliminary test results must be documented in the
170 medical record by the health care provider who ordered the test.
171 3. The results of rapid testing technologies shall be
172 considered preliminary and may be released in accordance with
173 the manufacturer's instructions as approved by the federal Food
174 and Drug Administration.
175 4. Corroborating or confirmatory testing must be conducted
176 as followup to a positive preliminary test. Results shall be
177 communicated to the patient according to statute regardless of
178 the outcome. Except as provided in this section, test results
179 are confidential and exempt from the provisions of s. 119.07(1).
180 (e) Except as provided in this section, the identity of
181 any person upon whom a test has been performed and test results
182 are confidential and exempt from the provisions of s. 119.07(1).
183 No person who has obtained or has knowledge of a test result
184 pursuant to this section may disclose or be compelled to
185 disclose the identity of any person upon whom a test is
186 performed, or the results of such a test in a manner which
187 permits identification of the subject of the test, except to the
188 following persons:
189 1. The subject of the test or the subject's legally
190 authorized representative.
191 2. Any person, including third-party payors, designated in
192 a legally effective release of the test results executed prior
193 to or after the test by the subject of the test or the subject's
194 legally authorized representative. The test subject may in
195 writing authorize the disclosure of the test subject's HIV test
196 results to third party payors, who need not be specifically

197 identified, and to other persons to whom the test subject
198 subsequently issues a general release of medical information. A
199 general release without such prior written authorization is not
200 sufficient to release HIV test results.
201 3. An authorized agent or employee of a health facility or
202 health care provider if the health facility or health care
203 provider itself is authorized to obtain the test results, the
204 agent or employee participates in the administration or
205 provision of patient care or handles or processes specimens of
206 body fluids or tissues, and the agent or employee has a need to
207 know such information. The department shall adopt a rule
208 defining which persons have a need to know pursuant to this
209 subparagraph.
210 4. Health care providers consulting between themselves or
211 with health care facilities to determine diagnosis and
212 treatment. For purposes of this subparagraph, health care
213 providers shall include licensed health care professionals
214 employed by or associated with state, county, or municipal
215 detention facilities when such health care professionals are
216 acting exclusively for the purpose of providing diagnoses or
217 treatment of persons in the custody of such facilities.
218 5. The department, in accordance with rules for reporting
219 and controlling the spread of disease, as otherwise provided by
220 state law.
221 6. A health facility or health care provider which
222 procures, processes, distributes, or uses:
223 a. A human body part from a deceased person, with respect
224 to medical information regarding that person; or

225 b. Semen provided prior to July 6, 1988, for the purpose
226 of artificial insemination.
227 7. Health facility staff committees, for the purposes of
228 conducting program monitoring, program evaluation, or service
229 reviews pursuant to chapters 395 and 766.
230 8. Authorized medical or epidemiological researchers who
231 may not further disclose any identifying characteristics or
232 information.
233 9. A person allowed access by a court order which is
234 issued in compliance with the following provisions:
235 a. No court of this state shall issue such order unless
236 the court finds that the person seeking the test results has
237 demonstrated a compelling need for the test results which cannot
238 be accommodated by other means. In assessing compelling need,
239 the court shall weigh the need for disclosure against the
240 privacy interest of the test subject and the public interest
241 which may be disserved by disclosure which deters blood, organ,
242 and semen donation and future human immunodeficiency virus-
243 related testing or which may lead to discrimination. This
244 paragraph shall not apply to blood bank donor records.
245 b. Pleadings pertaining to disclosure of test results
246 shall substitute a pseudonym for the true name of the subject of
247 the test. The disclosure to the parties of the subject's true
248 name shall be communicated confidentially in documents not filed
249 with the court.
250 c. Before granting any such order, the court shall provide
251 the individual whose test result is in question with notice and
252 a reasonable opportunity to participate in the proceedings if he

253 or she is not already a party.
254 d. Court proceedings as to disclosure of test results
255 shall be conducted in camera, unless the subject of the test
256 agrees to a hearing in open court or unless the court determines
257 that a public hearing is necessary to the public interest and
258 the proper administration of justice.
259 e. Upon the issuance of an order to disclose test results,
260 the court shall impose appropriate safeguards against
261 unauthorized disclosure which shall specify the persons who may
262 have access to the information, the purposes for which the
263 information shall be used, and appropriate prohibitions on
264 future disclosure.
265 10. A person allowed access by order of a judge of
266 compensation claims of the Division of Administrative Hearings.
267 A judge of compensation claims shall not issue such order unless
268 he or she finds that the person seeking the test results has
269 demonstrated a compelling need for the test results which cannot
270 be accommodated by other means.
271 11. Those employees of the department or of child-placing
272 or child-caring agencies or of family foster homes, licensed
273 pursuant to s. 409.175, who are directly involved in the
274 placement, care, control, or custody of such test subject and
275 who have a need to know such information; adoptive parents of
276 such test subject; or any adult custodian, any adult relative,
277 or any person responsible for the child's welfare, if the test
278 subject was not tested under subparagraph (b)2. and if a
279 reasonable attempt has been made to locate and inform the legal
280 guardian of a test result. The department shall adopt a rule to

281 implement this subparagraph.
282 12. Those employees of residential facilities or of
283 community-based care programs that care for developmentally
284 disabled persons, pursuant to chapter 393, who are directly
285 involved in the care, control, or custody of such test subject
286 and who have a need to know such information.
287 13. A health care provider involved in the delivery of a
288 child can note the mother's HIV test results in the child's
289 medical record.
290 14. Medical personnel or nonmedical personnel who have
291 been subject to a significant exposure during the course of
292 medical practice or in the performance of professional duties,
293 or individuals who are the subject of the significant exposure
294 as provided in subparagraphs (h)10.-12.
295 15. The medical examiner shall disclose positive HIV test
296 results to the department in accordance with rules for reporting
297 and controlling the spread of disease.
298 (f) Except as provided in this section, the identity of a
299 person upon whom a test has been performed is confidential and
300 exempt from the provisions of s. 119.07(1). No person to whom
301 the results of a test have been disclosed may disclose the test
302 results to another person except as authorized by this
303 subsection and by ss. 951.27 and 960.003. Whenever disclosure is
304 made pursuant to this subsection, it shall be accompanied by a
305 statement in writing which includes the following or
306 substantially similar language: "This information has been
307 disclosed to you from records whose confidentiality is protected
308 by state law. State law prohibits you from making any further

309 disclosure of such information without the specific written
310 consent of the person to whom such information pertains, or as
311 otherwise permitted by state law. A general authorization for
312 the release of medical or other information is NOT sufficient
313 for this purpose." An oral disclosure shall be accompanied by
314 oral notice and followed by a written notice within 10 days,
315 except that this notice shall not be required for disclosures
316 made pursuant to subparagraphs (e)3. and 4.
317 (g) Human immunodeficiency virus test results contained in
318 the medical records of a hospital licensed under chapter 395 may
319 be released in accordance with s. 395.3025 without being subject
320 to the requirements of subparagraph (e)2., subparagraph (e)9.,
321 or paragraph (f); provided the hospital has obtained written
322 informed consent for the HIV test in accordance with provisions
323 of this section.
324 (h) Notwithstanding the provisions of paragraph (a),
325 informed consent is not required:
326 1. When testing for sexually transmissible diseases is
327 required by state or federal law, or by rule including the
328 following situations:
329 a. HIV testing pursuant to s. 796.08 of persons convicted
330 of prostitution or of procuring another to commit prostitution.
331 b. HIV testing of inmates pursuant to s. 945.355 prior to
332 their release from prison by reason of parole, accumulation of
333 gain-time credits, or expiration of sentence.
334 c. Testing for HIV by a medical examiner in accordance
335 with s. 406.11.
336 d. HIV testing of pregnant women pursuant to s. 384.31.

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

337 e. HIV testing of inmates pursuant to s. 951.27 before
338 their release from a county or municipal detention facility.
339 2. Those exceptions provided for blood, plasma, organs,
340 skin, semen, or other human tissue pursuant to s. 381.0041.
341 3. For the performance of an HIV-related test by licensed
342 medical personnel in bona fide medical emergencies when the test
343 results are necessary for medical diagnostic purposes to provide
344 appropriate emergency care or treatment to the person being
345 tested and the patient is unable to consent, as supported by
346 documentation in the medical record. Notification of test
347 results in accordance with paragraph (c) is required.
348 4. For the performance of an HIV-related test by licensed
349 medical personnel for medical diagnosis of acute illness where,
350 in the opinion of the attending physician, obtaining informed
351 consent would be detrimental to the patient, as supported by
352 documentation in the medical record, and the test results are
353 necessary for medical diagnostic purposes to provide appropriate
354 care or treatment to the person being tested. Notification of
355 test results in accordance with paragraph (c) is required if it
356 would not be detrimental to the patient. This subparagraph does
357 not authorize the routine testing of patients for HIV infection
358 without informed consent.
359 5. When HIV testing is performed as part of an autopsy for
360 which consent was obtained pursuant to s. 872.04.
361 6. For the performance of an HIV test upon a defendant
362 pursuant to the victim's request in a prosecution for any type
363 of sexual battery where a blood sample is taken from the
364 defendant voluntarily, pursuant to court order for any purpose,

365 or pursuant to the provisions of s. 775.0877, s. 951.27, or s.
366 960.003; however, the results of any HIV test performed shall be
367 disclosed solely to the victim and the defendant, except as
368 provided in ss. 775.0877, 951.27, and 960.003.
369 7. When an HIV test is mandated by court order.
370 8. For epidemiological research pursuant to s. 381.0032,
371 for research consistent with institutional review boards created
372 by 45 C.F.R. part 46, or for the performance of an HIV-related
373 test for the purpose of research, if the testing is performed in
374 a manner by which the identity of the test subject is not known
375 and may not be retrieved by the researcher.
376 9. When human tissue is collected lawfully without the
377 consent of the donor for corneal removal as authorized by s.
378 765.5185 or enucleation of the eyes as authorized by s. 765.519.
379 10. For the performance of an HIV test upon an individual
380 who comes into contact with medical personnel in such a way that
381 a significant exposure has occurred during the course of
382 employment or within the scope of practice and where a blood
383 sample is available that was taken from that individual
384 voluntarily by medical personnel for other purposes. The term
385 "medical personnel" includes a licensed or certified health care
386 professional; an employee of a health care professional or
387 health care facility; employees of a laboratory licensed under
388 chapter 483; personnel of a blood bank or plasma center; a
389 medical student or other student who is receiving training as a
390 health care professional at a health care facility; and a
391 paramedic or emergency medical technician certified by the
392 department to perform life-support procedures under s. 401.23.

393 a. Prior to performance of an HIV test on a voluntarily
394 obtained blood sample, the individual from whom the blood was
395 obtained shall be requested to consent to the performance of the
396 test and to the release of the results. The individual's refusal
397 to consent and all information concerning the performance of an
398 HIV test and any HIV test result shall be documented only in the
399 medical personnel's record unless the individual gives written
400 consent to entering this information on the individual's medical
401 record.
402 b. Reasonable attempts to locate the individual and to
403 obtain consent shall be made, and all attempts must be
404 documented. If the individual cannot be found, an HIV test may
405 be conducted on the available blood sample. If the individual
406 does not voluntarily consent to the performance of an HIV test,
407 the individual shall be informed that an HIV test will be
408 performed, and counseling shall be furnished as provided in this
409 section. However, HIV testing shall be conducted only after a
410 licensed physician documents, in the medical record of the
411 medical personnel, that there has been a significant exposure
412 and that, in the physician's medical judgment, the information
413 is medically necessary to determine the course of treatment for
414 the medical personnel.
415 c. Costs of any HIV test of a blood sample performed with
416 or without the consent of the individual, as provided in this
417 subparagraph, shall be borne by the medical personnel or the
418 employer of the medical personnel. However, costs of testing or
419 treatment not directly related to the initial HIV tests or costs
420 of subsequent testing or treatment may not be borne by the

421 medical personnel or the employer of the medical personnel.
422 d. In order to utilize the provisions of this
423 subparagraph, the medical personnel must either be tested for
424 HIV pursuant to this section or provide the results of an HIV
425 test taken within 6 months prior to the significant exposure if
426 such test results are negative.
427 e. A person who receives the results of an HIV test
428 pursuant to this subparagraph shall maintain the confidentiality
429 of the information received and of the persons tested. Such
430 confidential information is exempt from s. 119.07(1).
431 f. If the source of the exposure will not voluntarily
432 submit to HIV testing and a blood sample is not available, the
433 medical personnel or the employer of such person acting on
434 behalf of the employee may seek a court order directing the
435 source of the exposure to submit to HIV testing. A sworn
436 statement by a physician licensed under chapter 458 or chapter
437 459 that a significant exposure has occurred and that, in the
438 physician's medical judgment, testing is medically necessary to
439 determine the course of treatment constitutes probable cause for
440 the issuance of an order by the court. The results of the test
441 shall be released to the source of the exposure and to the
442 person who experienced the exposure.
443 11. For the performance of an HIV test upon an individual
444 who comes into contact with medical personnel in such a way that
445 a significant exposure has occurred during the course of
446 employment or within the scope of practice of the medical
447 personnel while the medical personnel provides emergency medical
448 treatment to the individual; or who comes into contact with

449 nonmedical personnel in such a way that a significant exposure
450 has occurred while the nonmedical personnel provides emergency
451 medical assistance during a medical emergency. For the purposes
452 of this subparagraph, a medical emergency means an emergency
453 medical condition outside of a hospital or health care facility
454 that provides physician care. The test may be performed only
455 during the course of treatment for the medical emergency.
456 a. An individual who is capable of providing consent shall
457 be requested to consent to an HIV test prior to the testing. The
458 individual's refusal to consent, and all information concerning
459 the performance of an HIV test and its result, shall be
460 documented only in the medical personnel's record unless the
461 individual gives written consent to entering this information on
462 the individual's medical record.
463 b. HIV testing shall be conducted only after a licensed
464 physician documents, in the medical record of the medical
465 personnel or nonmedical personnel, that there has been a
466 significant exposure and that, in the physician's medical
467 judgment, the information is medically necessary to determine
468 the course of treatment for the medical personnel or nonmedical
469 personnel.
470 c. Costs of any HIV test performed with or without the
471 consent of the individual, as provided in this subparagraph,
472 shall be borne by the medical personnel or the employer of the
473 medical personnel or nonmedical personnel. However, costs of
474 testing or treatment not directly related to the initial HIV
475 tests or costs of subsequent testing or treatment may not be
476 borne by the medical personnel or the employer of the medical

477 personnel or nonmedical personnel.
478 d. In order to utilize the provisions of this
479 subparagraph, the medical personnel or nonmedical personnel
480 shall be tested for HIV pursuant to this section or shall
481 provide the results of an HIV test taken within 6 months prior
482 to the significant exposure if such test results are negative.
483 e. A person who receives the results of an HIV test
484 pursuant to this subparagraph shall maintain the confidentiality
485 of the information received and of the persons tested. Such
486 confidential information is exempt from s. 119.07(1).
487 f. If the source of the exposure will not voluntarily
488 submit to HIV testing and a blood sample was not obtained during
489 treatment for the medical emergency, the medical personnel, the
490 employer of the medical personnel acting on behalf of the
491 employee, or the nonmedical personnel may seek a court order
492 directing the source of the exposure to submit to HIV testing. A
493 sworn statement by a physician licensed under chapter 458 or
494 chapter 459 that a significant exposure has occurred and that,
495 in the physician's medical judgment, testing is medically
496 necessary to determine the course of treatment constitutes
497 probable cause for the issuance of an order by the court. The
498 results of the test shall be released to the source of the
499 exposure and to the person who experienced the exposure.
500 12. For the performance of an HIV test by the medical
501 examiner or attending physician upon an individual who expired
502 or could not be resuscitated while receiving emergency medical
503 assistance or care and who was the source of a significant
504 exposure to medical or nonmedical personnel providing such

505 assistance or care.
506 a. HIV testing may be conducted only after a licensed
507 physician documents in the medical record of the medical
508 personnel or nonmedical personnel that there has been a
509 significant exposure and that, in the physician's medical
510 judgment, the information is medically necessary to determine
511 the course of treatment for the medical personnel or nonmedical
512 personnel.
513 b. Costs of any HIV test performed under this subparagraph
514 may not be charged to the deceased or to the family of the
515 deceased person.
516 c. For the provisions of this subparagraph to be
517 applicable, the medical personnel or nonmedical personnel must
518 be tested for HIV under this section or must provide the results
519 of an HIV test taken within 6 months before the significant
520 exposure if such test results are negative.
521 d. A person who receives the results of an HIV test
522 pursuant to this subparagraph shall comply with paragraph (e).
523 13. For the performance of an HIV-related test medically
524 indicated by licensed medical personnel for medical diagnosis of
525 a hospitalized infant as necessary to provide appropriate care
526 and treatment of the infant when, after a reasonable attempt, a
527 parent cannot be contacted to provide consent. The medical
528 records of the infant shall reflect the reason consent of the
529 parent was not initially obtained. Test results shall be
530 provided to the parent when the parent is located.
531 14. For the performance of HIV testing conducted to
532 monitor the clinical progress of a patient previously diagnosed

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533 to be HIV positive.
534 15. For the performance of repeated HIV testing conducted
535 to monitor possible conversion from a significant exposure.
536 Section 3. This act shall take effect July 1, 2007.

HB 739

House Bill 739
Relating to Impaired Practitioners
By Rep. Holder

- Clarifies Department of Health ("department") rule-making provisions.

- Revises the criteria to qualify as an impaired practitioner consultant.

- Requires the department to provide students of Chapter 456, F.S., health care practitioner programs with impaired practitioner services as contracted by the department. These programs include: allopathic and osteopathic physicians; chiropractors; nurses; pharmacists; dentists; and numerous other medical professions.

- Grants sovereign immunity to an impaired practitioner consultant, its officers, employees, and agents whose actions are pursuant to contracts with the department.

- Requires the Department of Legal Affairs to defend acts performed by impaired practitioner consultants that are within the scope of a contract with the department; and

- Provides an effective date of July 1, 2007.

Fiscal Note
According to the department, portions of the bill will create a fiscal impact of $157,300 annually for additional staffing. An additional $25,000 will be needed for the first two years to pay for marketing efforts to students and programmatic startup costs.

According to the department, costs associated with provisions relating to student coverage in impaired practitioners program are unknown as it is not possible to predict the number of students who would utilize services.

According to the department, the fiscal impact of the language making the consultant, its officers, employees, and agents an agent of the department and requiring the Department Legal Affairs to defend actions against the consultant is unknown, but could be significant.

A bill to be entitled

An act relating to treatment programs for impaired practitioners; amending s. 456.076, F.S.; revising requirements for program consultants; requiring consultants to provide treatment services for all health professions and occupations students alleged to be impaired; providing limited sovereign immunity for certain program consultants; requiring the Department of Legal Affairs to defend actions against program consultants; providing an effective date.

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

Section 1. Subsections (1) and (2) of section 456.076, Florida Statutes, are amended, and subsection (7) is added to that section, to read:

456.076 Treatment programs for impaired practitioners.--

(1) For professions that do not have impaired practitioner programs provided for in their practice acts, the department shall, by rule, designate approved impaired practitioner programs under this section. The department may adopt rules setting forth appropriate criteria for approval of treatment providers. The rules may specify the manner in which the consultant, retained as set forth in subsection (2), works with the department in intervention, requirements for evaluating and treating a professional, and requirements for ~~the~~ continued care and monitoring ~~of a professional~~ by the consultant ~~by an approved treatment provider~~.

29 (2) The department shall retain one or more impaired
30 practitioner consultants. A consultant shall be a licensee under
31 the jurisdiction of the Division of Medical Quality Assurance
32 within the department who~~, and at least one consultant~~ must be a
33 practitioner or recovered practitioner licensed under chapter
34 458, chapter 459, or part I of chapter 464 or an entity that
35 employs a medical director who must be a practitioner or
36 recovered practitioner licensed under chapter 458, chapter 459,
37 or part I of chapter 464. The consultant shall assist the
38 probable cause panel and department in carrying out the
39 responsibilities of this section. This shall include working
40 with department investigators to determine whether a
41 practitioner is, in fact, impaired. The consultant shall also
42 provide, pursuant to contract with the department for
43 appropriate compensation, services for students enrolled in
44 schools for licensure under chapter 456 who are alleged to be
45 impaired as a result of the misuse or abuse of alcohol or drugs,
46 or both, or due to a mental or physical condition.
47 (7)(a) An impaired practitioner consultant, and its
48 officers, employees, and agents, retained pursuant to subsection
49 (2) shall be considered an agent of the department for purposes
50 of s. 768.28, while acting within the scope of its duties under
51 the contract with the department.
52 (b) The Department of Legal Affairs shall defend any
53 claim, suit, action, or proceeding against the consultant or its
54 officers, employees, or agents brought as a result of any act or
55 omission of action of any of its officers, employees, or agents

56 for an act or omission arising out of and in the scope of the
57 consultant's duties under its contract with the department.
58 Section 2. This act shall take effect July 1, 2007.

COUNCIL/COMMITTEE ACTION

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

Council/Committee hearing bill: Health Quality

Representative(s) Holder offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsections (1) and (2) of section 456.076, Florida Statutes, are amended and subsection (7) is added to that section, to read:

456.076 Treatment programs for impaired practitioners.--

(1) For professions that do not have impaired practitioner programs provided for in their practice acts, the department shall, by rule, designate approved impaired practitioner programs under this section. The department may adopt rules setting forth appropriate criteria for approval of treatment providers. The rules may specify the manner in which the consultant, retained as set forth in subsection (2), works with the department in intervention, requirements for evaluating and treating a professional, and requirements for ~~the~~ continued care and monitoring ~~of a professional~~ by the consultant ~~by an approved treatment provider~~.

(2) The department shall retain one or more impaired practitioner consultants. The~~A~~ consultant shall be either a

23 licensee under the jurisdiction of the Division of Medical
24 Quality Assurance within the department who~~, and at least one~~
25 ~~consultant~~ must be a practitioner or recovered practitioner
26 licensed under chapter 458, chapter 459, or part I of chapter
27 464 or an entity that employs a medical director who must be a
28 practitioner or recovered practitioner licensed under chapter
29 458, chapter 459, or part I or chapter 464. The consultant shall
30 assist the probable cause panel and department in carrying out
31 the responsibilities of this section. This shall include working
32 with department investigators to determine whether a
33 practitioner is, in fact, impaired. The department may contract
34 with the consultant, for appropriate compensation, for services
35 to be provided, if requested by the school, for students
36 enrolled in schools for licensees to be licensed under chapter
37 456 who are alleged to be impaired as a result of the misuse or
38 abuse of alcohol or drugs, or both, or due to a mental or
39 physical condition. There shall be no monetary liability on the
40 part of, and no cause of action for damages shall arise against,
41 any such school or its agents or employees for referring
42 students to the consultant retained by the department or for
43 taking actions in reliance of the recommendations, reports or
44 conclusions provided by such consultant, without intentional
45 fraud in carrying out the provisions of this section.
46 (7)(a) An impaired practitioner consultant, and its
47 officers, employees, and agents, retained pursuant to subsection
48 (2) shall be considered an agent of the department for purposes
49 of s. 768.28, while acting within the scope of its duties under
50 the contract with the department.
51 (b) The Department of Legal Affairs shall defend any
52 claim, suit, action or proceeding against the consultant or its
53 officers, employees, or agents brought as a result of any act or

54 omission of action of any of its officers, employees, or agents
55 for an act or omission arising out and in the scope of the
56 consultant's duties under its contract with the department.
57 Section 2. Subsection (13) of section 768.28, Florida
58 Statutes, is created to read:
59 768.28 Waiver of sovereign immunity in tort actions;
60 recovery limits; limitation on attorney fees; statute of
61 limitations; exclusions; indemnification; risk management
62 programs.--
63 (13) If the impaired practitioner consultant retained
64 pursuant to s. 456.076 (2) is retained by any other state
65 agency, the consultant, and its officers, employees, and agents,
66 shall be considered an agent of the State of Florida for the
67 purposes of this section, while acting within the scope of and
68 pursuant to guidelines established in the contract between the
69 impaired practitioner consultant and the state agency.
70 Section 3. This act shall take effect July 1, 2007.

HB 947

House Bill 947
Relating to Cardiology Services
by Rep. Skidmore

- Requires the annual distribution of a list of percutaneous intervention centers in the state by the Department of Health ("department") to the medical director of each licensed emergency medical services ("EMS") provider.
- Requires the department to develop a sample "cardiac triage assessment tool" and requires the use of that tool or its equivalent by each EMS provider.
- Requires the department to use the American Heart Association tool as a model for development of a Florida tool.
- Requires EMS providers to develop and employ cardiac patient protocols.
- Requires the department to develop and deploy technical support, equipment recommendations and training for EMS providers to identify acute ST elevation myocardial infarction patients.
- Requires the department to survey and report on EMS provider performance with regard to application of a "cardiac triage assessment tool".
- Authorizes the department to assist in the acquisition of equipment for use with a "cardiac triage assessment tool".
- Requires the department to facilitate stakeholder meetings regarding the use of a "cardiac triage assessment tool".
- Requires EMS providers to comply with the bill provisions by July 1, 2008.
- Provides an effective date of July 1, 2007.

Fiscal Note
According to the department, they will need to hire 1 FTE who is a licensed registered nurse or certified paramedic to implement the provisions in the bill. The cost is $60,992 for the first year and $ 69, 523 annually thereafter.

1 A bill to be entitled
2 An act relating to cardiology services; providing
3 legislative findings and intent; providing definitions;
4 requiring the Department of Health to create a list of
5 percutaneous intervention centers and distribute the list
6 to emergency medical services providers in the state;
7 directing the department to develop and distribute a
8 sample cardiac triage assessment tool; requiring emergency
9 medical services providers to use a similar assessment
10 tool; requiring licensed emergency medical services
11 providers to develop and use certain specified protocols;
12 providing duties of the department; requiring a report;
13 providing for meetings; requiring compliance by a certain
14 date; providing an effective date.
15
16 WHEREAS, every year, approximately 24,000 people in this
17 state suffer a life-threatening heart attack, one-third of whom
18 die within 24 hours after the attack, and
19 WHEREAS, fewer than 20 percent of heart attack victims
20 receive emergency angioplasty to open blocked arteries, and
21 WHEREAS, studies have shown that individuals suffering a
22 life-threatening heart attack have better outcomes if they
23 receive emergency angioplasty, and
24 WHEREAS, studies have shown that opening a blocked coronary
25 artery with emergency angioplasty within recommended timeframes
26 can effectively prevent or significantly minimize permanent
27 damage to the heart, and
28 WHEREAS, even fewer patients receive the procedure within

29 the timeframe recommended by the American Heart Association, and
30 WHEREAS, damage to the heart muscle can result in death,
31 congestive heart failure, atrial fibrillation, and other chronic
32 diseases of the heart, and
33 WHEREAS, organizations such as the American Heart
34 Association, the American College of Cardiology, and the Florida
35 College of Emergency Physicians recommend deploying protocols
36 and systems to help ensure that people suffering from a life-
37 threatening heart attack receive the latest evidence-based care,
38 such as emergency angioplasty, within recommended timeframes,
39 and
40 WHEREAS, Florida's trauma services system and emergency
41 stroke treatment system have dramatically improved the care
42 provided for individuals suffering from a traumatic injury or a
43 stroke, and
44 WHEREAS, a statewide emergency cardiac system can help
45 ensure that people suffering from a life-threatening heart
46 attack will receive the latest evidence-based care within
47 recommended timeframes, NOW, THEREFORE,
48
49 Be It Enacted by the Legislature of the State of Florida:
50
51 Section 1. Emergency medical services providers; triage
52 and transportation of ST elevation myocardial infarction victims
53 to a percutaneous intervention center; definitions.--
54 (1)(a) The Legislature finds that rapid identification and
55 treatment of serious heart attacks known as ST elevation
56 myocardial infarction according to the latest evidence-based

57 standards can significantly improve outcomes by reducing death
58 and disability by rapidly restoring blood flow to the heart.
59 (b) The Legislature further finds that a strong emergency
60 system to support survival from life-threatening heart attacks
61 is needed in our communities in order to treat victims in a
62 timely manner and to improve the overall care of heart attack
63 victims.
64 (c) Therefore, the Legislature intends to establish a
65 statewide emergency cardiac system to help improve outcomes for
66 individuals suffering from a life-threatening heart attack.
67 (2) As used in this section, the term:
68 (a) "Agency" means the Agency for Health Care
69 Administration.
70 (b) "Department" means the Department of Health.
71 (3) By June 1 of each year, the department shall send a
72 list of the names and addresses of every percutaneous
73 intervention center in the state to the medical director of each
74 licensed emergency medical services provider in the state.
75 (4) The department shall develop a sample cardiac triage
76 assessment tool. The department must post this sample assessment
77 tool on its website and provide a copy of the assessment tool to
78 each licensed emergency medical services provider no later than
79 March 1, 2008. Each licensed medical services provider must use
80 a cardiac triage assessment tool substantially similar to the
81 sample cardiac triage assessment tool provided by the
82 department.
83 (5) The medical director of each licensed emergency
84 medical services provider shall develop and implement

85 assessment, treatment, and transportation protocols for cardiac
86 patients and employ those protocols to assess, treat, and
87 transport cardiac patients to the most appropriate hospital.
88 (6) The department shall develop and provide technical
89 support, equipment recommendations, and necessary training for
90 effective identification of acute ST elevation myocardial
91 infarction patients to the medical directors of each licensed
92 emergency medical services provider. The department shall model
93 the sample cardiac triage assessment tool on the American Heart
94 Association's advanced cardiovascular life support chest pain
95 algorithm for prehospital assessment, triage, and treatment of
96 patients with suspected ST elevation myocardial infarction. The
97 department shall conduct an annual survey of all licensed
98 emergency medical services providers to determine the quality of
99 their equipment, their training requirements, and their
100 performance regarding the practical application of protocols and
101 the identification of acute ST elevation myocardial infarction
102 in the field. The department shall report its survey finding and
103 make the results of the survey available to emergency medical
104 services providers and other stakeholders.
105 (7) The department is encouraged to identify and provide
106 opportunities, partnerships, and resources to secure appropriate
107 equipment for identification of ST elevation myocardial
108 infarction in the field to all licensed emergency medical
109 service providers.
110 (8) The department shall convene stakeholders at least
111 once a year after implementation of the assessment tool to
112 facilitate the sharing of experiences and best practices. The

113 best practices shall be made available on the department's
114 website.
115 (9) Each emergency medical services provider licensed
116 under chapter 401, Florida Statutes, must comply with this
117 section by July 1, 2008.
118 Section 2. This act shall take effect July 1, 2007.

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: Health Quality
2 Representative(s) Skidmore offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Emergency medical services providers; triage and
7 transportation of ST elevation myocardial infarction victims to
8 a percutaneous intervention center; definitions.--
9 (1)(a) The Legislature finds that rapid identification and
10 treatment of serious heart attacks known as ST elevation
11 myocardial infarction according to the latest evidence-based
12 standards can significantly improve outcomes by reducing death
13 and disability by rapidly restoring blood flow to the heart.
14 (b) The Legislature further finds that a strong emergency
15 system to support survival from life-threatening heart attacks
16 is needed in our communities in order to treat victims in a
17 timely manner and to improve the overall care of heart attack
18 victims.
19 (c) Therefore, the Legislature intends to establish a
20 statewide emergency cardiac system to help improve outcomes for
21 individuals suffering from a life-threatening heart attack.
22 (2) As used in this section, the term:

23 (a) "Agency" means the Agency for Health Care
24 Administration.
25 (b) "Department" means the Department of Health.
26 (c) "Percutaneous Intervention Center" means a provider of
27 adult interventional cardiology services licensed by the Agency
28 pursuant to s. 408.0361.
29 (3) By December 1, 2007 or six months following the
30 Agency's certification of Percutaneous Coronary Intervention
31 Centers or whichever is later, and June 1 of each year
32 thereafter, the department shall send a list of the names and
33 addresses of every percutaneous intervention center licensed by
34 the Agency to each licensed emergency medical services provider
35 in the state.
36 (4) The department shall develop sample cardiac triage
37 assessment criteria. The department must post this sample
38 assessment criteria on its website and provide a copy of the
39 assessment criteria to each licensed emergency medical services
40 provider and emergency medical director no later than December
41 1, 2007 or six months following the Agency's certification of
42 Percutaneous Coronary Intervention Centers or whichever is
43 later. Each licensed medical services provider must use cardiac
44 triage assessment criteria substantially similar to the sample
45 cardiac triage assessment criteria provided by the department.
46 (5) The medical director of each licensed emergency medical
47 services provider shall develop and implement assessment,
48 treatment, and transportation protocols for cardiac patients and
49 employ those protocols to assess, treat, and transport cardiac
50 patients to the most appropriate hospital.
51 (6) The department shall develop and provide technical
52 support and equipment and training recommendations for effective
53 identification of acute ST elevation myocardial infarction

54 patients to each licensed emergency medical services provider
55 and emergency medical services director. The department shall
56 model the sample cardiac triage assessment criteria on the
57 American Heart Association's advanced cardiovascular life
58 support chest pain algorithm for prehospital assessment, triage,
59 and treatment of patients with suspected ST elevation myocardial
60 infarction or a substantially similar program or programs with
61 evidence based guidelines. The department shall conduct biennial
62 surveys of all applicable licensed emergency medical services
63 providers to determine the quality of their equipment, their
64 training requirements, and their performance regarding the
65 practical application of protocols and the identification of
66 acute ST elevation myocardial infarction in the field. The
67 department shall report its survey findings and provide a copy
68 of the survey to emergency medical services providers and
69 emergency medical services directors and to other stakeholders.
70 (7) The department is encouraged to identify and provide
71 opportunities, partnerships, and resources to secure appropriate
72 equipment for identification of ST elevation myocardial
73 infarction in the field to all licensed emergency medical
74 service providers.
75 (8) The department shall convene stakeholders at least once
76 a year, if necessary after implementation of the assessment
77 criteria to facilitate the sharing of experiences and best
78 practices. The best practices shall be made available on the
79 department's website.
80 (9) Each emergency medical services provider licensed under
81 chapter 401, Florida Statutes, must comply with this section by
82 either July 1, 2008 or six months following the receipt of the
83 list of percutaneous intervention centers or whichever is later.
84 Section 2. This act shall take effect July 1, 2007.

85
86 ================ T I T L E A M E N D M E N T ================
87 Remove the entire title and insert:
88 A bill to be entitled
89 An act relating to cardiology services; providing
90 legislative findings and intent; providing definitions;
91 requiring the Department of Health to distribute the list
92 of percutaneous intervention centers to emergency medical
93 services providers and emergency medical service directors
94 in the state; directing the department to develop and
95 distribute a sample cardiac triage assessment criteria;
96 requiring emergency medical services providers to use
97 similar assessment criteria; requiring licensed emergency
98 medical services providers to develop and use certain
99 specified protocols; providing duties of the department;
100 requiring a report; providing for meetings; requiring
101 compliance by a certain date; providing an effective date.
102
103 WHEREAS, every year, approximately 24,000 people in this
104 state suffer a life-threatening heart attack, one-third of whom
105 die within 24 hours after the attack, and
106 WHEREAS, fewer than 20 percent of heart attack victims
107 receive emergency angioplasty to open blocked arteries, and
108 WHEREAS, studies have shown that individuals suffering a
109 life-threatening heart attack have better outcomes if they
110 receive timely emergency angioplasty, and
111 WHEREAS, studies have shown that opening a blocked coronary
112 artery with emergency angioplasty within recommended timeframes
113 can effectively prevent or significantly minimize permanent
114 damage to the heart, and

115 WHEREAS, even fewer patients receive the procedure within
116 the timeframe recommended by the American Heart Association, and
117 WHEREAS, damage to the heart muscle can result in death,
118 congestive heart failure, atrial fibrillation, and other chronic
119 diseases of the heart, and
120 WHEREAS, organizations such as the American Heart
121 Association, the American College of Cardiology, and the Florida
122 Association of Emergency Services Medical Directors recommend
123 deploying protocols and systems to help ensure that people
124 suffering from a life threatening heart attack receive the
125 latest evidence-based care, such as emergency angioplasty,
126 within recommended timeframes, and
127 WHEREAS, Florida's trauma services system and emergency
128 stroke treatment system have dramatically improved the care
129 provided for individuals suffering from a traumatic injury or a
130 stroke, and
131 WHEREAS, a statewide emergency cardiac system can help
132 ensure that people suffering from a life-threatening heart
133 attack will receive the latest evidence-based care within
134 recommended timeframes, NOW, THEREFORE,

DOH
Information Technology

Florida Department of Health

Information Technology

Legislative Budget Requests

2007-08

Kit Goodner, Bureau Chief – Application Development & Support

2007- 08 Budget Requests
Information Technology

Issue	Amount	Funding Source
<u>Ongoing IT Support Costs</u> • Includes resources necessary to provide support for over 17,000 users • Includes $832,000 primarily for infrastructure hardware refresh • Includes $2.8 million for staff augmentation necessary to support applications	**$4,789,824** **-0- FTE**	**Recurring Administrative Trust Fund**

2007- 08 Budget Requests

Improving Health Infrastructure

Issue	Amount	Funding Source
CMS (Children's Medical Services) Infrastructure Development Project •Foundation for creation of virtual statewide HMO/PPO operations •Will replace the current data processing system •Will support electronic file imaging, provider databases and client eligibility data	**$1,814,400** **-0- FTE**	**Non-recurring Maternal & Child Health Block Grant Trust Fund**
SPIN (Statewide Pharmacy Inventory Network) • Replacement for the supply inventory management system (SIMS) which is hosted and supported by the Department of Children and Families • Integration with the statewide Health Management System	**$1,800,000** **-0- FTE**	**Non-recurring Administrative Trust Fund**

2007- 08 Budget Requests

Improving Health Infrastructure

Issue	Amount	Funding Source
EMSTARS – Trauma Projects • Emergency Medical Services Tracking and Reporting System • Develops a centralized database for collecting, analyzing and reporting pre-hospital data	**$483,957** **-0- FTE**	**Non-recurring Emergency Medical Services Trust Fund**
Vital Statistics Electronic Death Registration • Web-based, paperless system • Housed in hospitals, funeral homes and hospice facilities	**$726,541** **-0- FTE**	**Non-recurring Planning & Evaluation Trust Fund**

2007- 08 Budget Requests

Improving Health Infrastructure

Issue	Amount	Funding Source
Vital Statistics Electronic Birth Registration • Web-based paperless system • Housed in 120 hospitals, birthing facilities • Should realize annual savings of $300,000 in labor costs	**$227,150** **-0- FTE**	**Non-recurring Planning & Evaluation Trust Fund**
FDENS (Florida Department of Health Emergency Notification System) • Supports 24/7 notification and alerting of public health professionals during emergencies • Florida's implementation of the federal Centers for Disease Control Health Alert Network system	**$362,974** **1 FTE**	**Recurring Administrative Trust Fund**

Q & A

CMS Transformation Grant GenRx Expansion Project

Sybil M. Richard
Assistant Deputy Secretary
for Medicaid Operations

Presented to the House Health Quality Committee
March 13, 2007

Transformation Grant

- In the Deficit Reduction Act of 2005 (DRA), Congress Approved a total of $150 million for Medicaid Transformation Grants
- In July 2006 CMS announced grant funding for projects to "Transform" healthcare
- Permissible use of Federal Funds include:
  - Emphasis on increasing generic drug utilization
  - Enhancing patient safety through the use of technology (e-prescribing, EMR … ect.)

Transformation Grant

- Florida Medicaid submitted the GenRx Expansion Proposal on October 1, 2006
- January 25th, 2007 CMS Awarded a total of $103 million to 27 states to fund implementation of new ways to improve Medicaid efficiency, economy and quality
- Florida Medicaid received a 2 year, $1.73 million grant to implement the GenRx Expansion Project

Vision

- Promote e-prescribing via eMPowerRx
- Provide 10 day generic starter pak
- Increase utilization of generic medications
- Promote recruitment and retention of Medicaid Providers
- Improve patient outcomes with more direct contact with clinical pharmacists

Scope

- Year One
  - Implement Dispensing Practitioners
  - Enhance Academic Detailing messages to include generic sampling
- Year Two
  - Full integration of new message in traditional Academic Detailing model
  - Focused presence in clinics
  - Disease Management/Document Outcomes

Goals

- Enroll 300 to 600 prescribers as dispensing practitioners
- Establish over 100 practice sites as Medicaid Pharmacy Providers
- Train office staff and medical personnel in appropriate dispensing practices
- Increase e-prescriptions from 2% to 10%
- Increase average generic utilization in select drug categories from 27% to 50%

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Why?

- Generic “samples” offset additional dispensing costs
- Compensate the prescriber for extra effort
- Patient satisfaction – One stop shopping
- Enhanced skill set for Academic Detailers

Year One

Prescriber's Office

Office Medical Record

Patient

Dispensing Prescriber

Rx Claims
PDL
Drug-Drug Interactions

e-Prescription

Local Pharmacy

10 day Starter Pak

GenRx

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Initial Encounter

- Creation of Face Sheet
  - Patient Demographics
  - Medication History past 6 months
  - Procedures & ICD-9 Codes 2 years
- Patient Eligible for Office Dispensing

Office Medical Record

Patient

Dispensing Prescriber

GenRx

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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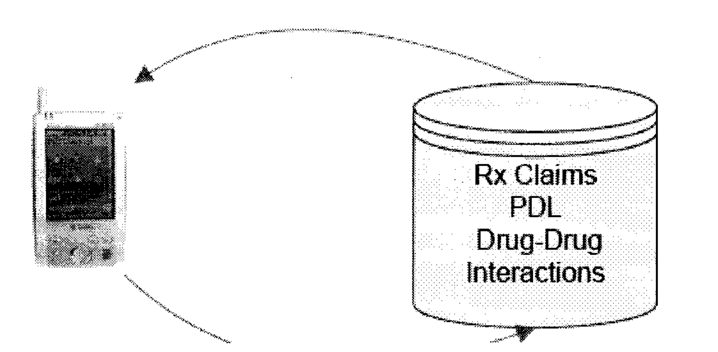
Prescribing Encounter

- Review medication profile & compliance issues
- New medication needed
  - Clinical Pharmacology Assistance
  - Florida Medicaid Formulary/Plan Limits
- Patient desires 10 day Starter Pak

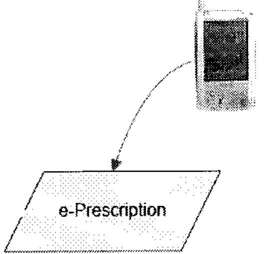
Dispensing Prescriber



GenRx

Heritage Hand-Off

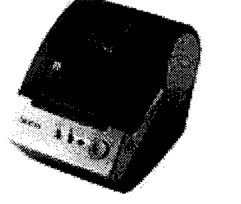
- Empowerx sends transaction to Heritage Info Systems
  - Smart PA Rules
    - Validates Prescriber's own script
    - Blocks ProDUR edits
    - Sends claim to ACS for payment
    - Sends Labels back to Prescriber's Office

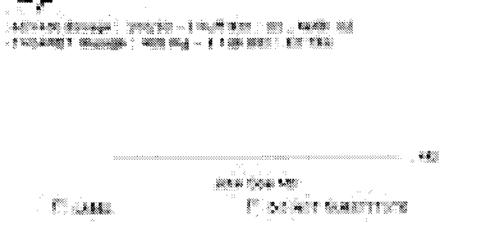


GenRx

Back at the Office

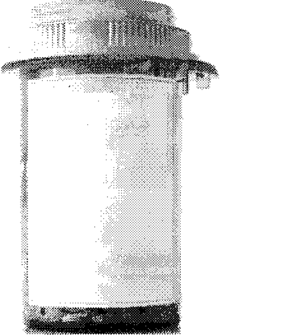
- Duplicate Prescription Labels Printed
  - Signal to build prescription
    - Duplicate Label becomes script to be signed
    - Script added to daily dispensing log

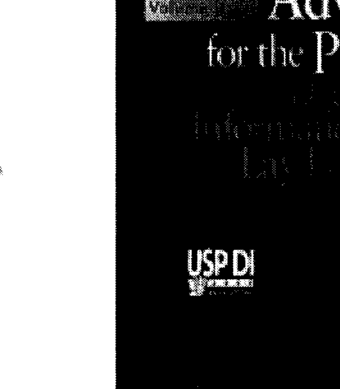




Prescription Building

- Pre-packed medications have duplicate labels
  - Tear-off label attached to script
  - OBRA 90 medication instructions selected
  - Meds/Script/Instructions back to prescriber





GenRx

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Prescriber Hand-Off

- Prescriber's Role
  - Checks medication label against script
  - Hands medication/instructions to patient
  - Offers to counsel

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Patient Follow-Up

- Patient stops at front desk
  - Obtains new appointment
  - Receives discharge instructions
  - Designates local pharmacy where refills are to be sent

GenR$_X$

Area Pharmacist's Role

- Selection of Prescribers as Medicaid Rx Providers
- Development of Business Plan for Prescriber
- Setup and implementation of dispensing functions
- Train Office staff & Medical personnel
- Communication bridge between vendors and prescriber
- Follow-up and problem resolution

Area Pharmacist's Role

FLORIDA MEDICAID

Communication bridge between vendors and prescribers

Prescriber

Office Staff

Pharmacist

CyberAccess

AmPowerRx

RepakRx.com
Customized Pharmaceutical Packaging

AHCA

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GenRx

Year Two

- Full integration of new message in traditional Academic Detailing model
- Area Pharmacist remains in clinic one day a week
  - Disease Management
    - Dyslipidemia
    - Diabetes
    - Hypertension
  - Compare Outcomes between clinic patients and patients receiving only Academic Detailing chart reminders

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Questions